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IEC STRATEGY PLAN
FOR USAID ASSISTANCE IN
FAMILY PLANNING,
MATERNAL CHILD HEALTH,
AND POLICY COMMUNICATION

1994 - 1999

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ACRONYMS

AES	Animateur d'Education Sanitaire
AIDSCOM	Communication project for Aids
CDD	Control of Diarrheal Disease
CRS	Catholic Relief Services
DES	Division d'Education Sanitaire
DPES	Direction de la Prevention et de l'Encadrement Sanitaire
FP	Family Planning
IEC	Information, Education, Communication
INAS	Institut National d'Administration Sanitaire
KAP	Knowledge, Attitude, and Practices
MCH	Maternal and Child Health
MIS	Medical Information System
MSP	Ministère de la Santé Publique
ORS/ORT	Oral rehydration solution/therapy
RTM	Radio, Television Marocaine (state radio and TV)
SCPF	Service Central de Planification Familiale
SEATS	Services Expansion and Technical Support
SMI	Santé Maternelle et Infantile (MCH)
TOT	Training of Trainers
TQM	Total Quality Management
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
VDMS	Visites à Domicile de Motivation Systematique
WHO	World Health Organization

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EXECUTIVE SUMMARY

USAID has invested over \$50 million in family planning and maternal and child health (FP/MCH) in Morocco in the past 15 years in a series of four projects done in collaboration with the Government of Morocco (GOM). USAID is now in the planning phase of its fifth and perhaps final, major FP/MCH bilateral project in Morocco--to span the years 1994-1999.

In November, 1992, a four member team of consultants reviewed documents, met with Ministry of Public Health (MSP) staff, USAID health and population officers and other key actors in Rabat and two provinces, to design a strategy to guide USAID's funding of the IEC component of the expanded FP/MCH project. USAID has chosen to focus most of its IEC support on five specific health sectors, of which family planning is highest priority, over the next six years:

- Family planning
- Diarrheal disease control
- Safe motherhood
- Breastfeeding
- AIDS.

This report describes the team's recommendations to USAID for an IEC strategy to:

- a) increase demand for and quality of FP/MCH services through more effective IEC programs,
- b) strengthen the MSP's capacity at the central and provincial levels to produce and manage sustainable IEC programs through both interpersonal and mass media channels, and
- c) through a policy communication component, to prepare the GOM to assume financial responsibility for FP programs by the end of the decade as well as to initiate policy changes to support a strong IEC initiative in FP/MCH.

Over the past 15 years, health trends in Morocco have been mostly positive: total fertility and mortality of infants and children have declined, vaccination coverage and contraceptive prevalence have increased, and compared to other African nations, Morocco reports few cases of AIDS. Nevertheless, there is much work yet to be done to improve the quality of health care to mothers and children, to increase the use of effective preventive practices among parents and pregnant women, and increase the use of modern methods of contraception. It is in this context that USAID developed the above objectives for an intense IEC initiative until 1999. The following is a brief description of the IEC strategy the team recommends.

In order to **strengthen the Ministry of Public Health's (MSP) capacity to produce and manage quality IEC programs**, USAID should work with the Division de l'Education Sanitaire (DES) and other divisions of the Direction de la Prevention et de l'Encadrement Sanitaire (DPES) to develop a strong provincial interpersonal education program in four to five pilot areas. This program would be backed up by regional radio programming specifically designed to reach

isolated rural populations. Through technical assistance and training, the DES would be prepared to provide technical services to the DPES in three key IEC areas--pretesting, formative research, and monitoring and evaluation.

A key aspect of USAID's support to **family planning** is to foster the coordination of the Ministry's work with that of the various PVOs and other organizations implicated in FP IEC efforts in Morocco. Through the involvement of these public and private sector organizations, the team recommends prioritizing the following activities to increase demand for family planning services and to promote behavior change in target audiences: interpersonal communication training for front-line health and family planning workers, production of appropriate visual and teaching aids for clinic-based and outreach workers, production of IEC materials for clients and potential clients, and initiating a mass media effort to support the ground level IEC activities at the national and provincial levels.

To promote a shift in FP method mix from temporary to long-lasting and permanent methods, the team recommends special training in long-term method counseling for health professionals in hospitals, "maternites", and private sector clinics; production of print materials, visual aids and mass media programming emphasizing long-term methods; and IEC training for VDMS and other outreach workers emphasizing referral of potential clients. In order to promote a shift from public to private sector delivery of services and products, the recommended strategy is to promote pharmacists and private physicians as FP service providers and reinforce AMPF's capacity as a provider of FP IEC and services.

Three areas in MCH are included in the IEC strategy. All of these, along with much of the work in FP, would be carried out in the context of the strengthened provincial IEC program carried out by the DES and described in chapter 1. In **diarrheal disease control**, the first step is to document more closely through research, the current quality of health workers' interpersonal communication and the current practices and beliefs of mothers concerning the home treatment of diarrhea and the mixing of oral rehydration solution. Based on these results, health worker training, radio messages, and teaching aides can be more effectively designed. These activities would be carried out largely in the four to five pilot areas mentioned above. USAID should also support a second wave of research to evaluate the impact of these initial efforts in order to modify the program and update radio messages.

In **safe motherhood**, much still needs to be learned about women's practices and beliefs concerning pregnancy and birthing. The team therefore recommends research to supplement existing studies in order to focus IEC efforts most effectively. A large proportion of both urban and rural women give birth without medically trained attendants. Regional radio, traditional birth attendants, and foyers feminin are channels recommended to reach women a) to increase their use of MCH services where available, and b) to help them avoid high risk pregnancies and change harmful practices during pregnancy and childbirth, especially for women who cannot access health facilities.

In **breastfeeding**, small qualitative studies need to be done on the constraints to breastfeeding of selected target audiences. (Excellent survey research already exists.) Following support of selected IEC activities in the current IEC action plan for breastfeeding, USAID should fund evaluation research to validate the impact of IEC efforts on women's and health professionals' practices. Breastfeeding spots can also be incorporated into the regional radio programs mentioned earlier.

In **AIDS**, the team recommends that USAID focus its investment in reaching three specific groups of the population of which the first two have priority: selected high risk groups such as prison populations, prostitutes, and the military; youth of both sexes; and lastly, through clinic visits, women can be reached about their perceived risk and the most appropriate contraceptive for their risk group. USAID support would help the Programme National de la Lutte contre le SIDA, charged with the MSP's IEC efforts in AIDS, carry out a communication program with some of the populations mentioned above: formative research, program and materials design, pretesting, monitoring and evaluation. The team recommends that USAID focus its support on reaching selected target audiences rather than supporting efforts to "sensibiliser le grand public".

Lastly, although the GOM has recognized the importance of slowing rapid population growth in each five-year plan since the mid 1970's, and has successfully integrated family planning into its MCH services, significant **policy issues** remain. These issues are specific to USAID's objectives for its final phase of family planning in Morocco, objectives aimed at leaving in place by the end of the decade a sustainable, high-quality FP/MCH program.

The strategy to achieve policy objectives mentioned earlier (see item c above) is two-pronged. The first consists of an outreach program to community, provincial and national leaders to build their support for increased government funding of population and FP programs. Activities will include targeted distribution of written and audiovisual materials; workshops, seminars, including RAPID and storyboard presentations; and a program of collaboration with the media. The second part consists of policy dialogue at high levels to deal with the most sensitive issues. It also includes provision of technical assistance to the MSP to facilitate a two-way communication with its provincial and interministerial colleagues on the need for and implementation of the proposed changes.

In following these recommendations, USAID would be reinforcing an IEC infrastructure already in place, but one that needs clearer terms of reference, better management and coordination, and better use of IEC methodology to produce well-focused programs. The team believes that sustainable behavior change through IEC programs is best achieved through addressing these systems issues as well as by supporting the production of effective IEC materials and messages.

INTRODUCTION TO USAID'S IEC STRATEGY PLAN

In Morocco, USAID has invested over \$50 million in family planning (FP) and maternal and child health (MCH) over the past 15 years in a series of four projects done in collaboration with the GOM. USAID is now in the planning phase of its fifth and perhaps final, major FP/MCH bilateral project in Morocco--to span the years 1994-1999.

The Moroccan health situation and USAID's role in FP and MCH over those 15 years have been well described in previous reports, most notably: "Evaluation of A.I.D. Child Survival Programs: Morocco Case Study" (Dec., 1991), "Morocco, Implementation Plan for USAID Assistance in Population and Health, 1992-1996" (May, 1992), and the Demographic and Health Survey (DHS) preliminary report, "Enquete Nationale Sur la Population Et la Santé au Maroc, 1992."

The new project can build upon several positive health trends which the above reports have described. For example:

- contraceptive prevalence in Morocco has increased from approximately 20% in 1979 to 42% in 1992,
- total fertility has declined from 5.9 in 1979 to 4.2 in 1992,
- vaccination coverage has increased from 40-50% in 1985 to over 70% in 1989 (fully documented),
- mortality of children age 1-4 has decreased from an estimated 77 per 1000 in the early 1970s to 20 in 1992,
- infant mortality has declined from an estimated 122 per 1000 live births in the early 1970s to 57 in 1992, and
- from 1986-1992 there have been only 121 reported cases of AIDS.

Despite these encouraging results, the 1992 DHS indicated several areas where both program development and donor support are still needed. For example, programs need to focus on satisfying unmet contraceptive need (31% of women who said they want to end or delay child bearing are not yet contracepting), increasing attended deliveries during child birth (only 31% of deliveries nation-wide are attended by medical practitioners) and increasing the number of women receiving prenatal care (only 32% of pregnant women receive modern prenatal care).

Improving the quality of services also needs attention. The range of contraceptive choices needs to be expanded and promoted. Currently, oral contraceptives represent 80% of the modern

methods utilized. One of the cornerstones of child survival technologies, oral rehydration therapy to combat dehydration during diarrhea, was reportedly used in only 16% of recent cases of diarrhea (DHS, 1992). The lack of integrated interpersonal and media based IEC programs to support service delivery efforts at the provincial level has also been noted despite an active FP/MCH outreach program and a well-developed and broad-reaching radio and television system throughout Morocco.

The major activities proposed in "Morocco, Implementation Plan for USAID Assistance in Population and Health, 1992-1996" are to:

- Prepare the Ministry of Public Health (MSP) to assume responsibility for contraceptive procurement,
- Test alternative approaches to outreach,
- Expand prenatal and postpartum services,
- Implement an Information, Education and Communication (IEC) initiative,
- Improve service delivery quality in FP/MCH,
- Improve management systems in FP/MCH programs,
- Strengthen MSP institutional capabilities,
- Stimulate increased private sector involvement, and
- Support research and evaluation.

In November, 1992, a four member team of consultants met with MSP staff, USAID health and population officers and other key actors in Morocco to design a strategy to guide USAID's funding of the IEC component of the expanded FP/MCH project. The IEC strategy also includes a policy communication component, largely to prepare the GOM to assume financial responsibility for this program by the end of the decade as well as to support a strong IEC initiative in FP.

This report therefore describes the team's recommendations to USAID for an IEC strategy to a) increase both the demand for and quality of FP/MCH services through more effective IEC programs, b) to strengthen the MSP's capacity at the central and provincial levels to produce and manage sustainable IEC programs through both interpersonal and media channels, and c) to build a consensus among policy makers for increased GOM support for FP programs and to address policy obstacles to IEC in FP/MCH. The proposed IEC strategy is therefore closely linked to the general FP/MCH activities outlined above. This linkage is critical because an adequately functioning health care delivery system is the backdrop for much IEC programming in Morocco.

For example, the development of adequate prenatal services accessible to most women must go hand in hand with the promotion of those services over the radio. How patient flow and referral are handled at health facilities directly affects the amount of time available for and the content and quality of health worker/mother interactions. Thus, improvements in areas such as program management, health worker performance, and clinic and outreach services are important to sustain changes in health behavior achieved through communication.

Information, Education and Communication Context

Despite the improvements in maternal and child health and family planning noted above, the IEC component has not yet achieved the effectiveness nor the visibility of the service delivery component. Despite some successes, such as the mobilization of populations for vaccination campaigns, and the *Protex* condom social marketing campaign, IEC has not reached its full potential for helping people change their health behaviors and for stimulating demand for FP/MCH services.

The IEC strategy design team assessed the current state of IEC capacity and programs in the MSP as well as with its current and potential partners. It has identified the following general strengths and weaknesses. A more detailed analysis of the IEC situation is included in each of the report's chapters.

1. The MSP maintains a large Division de l'Education pour la Santé (DES) in the Direction de la Prevention et de l'Encadrement Sanitaire. Despite a sizeable permanent staff and a mandate to produce the Ministry's IEC outputs, the well-equipped DES seldom gets budgets of its own for major FP/MCH programs. Instead, the vertical health programs use funds available to them from various donors to develop their own communication programs--rarely relying on input from the DES. They prefer to sidestep the DES--which has some credibility problems within the Ministry--and deal directly with advertising agencies.
2. Health communication programs appear to be driven by outputs, rather than by objectives. IEC activities are not part of a systematic development process where quantifiable objectives are set, and messages and audience selection are based on some formative research. In addition, pre-testing of messages and materials is usually skipped, and impact evaluation has rarely been done.
3. There is insufficient support from the central level MSP for communication efforts in the rural areas. The DES has yet to take on a viable coordinating and supportive role with the health education "animateurs" working in the 60 provinces and prefectures in Morocco. Monitoring visits by DES staff to provide technical assistance, encouragement, and IEC materials are infrequent. By a number of accounts, visual and teaching aids are inadequate or in insufficient quantity.

4. The broadcast media infrastructure is highly developed in Morocco. State radio and television--through la Radio-Télévision Marocaine (RTM)--cover the entire country. Regional stations allow for the production of local programming aimed at specific audiences. In addition, Morocco has a private radio and television station. Penetration of the mass media is high: in the 1992 DHS, almost 90 percent of urban households and 80 percent of rural households reported owning a radio receiver, while 85 percent of urban areas reported owning a television set, 33 percent in rural sectors.
5. The full potential of broadcast media has not been exploited with creative, informative programming aimed at specific target audiences. Much of the current programming consists of panel discussions or interviews with health specialists who have not necessarily mastered the art of conveying health information in easy-to-understand language. Other types of programs use messages that often come across as unfocused and impersonal, and lack strong motivational arguments or call-to-action messages.
6. In addition to the content of programs, the DPES seldom plans with the broadcast media to create a variety of well-sequenced health and family planning programs and spots to be aired at regular times year-round.
7. Although competent private advertising and marketing firms have often taken on the production of IEC materials for the MSP, they usually do not conduct the research and pre-testing critical to the effective promotion of health behaviors. While the technical quality of materials is often high, whether they are suited to a particular target audience's needs remains questionable.
8. Advertising agencies and mass media time are expensive in Morocco (See Annex A for unit prices), which calls into question the cost effectiveness of these means of communication. In addition, the 19 percent Value Added Tax is sometimes added to the production costs of IEC materials and whether it should be applied to government sponsored IEC materials needs clarification.

Significant policy issues must also be addressed as USAID prepares to wind down and then terminate its large-scale funding for integrated FP/MCH. These policy issues are associated with each of USAID's objectives for the final stage of its funding, objectives aimed at leaving in place a sustainable, high-quality program: transferring substantial financial responsibility (with particular reference to commodities) to the GOM, implementing a shift to long-term methods, expanding the role of the private sector, and strengthening the IEC program (and its institutional base) to increase demand and promote desired behavior changes. The level of commitment needed to support a primarily GOM-financed family planning program is much higher than that called for under the current situation, characterized by major USAID support. A lack of information about Morocco-specific population dynamics -- the future numbers of women to be served -- and of the critical "turning-point" stage of the family planning program may leave many leaders unaware that fertility may plateau without the significant shifts in strategy proposed by USAID. In addition, the desired programmatic changes call for consensus-building, official

approvals, implementation plans, and promulgation of the new policies and both the central and provincial levels of the MSP. In particular, the budgetary shift to the GOM -- and concomitant need for greater private sector involvement -- requires sensitive policy dialogue and technical assistance for planning.

Recommended IEC Strategy

Against this backdrop of opportunities and constraints, the strategy that follows proposes options among IEC activities to meet a number of major communication objectives. USAID has chosen to focus most of its IEC support on five specific health sectors over the next six years, with FP as the highest priority:

- . Family planning
- . Diarrheal disease control
- . Safe motherhood
- . Breastfeeding
- . AIDS

These health sectors have been chosen as much for the urgent attention they require, as for the synergy a coordinated communication effort in these sectors can create.

While it is understood that IEC alone cannot effect health changes--and that upgrading skills, the quality of services and facilities are prerequisites--a strong IEC effort is essential, if Morocco's FP/MCH program is to meet the major public health challenges ahead. The proposed IEC strategy can help USAID achieve its objectives in the following areas:

Priority FP/MCH Sectors

1. Reaching people in the rural areas. Most of the FP/MCH gains have been achieved in the cities and, to some degree, in the periurban areas. Rural populations--where health services and communications are limited--still lag much behind in virtually all health indicators.
2. Increasing the demand for FP/MCH services in areas where they are available and adequate. These services, even when available, are not being fully used.
3. Increasing the integration of services and FP/MCH counseling at the time of client contact. Many opportunities to treat other FP/MCH problems and to give instruction for preventive measures or home treatments are missed because of the actual vertical nature of delivery systems and IEC programs, despite of their seeming "integration" at the provincial level in terms of site and staff.

4. Shifting some of the burden of health care to the private sector. The MSP currently provides FP/MCH services to 75-80 per cent of the population free of charge. The GOM recognizes that the private sector should play a larger role.
5. Increasing the use of long-term family planning methods. Currently, about 80 percent of family planning adopters use oral contraceptives, a temporary method which is expensive for the MSP to deliver and to maintain compliance among users.
6. Increase the use of condoms and other preventive practices among groups at high risk for contracting AIDS.

Strengthening Institutional Capacity

7. Increasing the capacity of the MSP to plan, produce and manage effective IEC programs at both the central and provincial levels.

Policy Communication

8. Promoting selected FP/MCH policy changes through a structured communication program with decision makers at the central and provincial levels. The MSP will be assisted in building consensus for new objectives such as a shift to long-term FP methods or changes in regulations governing ORS packet distribution.
9. Increasing the commitment of provincial and central leaders to support the GOM's assumption of financial responsibility for an integrated family planning program.

These objectives will be met through the strategies described in the chapters that follow. The mechanism by which these strategies will be implemented will largely be through a stronger provincial interpersonal communication program coordinated by the local health education "animateurs" and the central DES. The program will also be supported with comprehensive national and regional radio programming specifically designed to reach out-lying rural populations. At the central level, the DES will be strengthened in its pretesting, formative research and evaluation research capacity to better assist the vertical program areas develop effective communication programs. Policy changes necessary to support positive family planning and maternal and child health practices will be promoted through publications, broadcast media, seminars and policy dialogue.

CHAPTER 1

INSTITUTIONAL CAPACITY BUILDING WITHIN THE MINISTRY OF PUBLIC HEALTH

The Division d'Education Sanitaire (DES) is responsible for health education activities within the Direction de la Prevention et de l'Encadrement Sanitaire (DPES). However, due to historical precedents - most importantly the vertical structure of the Ministry of Public Health (MSP) and the donor programs which have supported it - most of the central health education activities of the country are carried out not by the DES but by the technical divisions of the DPES.

However, the Ministry of Public Health and USAID, recognizing the importance of integration both at the national and provincial levels, acknowledging the importance of a single, specialized agency with staff trained in the many procedural elements of IEC, wish to strengthen the DES.

A strong DES can play a leadership role in many areas. It can help to restructure and revitalize the provincial health IEC program, a program with a solid infrastructure and innovative programs, but suffering from a lack of direction and inefficient use of resources. Centrally, it can provide needed technical assistance to family planning and MCH IEC programs generated by the technical divisions of the DPES, particularly in the areas of pretesting, research, and monitoring and evaluation. It can help to improve and expand current training in IEC, providing more information to trainees on the socio-cultural context into which new ideas are introduced; on the techniques of communication most appropriate for the many and varied groups of the population; on the effective management of counseling caseloads, IEC outreach and community activities. Eventually, with experience, it can help to develop a truly national health and family planning IEC program - one with complementary media and interpersonal elements; and one which combines technical information most relevant to each target audience with the most effective communication media and techniques.

It is recommended, therefore, that to begin the institutional development process which will enable the DES to carry out these activities, technical and financial assistance be provided to the DES to:

1. Develop a strong provincial interpersonal education program in 4-5 provinces.
2. Provide technical services to the DPES in three key IEC areas - pretesting, formative research, and monitoring and evaluation.

A strong interpersonal program is the key to behavioral change. Contact with clients in clinic counseling sessions and in community outreach is indispensable to provide individualized information, to afford intimacy and privacy, to offer accountability, and to offer easy, repeated

access. While the mass media can and should spread information quickly, attract attention, and provide strong motivational messages, it will be the personal contact between health worker and client - particularly for sensitive issues such as family planning and child health - which will ultimately determine and sustain change.

As suggested above, an interpersonal structure already exists at the provincial level. In fact, the majority of health education activities in the country take place in the provinces where both fixed facility staff (i.e. doctors, nurses, and paramedical staff at hospitals, health centers, and dispensaries) and outreach staff (itinerant nurses - infirmiers itinerants, and mobile health teams - équipes mobiles) provide health education and counseling to urban and rural clients; and where local radio programs on various health themes are produced and broadcast. USAID funded six years of training to VDMS and other provincial level health professionals in a variety of topics including IEC in family planning, TOT and management. However, according to both outside observers and *delegues medicaux*, provincial IEC programs are less effective than expected and suffer from a lack of planning, management, and programmed investment.

A number of outstanding problems have been identified at the provincial level which must and can be addressed in a new, more focussed program:

- little systematic and quality counseling on child health or family planning is carried out at health facilities, in part due to insufficient training and educational materials, but equally due to the lack of MIS and referral systems which permit easy access to patient histories and counseling by the most appropriate health agent;

- an outreach program which, while increasing contact between health worker and client, does little to increase educational contact - the need for health care is so great that time afforded for counseling is severely limited. Home visits, while important and justified in many cases (such as follow up on infectious disease) have taken a disproportionate amount of outreach time and resources, further reducing the number of educational encounters possible. Outreach worker personnel issues have eroded commitment and performance;

- little community-based IEC takes place at the regional level. Largely because of a less-than-successful performance of the country's recent Primary Health Care program, national and provincial health officials have been reluctant to invest again in community volunteer activities;

- although regional radio offers an important resource for supporting provincial interpersonal efforts and reaching hard to access populations, it has not been used in any systematic and planned way.

A more detailed discussion of issues related to provincial IEC programs can be found in Annex D.

A new, DES-managed provincial program can address these and other issues. It can support research to identify IEC needs and can help develop operational plans to meet them. It can provide training and supervision for provincial staff according to these plans. It can assure the provision of relevant support print materials and assist in the more productive use of media.

It is recommended, therefore, to make the revitalization of the provincial program be a major activity of DES during the proposed USAID funded project. Proposed efforts can build upon the work done from 1986-92 with the VDMS (outreach nurses), INAS (Institut National de l'Administration Sanitaire) and others. Not only is such a revitalization still needed, but developing a strong program will provide DES with the varied experience and the credibility it has lacked in the past. Perhaps most importantly, there is an apparent commitment on the part of provincial delegates medicaux to reform and strengthen their programs.

The DES also has an increasing role to play in central-level IEC programs. While an immediate and complete turnover of all central IEC activities to the DES is neither justified nor recommended, a progressive devolution of responsibility to the DES will assure better coordination and effectiveness of IEC programs in Morocco. While the technical contributions to IEC must rest with the various technical divisions in the DPES, it makes sense to centralize, within the DES, certain generic communication functions. It is therefore recommended that the DES undertake three important central IEC activities over the life of the USAID funded project:

- 1) pretesting of all materials produced by the DPES will provide an independent review of materials produced privately (i.e. by advertising agencies), will assure that all materials and messages conceived in the DPES have been tested on target audiences, and will enable the DES to fill a much needed role in planning of IEC programs.
- 2) formative research will allow the DES to contribute to the IEC planning process carried out by the various technical divisions of the DPES. By working in conjunction with the technical divisions, the DES will provide the research expertise to explore key issues in shaping messages and materials for specific target audiences; and
- 3) monitoring and evaluation of IEC programs and materials will also fill another gap in IEC programming, will enrich the DES's analytical skills and capabilities, and will permit an even further mastery of overall planning and management of IEC programs.

At the same time, the DES must be strengthened to assume progressively more responsibility for two other key elements of the IEC process - program planning and development and media design and production. The development of a core of IEC specialists, able to design and carry out research, prepare strategic plans, and creatively develop and produce media for a variety of different subjects, is a cost-effective and efficient use of resources. A working partnership between technical divisions (such as Planning Familial (PF) and Sante Maternelle et Infantile (SMI)) which provide the medical, clinical, and programmatic context for educational

programs; and an IEC division which provides message, theme, and media has been an effective management model in many countries.

Recommended Plan of Action

Development of a renewed provincial IEC program

As suggested in the introduction, it is recommended that the health education program at the provincial level should be revitalized. In brief, this would include the following elements: The Animateur d'Education Sanitaire (AES), a person currently in all 60 provinces and prefectures under the supervision of the DES, would be the coordinator of program activities at the provincial level. The provincial animateurs for PF, SMI, CDD, and other specialized health programs, would form the support network through which IEC programs are designed and implemented. The current clinic and VDMS outreach staff would be the principal field educators for the provincial program, complemented by community groups and individuals, where appropriate. The delegue medical would be the director of the provincial IEC effort. Lastly, the DES would be responsible for technical support and supervision.

Following is a suggested implementation plan for such a provincial program:

1. Four to five provinces would be selected for inclusion in a first 3-year pilot phase. These provinces could be those in which SEATS is operating or selected according to other criteria such as: level of urbanization and population density, cultural or socio-economic characteristics, type of public health issues, existence of strong regional radio capacity, etc.
2. Three animateurs from each province would be selected to form a Core IEC Team - the AES, the animateur/PF and the animateur/SMI. This Team would be responsible for all the activities described in some detail below: needs assessment, development of an action plan, and implementation of IEC activities (training, supervision, and actual participation in educational events and encounters). The leader of the Team would be the AES, providing direction and coordination of the IEC efforts. The two other animateurs would provide the necessary technical support for the Team's activities, as well as being responsible for specific IEC activities. Other provincial animateurs would be adjunct members of the Core Team, called on to provide specific inputs to the IEC program where appropriate.
3. The provincial Core Teams from the 4-5 provinces selected for inclusion in the pilot project would be invited to participate in a training workshop designed, organized, and run by the DES. This workshop would have three main goals: a) plan the general design of the proposed provincial IEC program, its goals, objectives, rationale, and interventions; b) establish the terms of reference of the Core Team: the specific role of the AES, the PF and SMI animateurs, and the other animateurs of the provincial health staff; and c) learn how to conduct a health and family planning IEC needs assessment. The needs assessments would be based, where appropriate, on those etudes du milieu carried out under the auspices of the Division de

SMI at the provincial level. In many instances, the IEC needs of a province may already be documented (eg. SEATS project). The idea for this workshop is for animateurs to learn how to collect relevant data (primary and secondary data) to serve as the basis for sound planning in IEC. The animateurs need to go through this collection-of-information process before starting to plan IEC activities for their province.

4. The Core Teams would then return to their respective provinces and carry out a health and family planning IEC needs assessment. This needs assessment would include an analysis of both traditional IEC components, such as the type and quality of interpersonal contacts; but would also analyze those management factors which directly affect the ability of interpersonal workers to carry out clinic-based counseling. These non-traditional factors, such as MIS, referral systems, patient waiting time, and patient flow, are often the key to improved counseling, for they affect the time, place, and conditions under which education takes place. Because these non-traditional management elements of clinical health care fall outside of the traditional experience of animateurs, they would be carried out in collaboration with INAS, whose students and faculty have the skills requisite for such a review of health management issues.

Following, then, are the most important elements of a Health IEC Needs Assessment:

- the VDMS system to determine how to make it more efficient - whether home visits can be reduced, for example, to give more time to points de contact; whether the number of points de contact and/or mobile health teams can be increased; whether the personnel composition of these contact points and mobile teams can be changed to include specially-trained educators;
- alternative community participation programs to determine which are the most cost-efficient and appropriate;
- the clinic (dispensary and health center) counseling system, with particular emphasis on the health information system, to determine how tracking and referral procedures can be simplified; the referral system itself, to determine if it can be better structured and managed to provide more quality counseling time; and the patient flow system, to determine if patient waiting and service time is efficiently used to provide counseling; and on health worker interpersonal communication skills;
- all norms and standards (see Policy section of this report) to determine how correctly and uniformly they are applied in any given province. A notable example is ORT, where confusion persists about the policy of providing packets to rural families to take home and stock in case of future diarrheal episodes;
- all print materials and radio programs to determine accuracy, appropriateness, adherence to regional priorities, specificity, given the diversity of target groups, etc.;
- all training activities and materials.

5. Based on this needs assessment, the Core Teams of the pilot project would then convene in a second workshop to develop IEC action plans for each province. These action plans would include: identification of the specific IEC interventions to be undertaken, such as: the training of clinic workers, the mobilization of community volunteers, participation in expanded outreach activities, radio programming, the distribution of print materials, technical support and supervision. (For details on the specific interventions proposed by sector - i.e. Family Planning, CDD, Breastfeeding, etc. - refer to other sections of this document). The action plan would also include an identification of the provincial personnel to carry out each IEC intervention (i.e., the members of the Core IEC Team and their amateur colleagues), and the time period in which the activity should be undertaken. Finally, the action plan would include an identification of those elements of clinic management which would have to be addressed by the delegue medical and the DPES.

The action plan will identify two priority health areas for attention during the pilot phase - Family Planning plus one SMI category, such as CDD. While integration of all FP/SMI components will be stressed for clinic workers, the focus on two major PF/SMI elements for outreach, community action, and for radio, will enable program managers in this pilot phase to assure quality.

The Core Teams then return to their provinces to modify and finalize the plan with the participation of key provincial personnel.

6. Once the plan is finalized from a technical point of view, it must be approved by the provincial delegue medical. This approval will be more than a formality, for, as suggested above, it is likely that the action plans will include new activities which require major policy and programming decisions. The introduction of a modified MIS system in clinics, for example, to facilitate patient tracking, referral, and counseling, will require lobbying and high-level decisions. The restructuring of the VDMS system to make more efficient use of existing personnel and to offer more IEC and patient counseling will require similar efforts. The institution of a more regular and planned provincial radio effort will need delegue approval. In the case of management issues, proposed modifications in clinical procedures would have to be reviewed by DPES. Requests to do so would be made by the DES in consultation with the AESs of the pilot project provinces.

7. Other important issues to be covered in later workshops with the Core Teams during the pilot phase are: 1) the training of other health staff in Family Planning and SMI IEC; 2) the mobilization and organization of community IEC activities; and 3) where regional radio stations exist, radio programming in Family Planning and SMI. Program producers of the local radio stations would be invited to participate in the workshop. An output of this workshop would be a draft Year 1 Radio Action Plan.

8. In order to carry out the TOT exercise envisaged for the workshop described above, the DES will have to prepare a program guide in collaboration with the SMI and Family Planning Divisions of the DEPS especially for norms clarification. This program guide should contain:

a) a list of all messages for each subject area (i.e. Family Planning, CDD, etc.). These messages must reflect correct norms and standards, and if these norms and standards do not exist or are not clearly defined, a technical consensus must be reached. Critical norms which have been problematic in other countries have been: at what point in a diarrheal episode should a mother seek medical help; what liquids should be excluded from home liquid management; can mixed breast-bottle feeding be promoted for working mothers; what should a woman do if she misses one oral contraceptive, two, or three?

b) a recommended communication strategy for each message, based on KAP research (see discussion on formative research, below). This portion of the guide should suggest how a technical message should be couched within the particular socio-cultural and economic context of the country and the province;

c) recommended techniques of communication: how to communicate in large groups, small groups, and with individual patients; what particular communication techniques are most appropriate for which messages;

d) program management: how to manage a difficult IEC caseload - how to prioritize, how often to repeat visits, how to keep track of progress or difficulties;

e) how to supervise and/or provide technical support to those IEC workers (clinicians, outreach workers, community volunteers);

f) how to train these workers. (e.g. Build upon the IEC module in the National School of Nursing curriculum developed through the PAC II project.)

An excellent model for this guide exists and has been successfully implemented in the Dominican Republic. Although the program guide is comprehensive, and is comprised of many different communications elements, its preparation need not be time-consuming. A recent experience in the Dominican Republic (in a child survival project funded by USAID) indicated that such program guides could be completed easily within 6 months and require approximately 3 person-months of consultant time and approximately 3 person-months of local staff time. In the Dominican Republic, the chief of party responsible for the preparation of the guide was not a communications expert. If she had been, the consultant time and the total development time would probably have been less. Copies of the guide can be obtained through USAID.

9. Once training is complete, Core Teams would return to their provinces and begin implementing the activities agreed upon in the action plan. The DES would provide technical supervision of the Core Teams periodically (at least once a month during the first year; bi-monthly in the second; and quarterly in the third. The DES would develop protocols for such supervision in collaboration with provincial Core Teams.

10. The DES will have two other important responsibilities: First, to provide those provinces with radio stations prototype materials; and second, to work closely with the SMI and

FP Divisions of the DPES to produce appropriate print materials. The execution and development of needs assessments and action plans will provide these Divisions with important information concerning the type and quantity of print materials required at the provincial level. The pre-testing of these and other materials by the DES (see below) will ensure appropriateness and quality of these materials.

While it is recommended that no unnecessary and costly superstructure be provided for this provincial program at the DES, it is nonetheless recommended that clear responsibility for the activity be given to one person within the Division and that a core DES provincial management team be created to carry out the many activities described above. This Team should include at least one member of the central SMI and PF Divisions, with the understanding that team membership would imply a major functional role.

Strengthening Central Activities

In addition to this increased role in provincial-level IEC, it is recommended that the DES play an increased role centrally in pretesting, formative research, and monitoring and evaluation.

The development of a strong pretesting capability within the DES will provide an important and heretofore missing element in the communication process. Pretesting of all print materials, radio and television spots and programs, and messages for interpersonal communication designed for use by health workers, will assure that information provided to target audiences is understandable, meaningful, and acceptable.

The development of this DES Pretesting Service should proceed as follows:

1. The DPES, in conjunction with the IEC Advisory Committee and with the technical assistance of project advisors will undertake an institutional assessment of both the DES and other institutions, such as INAS or private research institutions, to determine who would be responsible for what elements of the process: given the relatively large number of DES personnel currently on staff, could it undertake the entire pretesting program, including both research design, selection of test audiences, and actual field testing? Or should it only be responsible for the design of research protocols, leaving to other institutions the actual pretesting of materials?

2. Once this assessment has been completed, and the DPES has designated an organization to carry out pretesting in the field, the DPES (with the assistance of the IEC Technical Advisor of the project) can write the terms of reference for each institution, and design, prepare, and carry out training courses for the personnel to be involved. The training should include elements of pretesting design for different media, management of subcontractors, field execution, etc.

3. The DES would undertake two or three pilot pretesting exercises whereby one IEC product - such as a leaflet or a radio spot - is carefully pretested according to an established methodology.

4. Based on the results of these pilot exercises, the DES would modify pretesting methodology and/or procedures and would carry out the formal pretesting program.

5. The Pretesting Service would maintain close liaison with the technical divisions of the DPES to assure that the DES can plan in advance for the pretesting of SMI and PF materials, and effectively transmit pretesting results to those divisions.

Formative research is investigations done usually at the beginning of an IEC program to base message design and communication strategy on data from those people whose health behavior is targeted for change. Formative research (e.g., KAP surveys, observational studies, focus groups) is a crucial component of any IEC program, but particularly for the one proposed in this section. An extensive provincial IEC program, including both interpersonal and radio components must be based on the best and latest information possible about local populations.

The DES will conduct formative research in collaboration with the technical divisions in the following ways:

1. It will review all recently-done KAP studies and those underway will be done to identify any outstanding information gaps.

2. Based on this identification, the DES would propose:

a) to modify currently-planned KAP studies to be undertaken by the technical divisions to include more specific IEC-related questions (often technical KAPs refer more to service delivery and patient perceptions of care than IEC); and

b) new KAP studies that are to be undertaken by the technical divisions which would have a strong IEC orientation.

It is recommended that the DES not undertake any KAP studies on its own for the first three years of the project, given the other major responsibilities for which it will be responsible and the past experience of the technical divisions in formative research. However, by the fourth year of the project, the DES should have gained the skills and experience to take more of a lead in this area.

Monitoring and evaluation should be an important component of the DES-led effort in IEC and should be accomplished in the following ways:

1. Based on the provincial action plans (see above) designed for each province, a performance evaluation protocol should be developed to assess each IEC input. For example, if, under the action plans, a new clinic-based counseling program is put into place based on revised MIS and referral procedures, the degree to which these new procedures are followed and accepted must be monitored. Where possible a measure of performance (e.g. increase in number of referrals), should be undertaken. Similarly, if radio programs are prepared and broadcast, they

should be monitored to determine whether the target population heard them, understood them, accepted them, and were favorably disposed to their messages.

2. A baseline study should be carried out in each of the 4-5 provinces of the pilot project to provide the data against which eventual impact evaluation data can be compared. This baseline study should be undertaken in collaboration with the technical divisions (to assure technical accuracy) and with institutions such as INAS, with experience in field research.

3. An impact evaluation can be considered during Year 5 of the project. Impact evaluations need not be large population-based surveys to give useful information to IEC programs. There are many different kinds of less ambitious impact evaluation methodologies which should be considered when the design of USAID funded activities are more specifically designed.

In general, USAID inputs to strengthen the capacity of the DPES to produce quality IEC programs in family planning and maternal and child health would be as follows:

- The recruitment of a full-time resident advisor (see below, discussion of Project structure and location). He/she should have a strong background and experience in IEC, but should be particularly strong in interpersonal education and health program planning and management. The full-time advisor would be the primary technical advisor for the Provincial IEC program;
- Short-term technical assistance would be required for training; training materials production; needs assessment; operations research ; workplanning; pretesting methodologies, protocols, etc.; formative research; and monitoring and evaluation;
- Financial support for: training and training materials production, prototype materials development, program guide development, formative and evaluative research, pretesting, and supervision of pilot phase activities.

The technical assistance and financial support given to the technical divisions (SMI and FP) will be detailed in other sections of this report.

Support from other USAID projects will be important to support the activities proposed here. The SEATS Project, for example, can provide critical assessment in the development guidelines and protocols for the provincial needs assessment activities, particularly with reference to clinic management. Other chapters suggest collaboration with the USAID private sector health project.

It should be noted that UNFPA is also planning to support the DES and has already presented a number of candidates for the post of resident advisor to manage their support (28 month residency). The terms of reference for this advisor are comprehensive but refer more to the current structure and program of the DES than the modified one proposed here. It is

recommended that USAID, UNFPA, and the DPES work closely together to assure that the two resident advisors be complementary. For example, the USAID advisor might be stronger in field-level interpersonal communication and program management and the UNFPA advisor stronger in media, materials, production, pretesting, and research.

Suggested budget guidelines for this Institutional Development activity are as follows:

- Resident advisor at 75 percent time
(25 percent spent with SMI and FP)
@ \$150,000 per year x 4 years \$450,000
- Related advisor costs \$100,000
- Vehicle and equipment (computer, etc.) \$ 60,000
- Training: 3 workshops @ \$10,000 (all in
-clusive) \$ 30,000
- Needs Assessments - 4 @ \$1000 \$ 4,000
- KAP research \$ 10,000
- Pretesting costs (including institu-
tional assessment, training, pilot
testing, 4-year testing of materials:
10 materials to be tested per year
@ \$1000 per test) \$ 50,000
- Supervisory costs (@ 48 Yr1; 24 Yr2;
12 Yr3; 48 Yr4 @ \$500) \$ 66,000
- Short-term TA (8 mos. over 4 years)
@ \$10,000 per mo. \$ 80,000

TOTAL \$860,000

CHAPTER 2

CENTRAL LEVEL MANAGEMENT OF USAID-FUNDED IEC PROJECT

The recommendation of this strategy is that USAID increase its support of family planning and key health sectors by funding--over a five-six year period--a major project of integrated IEC activities that would have a maximum impact on the well-being of the Moroccan family. The project, in terms of funding and scope, would be the most important of its kind ever undertaken in Morocco.

This project's management and its position within the structure of the MSP will be a critical factor for its operational success and its acceptance by the key FP/health programs, their partners, and their immediate collaborators.

From the start, the project must be perceived as credible and legitimate. It must be visible and accessible to all branches of the MSP and to their IEC partners in other ministries and in the private sector. It must have the proper vantage point so that its management can benefit from the contribution of all and make informed decisions. It must have sound direction while maintaining the flexibility to act and react quickly. Finally, the project's outputs must be convergent with the MSP's overall goals, satisfy USAID's own internal requirements, and be coordinated with the activities of other donor agencies.

The management structure recommended below represents a general consensus based on discussions with representatives of many MSP branches and other groups that will be beneficiaries as well as executors of the IEC strategy.

It is thus proposed that the future IEC project be positioned within the Direction de la Prévention et de l'Encadrement Sanitaire (DPES) and that it be answerable directly to the head of the DPES. Situating the project at that level helps it meet the conditions listed above, and makes it a resource for all IEC partners; in addition, the project will benefit from the direct oversight of an MSP senior representative, while remaining close enough to the field level where IEC activities will be implemented.

This management section could, ideally have a snappy name--perhaps something like "IEC 2000"--to make it instantly recognizable and to reflect the dynamic nature of this new venture. For the purpose of this document, however, it will be referred to as the IEC management unit.

The Contractor

USAID and the MSP will first agree on the selection of a US-based contractor who will receive the project funds from USAID, have the responsibility of channeling them to FP/MCH IEC programs, and provide all the necessary inputs for the programs' success. The firm selected as the contracting agency will be chosen through a competitive bidding process and will thus be USAID's executing agency for the project.

Project Staffing

Given the shortage of personnel resources at the DPES, and to keep the structure flexible, the IEC management unit will have a small staff: the project manager (a Moroccan national), a resident advisor who will represent the contractor in dealings with the MSP and USAID, and a few support staff (secretary, chauffeur, etc). The project staff would be the direct contact with the vertical health programs, MSP branches and key FP/MCH players; as such, they would provide overall management and oversight of the FP/MCH IEC project. Specific responsibilities should be defined at the time of the design of USAID's project paper for the new project.

Linkage and coherence of the various programs would be ensured through an advisory IEC technical committee. The committee should be an informal working group, with a maximum of eight to nine members to keep it functional and not be part of any official structure. It would be directly answerable to the head of the DPES. The chair of the committee would be elected by its members and could change every year.

Working with the IEC management unit, the committee's role would be to review strategies, activities and outputs, and to advise. Given its broad-based membership, it would provide intellectual leadership and bring new ideas to the IEC strategy, review the program strategy every year, synchronize activities and provide an initial feedback on IEC outputs. Its presence would ensure that the interests of all principal parties inside and outside the MSP are represented, that high quality standards are maintained, and that the IEC management unit takes full advantage of all the resources available. In addition, the committee would be on the lookout for ad hoc IEC activities, not originally planned, but which deserve funding.

The committee would meet quarterly. Organizations represented could include the Division de la Population, the SMI Division, the DES, INAS, the School of Nursing, the AIDS Program, AMPF, the RTM, a local marketing or advertising firm, etc. An expanded version of the committee would include representatives of donor agencies active in FP/MCH and should meet regularly to be kept abreast of latest developments and to provide their own counsel.

Functions

The management unit will have direct overview of USAID-funded activities and will have three principal functions:

- 1) **Coordination.** The management unit will ensure that each IEC program is sound with the potential to have a positive impact on health behavior. Management will coordinate activities between the various groups that will be responsible for the design and implementation of the various FP/MCH communication programs; it will ensure that activities are complementary for maximum synergy. It will be the link between the MSP and USAID and will facilitate Ministry coordination with other donors funding IEC

activities. The unit will operate at the central level. Linkage between the central and the regional/provincial levels will be through the actual IEC programs.

Coordination will also exist at the program level. Within all the projected IEC programs in different health sectors, there will be opportunities for activities relevant and applicable to all programs. The potential for common activities and pooling of resources exists in research and evaluation, training, mass media, monitoring, and distribution of materials.

- 2) **Funding.** USAID funds for project activities will be channelled through the IEC management unit. When a health/FP communication program has been approved by all parties involved, the contractor and the MSP--or a non-Ministry organization in certain cases--contractor and grantee will sign a sub-contract for the execution of program activities. Monies will be given in installments linked to completion of phases of the program, and the beneficiary will be asked to provide the MSP, the contractor and USAID with regular narrative and financial reports. The unit will also be responsible for paying expenses linked to the general operation of the IEC project.
- 3) **Technical Assistance (TA).** As part of the project's goal to strengthen the MSP's capability to design and implement effective IEC programs, the management unit will provide appropriate support for the successful completion of programs. Areas suitable for TA include general management, curriculum development, training, materials development, mass media, research and evaluation, etc. The Unit's own staff may provide some TA, but it will be provided mostly by staff from the contractor's organization or by international and local consultants. It is recommended that, when possible, the IEC project try to retain the TA services of local consultants and firms. Reinforcement of capabilities may also include funding for Moroccan participants in international workshops, study tours, etc.

It is proposed that the resident advisor leave after the fourth year of the project; The contractor would continue to provide funding for activities, monitoring and counseling until the end of the project. At that time, the IEC management unit would disappear. It is realistic to expect that effective projects implemented without international TA, and smooth working relationship between the various FP/MCH partners will be the norm by that time. In that context, only the IEC advisory committee would continue in the same role.

Cost of the management of the project by a U.S.-based contracting agency for a period of five years--including the posting of a resident IEC advisor in Morocco for four years--and outside technical assistance is estimated at \$2,000,000.

CHAPTER 3

POLICY COMMUNICATION STRATEGY

Background

Evolution of Population Policy in Morocco: Population policy in Morocco has evolved in three distinct phases: 1) an awareness and official recognition of rapid population growth as a problem; 2) development of governmental structures to deal with population issues; and 3) direct actions to solve population problems.

During the first phase, in the early 1960s, analysis of the 1960 census and other research led to the recognition of the relationship between population growth and economic development. The second phase, beginning in the middle of the same decade, saw that recognition reflected in several new policies. His Majesty King Hassan II, for example, was one of the heads of state to sign the United Nations Declaration on Population in 1966. The king also created national and provincial population commissions to "develop and coordinate a governmental population policy, to implement and oversee its execution." A royal decree also abrogated the law prohibiting the promotion of contraception and liberalized the practice of therapeutic abortion.

The third phase began in the mid-1970s, when population became a priority in each subsequent five-year development plan of the government and demographic variables were integrated into relevant sectors. A division of population (family planning) was created in the Ministry of Public Health, advanced university training in demography was inaugurated, and demographic research gained new prominence.

Another important element -- foreign funding -- began at this time, as the government realized that in order to implement a large-scale family planning program and related activities, a high level of external assistance would be necessary. Since that time, USAID has been the major donor in population, with UNFPA a distant second in terms of funding. Since the mid-1970s, USAID has contributed over \$50 million to population activities, focusing its support on the seminal important VDMS program, associated training of personnel, contraceptive commodities, IEC, and large-scale demographic and health surveys (WFS, DHS I and II). UNFPA has provided major support for censuses, population education (both formal and non-formal), and policy-relevant activities (e.g., World Population Day activities) and has also contributed directly to family planning training and IEC. USAID and UNFPA have made a genuine effort to coordinate their activities in order to avoid duplication and to leverage their respective investments. It was also during the 1970s that the IPPF affiliate AMPF began adding its family planning clinics, outreach, and IEC to the efforts of mentioned above, although on a much smaller scale.

From all accounts, there have been no major policy obstacles posed by religious or other groups vehemently opposed to the government's demographic goals or to the practice of modern contraception. While some imams in the rural area may be opposed to family planning, they

have not prevented the adoption of family planning by large numbers of rural couples. Socioeconomic factors, such as low level of schooling for females, or structural factors, such as difficult access to services, have had a far greater effect.

The Policy Challenge of the 1990s: While the Moroccan government has not declared an "official " population policy, it continues to recognize the importance of demographic trends for development and to support family planning services throughout its maternal and child health network. Assessed some fifteen years after their inauguration (DHS II, 1992), activities to reduce fertility have been remarkably successful. However, a caution must be added to the congratulations: population policy now enters a fourth phase, one which will have a major impact on the future of the government program. In this phase, the GOM must focus on the fact that USAID funding of family planning -- which has dominated donor contributions -- will be diminished significantly and possibly terminated by the end of the next decade. The primary financial responsibility for the public family planning program, including large capital outlays for contraceptives, will be transferred to the GOM. While other donor support for FP/MCH interventions is likely to continue over the decade, this support is relatively minor compared to that of USAID. In sum, it is unlikely that other external funding will replace AID's large contribution to the family planning program.

The GOM must therefore be convinced that fertility reduction through family planning merits significantly increased support from its own treasury. The level of commitment needed by the government to implement a nationwide family planning program financed from its own resources is much higher than the level of commitment needed when those services are overwhelmingly supported by foreign donors. In the latter case, family planning will be forced to compete with other high-priority programs for scarce government funds. As it stands now, all government spending on public health represents only 3% of the GOM's annual budget, including external funding. Even with a shift of some of the burden to the private sector and possible savings due to new measures aimed at cost recovery and/or program cost-effectiveness, government leaders and those who influence them (including the media) will have to become convinced that a significantly larger investment in family planning is in the country's best interests.

Issues for Policy Communication: Some complacency may have developed. Because DHS and other data have shown such a steep drop in fertility, many leaders assume that these rates will automatically continue their dramatic decline. Some policymakers consequently believe the population problem has been solved. Few leaders -- and particularly provincial and community leaders -- seem aware that at its current rate of growth, Morocco's population will double in 29 years. Even fewer are aware that due to previous high fertility, the number of women of reproductive age will increase significantly in this decade, and that family planning services will have to expand coverage commensurately simply to maintain the current rate of contraceptive prevalence.

In spite of the need to provide services for the larger cohort of women entering their reproductive years in the 1990s, experience from other countries suggests that much of the gain

to be had from quantity -- in Morocco's case, access to family planning/MCH services by 80 percent of the population -- has already been realized. Without strategically focused programmatic inputs, contraceptive prevalence could plateau at its current level (or even decline in the rural areas). Messages to leaders must emphasize that additional significant decreases in fertility will depend on improvements in the quality of IEC and services (including wider choice of methods and good counseling), careful targeting of IEC and expanded services to certain subgroups, and a significant shift from short-term to long-term and permanent methods.

The policy challenges today are more subtle than those of 15 years ago, but could nevertheless derail the future course of family planning progress. Policy communication efforts should therefore focus on:

- Convincing the GOM to assume dramatically increased financial responsibility for the family planning program;
- Raising the priority of family planning among national, provincial, and community leaders by increasing their understanding of population dynamics and impacts in Morocco;
- Developing support for diversifying the financial base of support for family planning by increasing the involvement of the private sector and the community;
- Building consensus for a major shift from temporary to long-term methods in order to increase choice and to reduce the burden on both client and provider;
- Providing assistance to the Population Division to disseminate information system-wide on key issues -- 1) the necessity of national and provincial-level planning for the growing numbers of women to be served over the decade; 2) the strategic importance of improving the quality of services, interpersonal communication, and mass media; 3) the priority of emphasizing long-term methods for the hundreds of thousands of appropriate candidates;
- Identifying and working to change policies that may retard implementation of the new programmatic directions, such as: overly restrictive regulations governing long-term methods and excessive tariffs on use of mass media.

Policy Communication Activities

The government and NGOs (notably, AMPF) occasionally sponsor seminars for leaders and the media on population and family planning. However, there has been no sustained, systematic, wide-reaching program to communicate information to national and provincial leaders on population growth and its socioeconomic, environmental, and health impacts. A substantial component of the new IEC amendment, therefore, should be devoted to a policy communication program whose overall goal is to help the government fully understand the implications of,

accept, and prepare for a greatly increased financial responsibility for family planning. These activities fall into two major categories:

- Outreach to policymakers and leadership groups at all levels to strengthen their commitment to increased government funding of high-quality, sustainable family planning services; and
- Policy dialogue with government leaders and information services to the DPES relevant to strategic planning, consensus-building, and implementation of the changes needed to assure program quality, sustainability and expansion.

Highest priority should be given to outreach activities for provincial and community leaders, because the need is greatest in rural areas. The contraceptive prevalence rate in rural areas is only half that of urban areas; support for renewed family planning efforts must have the support and active encouragement of provincial and community leaders if they are to be maximized.

Outreach to Increase Leaders' Support for Family Planning: The systematic program recommended to reach and inform national, provincial, and local Moroccan leaders should utilize a variety of approaches -- booklets, videos, RAPID presentations, local and national mass media, and interpersonal communication, among others. The program should be carefully designed according to the following steps:

a) Identification of important target audiences. In Morocco, these include political leaders, members of parliament, top ministerial officials, civic leaders, leaders of the medical community, influential members of the press and broadcast media (both private and public sector), religious leaders, business and industrial leaders, university professors and other leaders in formal and non-formal education, women's groups, student leaders, professional associations, advocacy groups (especially for child welfare, and the environment), and other donors. It is essential that the focus of this activity be primarily placed on identifying provincial and community leaders.

b) Audience research. A survey of representative Moroccan leaders' -- with particular attention paid to provincial and community leaders. Ascertaining these leaders' attitudes, concerns, interests, and level of commitment to population issues and to FP/MCH will permit the development of messages and utilization of channels most appropriate for them. In addition, focus groups and interviews will give a deeper understanding of leaders' perceptions. This information can also be used later as baseline data for evaluation.

c) Message development. Publications, AV materials, and seminar themes will be based on the research and with various audiences, both national and provincial, and pretested in order to address the interests of specific audiences. Some messages are of general interest, such as the relationship of population growth to the environment or to health.

Others can be tailored to groups particularly interested in economic development, health services, or school enrollment rates, both nationally and locally.

d) Channels and formats. Because many Moroccan leaders are located in urban areas, there are efficient channels to reach them. Care must also be taken to reach provincial and local leaders through the channels and formats most appropriate for them. The following are recommended:

- **A series of 10 booklets** over the life-of-project. These brief (12-16 pp), attractive booklets for non-technical audiences will focus on topics such as the relationship between population and 1) the quality of life in Morocco; 2) economic development; 3) education; 4) women's status; 5) the environment; and 6) urbanization; as well as 7) family planning and the health of mothers and children; 8) family planning success stories; 9) leaders' statements on population/ family planning (an effective approach in other countries); and 10) a special topic to be identified.

These booklets would be similar to the "popular" summary of the 1987 Moroccan DHS; an evaluation found that this booklet reached and was read by a significantly larger range of leaders than the technical report. These booklets can be mailed, disseminated through organizational networks, and/or distributed at workshops and conferences throughout the country. The identification of channels as well as the audiences must be part of a well-planned distribution strategy.

Supplementary materials such as briefing papers, data sheets, and reports can be added dealing with the same issues but at the provincial level.

- **Audiovisual presentations:** videos, slide shows, overheads, RAPID presentations, and computerized storyboards can be developed on population topics of wide interest and on special topics for specific audiences. These tools can be distributed to various leadership groups for use through their internal communication networks, used in conferences and workshops, and also broadcast on T.V.

Five videos (and slide show versions) are recommended on population trends and 1) the quality of life; 2) environment; 3) health; 4) women's issues, and 5) family planning services and methods; plus one RAPID and one storyboard, with national and provincial data.

- **Seminars, workshops, and presentations** for the above audiences. Morocco has a sound tradition of using conferences, "journées de réflexion," and other assemblies for education and development of

consensus on important issues. While such events have been used occasionally for population/FP issues, a regular and carefully targeted approach will be more effective. Workshops and conferences can be sponsored by counterpart organizations involved in the policy communication program but, equally important, population/FP/MCH can seize the opportunities offered by other conferences sponsored by various other interests.

A minimum of two project-sponsored conferences and five sessions at other conferences are recommended per year.

- Collaboration with the media. The media are critically important for policy communications. Decisionmakers read newspapers, watch T.V., and listen to the radio, and they are influenced by what the general public is exposed to and considers important. Special workshops are needed for media officials and for print and broadcast journalists to involve them as active partners in reaching influential people. These workshops should offer a chance to upgrade technical skills as well as usable information on population/FP topics. Programs for policymakers can be developed with radio and T.V. managers -- round tables, interviews, documentaries, etc. -- on a regular basis. Regular press releases and occasional news conferences on population/FP topics also increase the likelihood of coverage.

Two journalists' workshops and at least one monthly broadcast and newspaper article per year are recommended.

Policy Dialogue and Communication within Specific Ministries: The second strategy proposes policy dialogue with specific decisionmakers within the government who directly influence the achievement of family planning objectives. Priority will be placed on policy dialogue regarding 1) planning for transfer of substantial funding for family planning to the GOM, and in particular, the costs of commodities; 2) emphasis on long-term methods; 3) increased involvement of the private sector and the possibility of introducing sliding-scale cost recovery in the government program; and 4) increased commitment to family planning among provincial and community officials. Discussion aids such as fact sheets, briefing papers, and overheads will be provided to assist in this effort.

Other issues, although secondary to those above, are also important for policy dialogue: permission for advertising of or direct mention of contraceptives on T.V.; reduced costs or free air time for FP/MCH programs and spots; reducing excessive restrictions on access to sterilization; the possibility of non-physician insertion of Norplant, which would greatly enhance its availability at MCH centers.

To address other objectives, technical assistance will be provided directly to the MSP for internal communication of research findings, data analyses, and strategic planning options to various audiences within the MSP system. Systematic information dissemination at the ministerial and peripheral levels will be essential for the implementation of new policies and practices, particularly as the MSP moves to decentralize its system. Strategic planning must take into account -- and then communicate -- the following: the increased numbers and locations of women and children to be served, the current contraceptive prevalence rate by province and subunits within provinces, the expansion of services needed simply to maintain those rates plus the expansion of services needed to augment it to higher levels, as specified by the MSP. It must also develop and communicate projections of the desired method mix, including program and budget implications of a significant switch to long-term and permanent methods, and the proportion of contraceptives projected to be delivered through the private sector.

One of the MSP's most important internal communication activities will be to develop consensus within the system for programmatic and structural changes which will increase demand for FP/MCH services, promote needed health-related behavior change, and improve the quality of services and information provided clients. These include: the emphasis on long-term and permanent methods, intensive IEC training, research-based communication campaigns, selective revival of VDMS in underserved urban areas, and redeployment of personnel and reference centers for training and for Norplant and sterilization services. Under the new IEC amendment, the role of the DES is to be significantly strengthened and charged with bringing about many of the IEC objectives; given this change within the DPES, there will be a particular need for information-sharing and consensus-building in order to avoid "turf" problems and resentments which can sabotage even the best-designed and well-financed projects.

The program will offer the DPES assistance in building system-wide consensus for the above program changes through the most effective means of internal communication -- written, audiovisual, and interpersonal. Findings from pilot programs and centers of excellence which demonstrate the success of good interpersonal communication and other improvements in quality can be "packaged" and disseminated throughout the system. Help will be available to enliven small and large meetings and briefings to share information on this next phase of the FP/MCH program with all who need to "on board," both at the national and provincial levels. The quality of fact sheets, briefing papers, reports, summaries and action memos for top decisionmakers, as well as overheads, slides, videos, and storyboards, can make a major difference in how well indicated changes are accepted and implemented.

Counterparts

As part of the scope of work, the IEC contractor and appropriate Moroccan counterparts will identify a small number of appropriate counterpart organizations for policy communications. The success of the policy communications depends heavily on the authority, expertise, and political connections of counterpart individuals and their institutional base. Because of this, it would be presumptuous to suggest a priori individuals and organizations without devoting considerable time and background investigation to this effort; this should be the major work

undertaken for the first six-to-nine months of the project. While it would be convenient to identify just one counterpart, which could in turn deal with all the target policy audiences, it is unlikely that any one organization has the technical background, the capacity, or the political connections needed. Thus, three or four Moroccan groups might be identified. INAS, AMPF, a university department or institute, a medical society, influential advocacy groups, and certain subsets of target audiences -- media officials and women's group leaders -- are among possible candidates, or could at least play a minor role as partners in policy communication.

Evaluation Plan

The policy communications part of the new IEC program will be assessed by process, outcome, and impact indicators. 1) The process indicators consist of the number of booklets, slide shows, other AV and written materials produced and disseminated, the numbers of workshops and seminars held, the numbers of persons reached, and other quantitative indicators that reflect the contractor's scope of work. 2) The outcome indicators consist of those changes in knowledge, attitudes, and priorities among leaders (general and ministerial) that reflect a significantly improved positioning of population/FP/MCH issues on the national and ministerial agenda. The audience research necessary for the development of the policy communication program can be used for baseline data, and a post-intervention survey, focus groups, and interviews with the same sample can measure changes. Additional use by leaders of information/materials provided through the program for their own meetings and dissemination through networks can be measured as another indicator of a multiplier effect outcome. 3) Impact indicators for the policy communication component consist of population/FP policy and programmatic changes (e.g., specific ministerial plans for assuming financial responsibility for the FP program or removal of an unnecessary medical barrier to access for FP/MCH services) that can be at least partially attributable to the program's activities. The program should also build in its own assessment activities, so that it can make needed course corrections before the end of the project.

Time Frame

A five-year time frame is necessary to achieve the policy consensus or reform necessary to achieve programmatic objectives. The first year must be dedicated to essential start-up tasks: identification of target audiences, identification of appropriate counterpart institutions and/or individuals, identification of useful resources and tools, designing and implementing quantitative and qualitative research for program development and baseline data for evaluation, public relations, development of a system of coordination with other components of the IEC program, identification of effective channels and selection of written and AV material formats, development of carefully sequenced workplans with measurable objectives, and the beginning of activities described above. The second through fourth years will be marked by full implementation of the activities, with mid-term assessment followed by course corrections. The final year will be devoted to completion of remaining activities and a final program evaluation during the ninth months.

Management

Two people are needed at the IEC project headquarters for the policy communications component. A full-time professional will serve as the policy communication director and will direct and manage the diverse portfolio of activities. He or she will provide coordination among the counterpart partners and possible subcontractors. The policy communications director should be a Moroccan national, knowledgeable about population issues, highly respected, and well-connected politically. He or she should have the support of a full-time administrative assistant, also a local hire.

Estimated Cost

Approximately 12 to 15 percent of the overall costs of the IEC project should be devoted to the policy communications component.

MATERNAL/CHILD HEALTH POLICY

The GOM's MCH policy has also evolved over time from one devoted primarily to curative services to a system that recognizes the importance of implementing a program of preventive health measures such as immunization, breastfeeding, CDD, safe motherhood, and -- more recently -- AIDS. Morocco has participated in various international health conferences and movements which aim at a global response to the issues mentioned above. Substantial funding from USAID, UNICEF, the World Bank, and OMS have helped to translate the GOM's commitment to preventing these health problems into the major focus of its MCH program. The infant and child mortality rates have dropped dramatically as a result of the MCH program efforts. The support of various NGOs to maternal and child health must also be recognized.

Compared to the population arena, there are relatively few health policy issues to be addressed. However, the policy communication program should also address the following:

1. Changing the regulations governing distribution of ORS packets -- to make them available to mothers when they need them, independent of direct contact with the health system.
2. Clarification of DPES guidelines on breastfeeding, so that mothers will receive clear and consistent guidance on what is meant by "full" or "exclusive" breastfeeding, when supplementation should begin, and recommendation of duration of breastfeeding.
3. The question of how to support breastfeeding mothers in the workforce can be raised with ministerial officials dealing with industry and business. Nurseries, breast pumps, time out to express milk, and refrigerators in which to store breastmilk are arrangements employers have made in other countries.

4. If and how AIDS communication will be integrated into FP/MCH or dealt with as a free-standing program.
5. Policies prohibiting direct mention or showing of contraceptives on television.
6. High costs and tariffs on media programs and spots dealing with public health issues.

CHAPTER 4

FAMILY PLANNING

BACKGROUND

The ultimate goal of the FP/IEC strategy is to contribute to an increase in the number of Moroccan men and women who adopt family planning as a lifestyle for their well-being and that of their families, a goal that merges with the MSP's mandate to offer the best mother and child protection possible.

Family planning, first introduced in 1966, is today a very well known and understood concept in Morocco. The 1992 Demographic and Health Survey (DHS) shows that over 97 percent of all women could name at least one modern contraceptive method. Some 80 percent could name at least three modern methods. Over 94 percent could name a source where to obtain a modern method. The general attitude towards family planning is positive; for instance, nine out of ten women respondents in the DHS thought it was acceptable to talk about family planning on the radio or television. Men do not seem to pose a major obstacle to the acceptance of family planning; less than four percent of the dropout or discontinuation rate was because of a husband's disapproval of contraception.

The total fertility rate, currently at 4.2 children per woman of reproducing age, continues to go down while the actual use of family planning has grown steadily over the years. Some 35 percent of Moroccan couples now use a modern method. The prevalence rate has increased by over 20 percent in the last five years alone. If the present growth trend is maintained, Morocco's FP program will soon reach the same level as that of Tunisia, the leading program on the African continent.

Urban residents continue to account for the great majority of users in Morocco--more than three out every five--but the most significant recent gains have been in rural areas where the prevalence rate for modern methods is growing more than four times faster than in cities, and has increased by over 40 percent in five years. During the same time period, the contraceptive rate in cities increased by less than ten percent. While the current 54 percent prevalence rate in the cities should not necessarily be construed as evidence of plateauing of the FP program, it does suggest that it will be more difficult to gain new urban acceptors in the future.

The pill is, by far, the contraceptive of choice in Morocco, especially in rural areas. Nationwide, 80 percent of modern method users opt for oral contraceptives. This lopsided mix has direct implications on the IEC strategy. There is, however, a changing climate for the dispensing of longer-lasting contraceptive methods. IUD insertion is no longer restricted to physicians, but can now be handled by trained nurses or midwives. Norplant should also become available in the relatively near future.

Health concerns and side effects are important reasons why people stop using family planning. In the 1992 DHS, some 28 percent of pill users who dropped out, and fully 50 percent of IUD dropouts gave these reasons for discontinuing. Rumors and false information about family planning are frequent. Also, because several methods are available, and they are often comparatively difficult for health staff to explain effectively and for adopters to use correctly, effective family planning counseling is labor-intensive.

Women who are adopting family planning are starting earlier than ever. Among the younger generation--under 30 years of age--more than 40 percent of women start using FP while they are still childless or after having their first child. This is a dramatic difference from their sisters 40 years of age and up who only turned toward family planning after having had four or more children.

Moroccan women, nevertheless, continue to marry young and have long married reproductive lives with the potential to have many children. A typical Moroccan woman is under 19 years of age when she marries. The average age of urban woman at their marriage is actually going down, while remaining somewhat more stable in rural areas. Among those women who, at some point in their lives, made the decision to use family planning, there is still a significant dropout or failure rate--another challenge for health communicators. Recent comprehensive DHS data on discontinuation were not available at the time of this writing, but findings from the 1987 survey show high failure rates for the pill and the condom--over 25 percent--and for the IUD to a lesser degree.

On the other hand, the latent demand for family planning in Morocco is very high; 73 percent of women interviewed in the 1992 DHS said they wanted to wait at least two years before having their next child, or not to have any more children at all. The potential clientele for family planning numbers literally in the millions of men and women. IEC's challenge is to reach this audience of non--users to convince them to make an informed choice to control their fertility, while maintaining the base of couples already using a modern method.

Public Sector Family Planning Services

The Division de la Population (DP) in the DPES oversees all aspects of family planning programs at the MSP, including central responsibility for the VDMS outreach agents. Family planning is thus a vertical health program at the central level but is integrated into the overall health package in health facilities. There are approximately 1,600 public sector health facilities (hospitals, maternity centers, health centers and dispensaries) offering FP services. Over 60 percent of users obtain their family services from a public sector provider. The MSP is also by far the principal supplier of long-term contraception, providing more than 80 percent of IUD insertions and female sterilizations. By a number of accounts, including those of MSP officials, this heavy use of public facilities is due in part to an adequate quality of care, but is mostly a reflection of the free services available.

The DP has gained significant experience over the years in the implementation of IEC programs, having worked with local research and marketing firms and outside donor agencies. The Johns Hopkins University/Population Communication Services (JHU/PCS) has provided technical assistance over the years. Recent IEC project activities include formative research (a study on rumors), the design of an in-service IEC curriculum and some training sessions, a brochure on the pill, and the design and limited dissemination of a national FP logo. Family planning is also a regularly discussed topic on a weekly program on national radio.

While the MSP's IEC effort has resulted in some quality outputs, steady progress has been hurt by insufficient personnel at the DP where staff have many other responsibilities, and inadequate cooperation with the Direction de l'Education Sanitaire (DES) which has the potential to support family planning IEC activities. Despite these constraints, the DP should nevertheless continue to be considered the lead agency for the conceptualization of Morocco's FP/IEC programs. The success of a major FP/IEC initiative will require however, if not additional DP personnel, an apportionment of IEC responsibilities among those already on staff, and an increased collaboration with the DES.

Private Sector Family Planning Services

Slightly over one third of users (36 percent) obtain their FP method from Morocco's private health sector, mostly from pharmacists who supply 36 percent of country's pill users and are the principal source of condoms in the country. Pharmacists have been partners in a USAID-funded social condom social marketing project since 1989, and are poised to start a second-base project in December 1992 which will also include the promotion of oral contraceptives.

In the area of IEC, the other key player is the Association Marocaine pour la Planification Familiale (AMPF). The Association operates few health facilities and services only three percent of acceptors, but its size belies the importance of its role in FP communications. In addition to operating a very active community-based delivery (CBD) program, the AMPF, over the years, has been the initiator of most FP/IEC activities in Morocco--including an extensive use of the mass media: television mini-series, song contests, radio advertising, etc.

The extended network of potential FP private and public sector collaborators in Morocco offers great potential; NGOs, extension workers from the Ministries of Social Affairs, Agriculture, and Youth and Sports--many of them with some IEC training--could eventually have an important sensitization and motivation role to play. It is recommended however that the MSP strengthen its own base before training extension workers from other ministries in FP communication and phasing them into the IEC effort.

Family Planning IEC Bridging activities

In anticipation of the major IEC initiative included in the FP/MCH project to begin in mid-1994, the DP is scheduled to begin implementation in early 1993 of a series of bridging FP communication activities to be funded by USAID. The bridging activities will lay some of the

groundwork necessary for a successful start-up of the 1994 FP/MCH bilateral project; they will take into account the DP's staffing constraints and, on the institution building level, will focus on fostering a stronger working relationship between the DP and the DES.

Activities on the agenda will include setting up an IEC advisory committee (More information about this structure is provided later in the section); an expanded dissemination of the family planning logo; improved coverage of FP issues in the media; production of FP methods cue cards for health providers; short-term training of the Animateurs d'Education Sanitaire in the provinces; and production and distribution of a FP/sexual responsibility song. The MSP will receive external and Moroccan-based technical assistance to carry out these activities which are not budgeted under the strategy that follows and are funded under a separate agreement.

FAMILY PLANNING IEC STRATEGY

An increase in the contraceptive prevalence rate can be achieved through a two-pronged IEC strategy; by improving the quality of services and information offered to the population, and by stimulating the public's demand for services from both the public and private sectors.

On the one hand, good services and caring and competent health professionals confer a legitimacy and a good reputation to a health center, and attract a loyal clientele. On the other hand, outreach workers, with the support of mass media messages, motivate clients and potential clients to go to their nearest health center.

This approach will require interventions in four broad IEC sectors: IEC training of service delivery personnel; production of IEC materials and interventions for providers and their clients; mass media activities and; promotional campaigns.

The strategy incorporates many of the recommendations and suggested outputs contained in the "Stratégie d'Information, d'Education et de Communication pour la Planification Familiale" published by the MSP in July 1992.

The proposed interventions are arranged under USAID-defined objectives which should be quantified at the time of the design of a full-fledged project. In normal circumstances, they should be reached within a five-year timeframe. Recommended interventions have been set in order of priority under each objective. Donor funding and sustained external technical assistance will be essential inputs for the success of the project.

Family Planning IEC Objectives

- 1. Stimulate the demand for family planning by improving the quality of information and communication.**

2. Promote behavior change in primary target audiences and intermediaries that will prevent health problems and improve health practices in family planning.

The success of Morocco's family planning in the years ahead will depend on its ability to a) maintain its current base of acceptors; b) reduce the number of those clients who drop out or fail to use their method properly; and c) recruit new adopters. The following areas of intervention are proposed to achieve these goals.

a. Interpersonal communication training for front-line workers

As explained in greater detail in the section on Strengthening Institution Capacity, most health education activities take place in the provinces where both fixed clinic staff and outreach staff provide health education and counseling to urban and rural clients. From the accounts of MSP officials, it appears however that comparatively little counseling is done on a systematic basis, with activities being more reactive than proactive. In the same vein, the VDMS outreach program--through home visits, points of contact, and mobile team visits--puts the emphasis on curative interventions rather than on preventive education. Improving the quality of IEC on the frontline depends on one hand on reordering health workers' priorities--which is a MSP policy decision--and on improving the quality of information provided to clients.

There has never yet been a systematic IEC training program for health workers. For instance, less than half of the DES's 50-odd *Animateurs d'Education Sanitaire* (AES) assigned to each province and *préfecture* have received any kind of refresher IEC course since leaving school. As mentioned earlier, the DP has developed and in-service IEC training curriculum and trained some trainers, but that has translated only into one two-day counseling training session for health professionals attending an IUD insertion course.

Given the thousands of health workers nationwide, it would probably be overambitious to expect all health professionals to receive IEC training over a five-year period. It is, however, reasonable to expect that each province and *préfecture* in the country will have IEC-trained personnel. Priority will be given to the training of the AES; the Institution Strengthening section proposes the AES as the coordinators of program activities at the provincial level.

An appropriate course--which can also be offered to participants from the MSP, the AMPF and other partners--would last two weeks. It should include a refresher on the basics of physiology and contraceptive methods. The second part of the training will focus on upgrading participants' competence in such areas as needs assessments and simple evaluations, and the design of IEC programs at the provincial or unit level; it will also include a refresher look at such skills such as counseling and the use of visual aids. It is proposed to train up to 200 AES and other health workers at that level during the project.

At the implementation of the Strategy into an action plan, project managers can decide who are other suitable candidates for training. The MSP's VDMS workers who are the best positioned to recruit new clients in rural areas and in the mushrooming urban "bidonvilles" are

definite targets for training. The situation analysis carried out in late 1992 by the USAID-funded *Evaluation project* will help get a clearer understanding of training needs. In any event, it is proposed at this stage to offer one-two day interpersonal communication training (where, through role plays, participants will learn how to deliver motivating information, and effectively answer the most often asked questions and how to address rumors and false information) to the country's 1,200 VDMS workers.

The MSP's Division de la Population, working with the DES, will be the locus of the FP-specific training. As mentioned earlier, a basic curriculum as well as "workshop notes" for trainees have already been developed under a previous project with the Division. The nucleus of trainers will be the MSP team which attended a Training of Trainers (TOT) workshop under the same project and has already had some hands-on training experience.

Since successful training of health workers will have a beneficial effect not only on family planning, but on all health components of the project; it should be construed as a cornerstone of the entire IEC program. The cost of the proposed training, not including outside technical assistance, is estimated at \$600,000. An important factor in determining a more precise cost will be the resolution between the MSP and USAID on whether per diems and indemnities should be paid to workshop trainees.

b. Production/Purchase of appropriate visual and teaching aids for clinic-based and outreach health workers.

Reports of site visits, formal and informal feedback from health workers, and other forms of anecdotal evidence show that frontline MSP staff, whether based in health facilities or involved in outreach work, do not have adequate support materials to explain family planning or specific contraception methods to clients. During counseling or talks, they often have only contraceptive samples to illustrate their presentation. Using a visual aid, in addition to improving the clarity of the content, strengthens the confidence the health worker.

The *Evaluation project's* situation analysis which includes interviews with health providers--and other formative research activities--will help planners decide to what extent visual and teaching aids are required and, if so, what are the most appropriate materials. At this stage, however, possible items include a simple user-friendly reference booklet, FP methods "cue cards" (to be produced under the bridging activities), posters and a flipchart (the design of which was initiated under a previous project, but was never completed). The MSP will also purchase of anatomical models, films, videos and slide shows.

In addition, in order to upgrade and professionalize the image of service providers, the strategy proposes producing IEC kits for clinic-based and outreach workers. The kits--carrying cases or satchels--will be manufactured locally and be used to carry contraceptive samples, a reference guide, visual teaching aids, simple leaflets for clients, etc. At the time of the kit's

design, program managers can decide to include other health IEC materials in the kit. It is estimated that 1,500 such kits will be produced.

The Division de la Population will assess the requirements for the materials and propose themes and messages--with guidance from an IEC Advisory committee (the committee's role is explained in the Management section)--and will contract with either the DES or with an outside advertising or graphic arts agency for the design and production of the materials.

In all instances, the development of materials and activities will follow a proven communication development process which includes several steps: a) a careful assessment of needs; b) precise objectives, clearly identified target audiences, messages and communication channels; c) first versions of materials that will pre-tested and revised until proven satisfactory; d) production with executing agencies selected according to a competitive bidding process when applicable, and dissemination; and e) monitoring and evaluation.

Production of the materials will start early in the course of the project so that they will be available when the training of health providers goes on stream. When appropriate, production of materials should be staggered over two or three print runs to insure that they are available for the duration of the project.

As mentioned in the institutional development section, DES staff will be trained in pre-testing procedures, and will eventually become responsible for the pretesting of all IEC outputs within the MSP.

The estimated cost of the design and production and purchase of materials for health providers at this point is estimated at \$550,000.

c. Production of IEC materials for clients and potential clients

The same feedback from the field on the paucity of materials for service providers suggests that the situation is the same for materials for clients. Giving clients a simple explanation leaflet allows the health worker to formalize the counseling session which has just concluded. The leaflet will help clients have more information if they have not yet made a choice, or will serve as a reminder on how to use the method they have just adopted. Potential clients can also use the leaflet as a starting point for a discussion with their spouse.

The suitability of print materials for clients in developing countries must be assessed very carefully, given that large segments of the population are illiterate. In Morocco, for instance, the adult literacy rate for men is about 60 per cent for men and only 32 percent for women. These limiting factors must be factored into the decision whether to produce materials, and the type of materials required.

Any outputs for clients will be selected and produced according to the process mentioned earlier, and will be phased into the FP program according to demand. The strategy recommends large print runs (500,000 +) of very simple materials which can be understood by the non-reading public. Such materials which emphasize the visual content have been produced all over the developing world. Priority will be given to producing materials for long-term methods (IUD, Norplant and tubal ligation) or those which are in heavy demand (the pill). This will be facilitated through the proposed IEC advisory committee described in the Management section of this report.

In addition, visual aids and print materials (as well as mass media activities) will be "generic." They will belong to the entire family planning program, and not only to the MSP or to one specific group. All organizations in Morocco involved in FP/IEC will feel some sense of ownership of a brochure or a radio spot. Messages--whether in person-to-person communication or in the mass media--should encourage people to go to a FP center or a health facility, without mentioning any specific organization. The production of materials for all FP players will permit considerable savings at the time of their production and distribution.

In the same vein, the new Moroccan FP logo will identify all public and private sector health centers and facilities that offer FP services. It will also be the "signature" for all FP print and audio-visual materials, regardless of the source. The logo will be publicized nationwide through posters, stickers, badges and pins which will be distributed in all facilities. Verbal messages, in interpersonal communication settings, or in the mass media, will invite audiences to go at "the sign of the happy family," or whatever designation will have been chosen to describe the logo.

As was proposed for provider's visual aids, production of materials for clients will begin early in the project. Total estimated cost of materials for clients is \$1,250,000 over the lifetime of the project.

d. Initiating a major mass media effort to support the ground-level IEC activities

Future IEC programs should develop family planning mass media messages which will, on one hand, steer clients towards health centers, pharmacies and private physicians, and on the other hand, reinforce the interpersonal communication work carried out by health workers in the field. The crucial issue, if FP/IEC is to achieve maximum efficiency, is that mass media and interpersonal communication work in unison, delivering mutually reinforcing messages.

Radio--public and private--will be the medium of choice for the mass communication component. A remarkable 85 percent of women respondents in the 1992 DHS reported that they owned a radio receiver, and some 75 percent said that listened to the radio at least once a week. In rural areas where the prevalence rate is currently growing the fastest, two thirds of the respondents reported listening to the radio at least once a week. Nationwide, over 90 percent of women thought it was all right to talk about family planning on radio and television, and yet less

than six per cent had heard a FP message on radio in the past month. Radio--and to a lesser degree, television--represent powerful media whose potential has been barely tapped to disseminate family planning messages.

Radio can reach populations all over the Moroccan territory, including the large portion of the public which is illiterate. The strategy proposes the design of better-targeted messages in Arabic and Berber which will be broadcast in a variety of formats: advertising spots, entertainment and variety programs, news and public affairs programs. In appropriate cases, an entertainment based approach will be used to reach audiences not normally reached through regular programming.

Serious consideration will be given to the creation of a long-term weekly radio drama/comedy series (a popular format in Morocco) which would ensure an on-going FP/IEC presence on the airwaves. The emphasis will be on entertaining audiences; the FP/health educational content will always appear as a normal element of the storyline and of the characters' lives; it will never overwhelm listeners, giving them the impression of hearing a sales pitch.

The series will at first be sponsored by Morocco's family planning program, but it is hoped that the broadcast material will be of sufficiently high quality eventually to attract commercial broadcasters. Morocco already has some experience with entertainment activities, especially through the mass media work carried out by the AMPF in the past. In the proposed project, the Association could be entrusted with the responsibility of handling the radio series with the collaboration of appropriate theater groups and other consultants.

National television--public and private--will also have an essential role to play, especially in urban areas where 50 percent of the population now lives. Some 85 per cent of city dwellers and 33 percent of rural people own receivers according to the latest DHS, but less than five percent report having seen FP programming in the previous month. However, because of high production costs and the still sensitive nature of family planning on the airwaves, television may perhaps only be used in a support capacity to the radio effort.

FGDs and existing data will help get a better understanding of target audiences, message content and the most suitable type of programming. Different types of "quick and clean" evaluation instruments, such as day-after recall surveys and exit interviews, will assess the effectiveness of the mass media. All of this will be handled in-house by the DES with appropriate technical assistance.

Because it will be such an important feature of the overall communication effort, development of the program/spots will be entrusted to different groups (MSP, AMPF, etc). This will thus require a close working relationship within the IEC advisory committee; the committee will ensure the coherence of the radio programming.

The availability of the public airwaves for FP programming at an acceptable cost is a critical policy issue in the design of long-term mass media programming. For instance, there

appears to be no clear standards for the cost of health advertisements. Some health programs report receiving various types of discounts, while others have been told that they must pay the full commercial rate. Work protocols and obtaining favorable rates and time slots in the public sector mass media need to be agreed upon at the highest levels between the Minister of Information (which oversees the RTM) and the MSP. At the appropriate time, the Minister of Public Health will contact his Information counterpart to do this.

Regularly-scheduled quality radio programming will be introduced early in the FP/IEC program. In the initial stages, FP managers will concentrate on upgrading their contribution to existing radio programming, such as the weekly program on national radio devoted to health issues, by offering alternatives to the constraints of questions and answer sessions or panel discussions. In time, programming can become more diversified, creative and targeted with specific messages at specific audiences.

At this stage, the strategy proposes that a sum of \$1,500,000 be allocated to radio and television programming, both at the national and regional levels. Regional radio is discussed in the next section.

e. Instituting regional/provincial FP/IEC programs

The Strengthening Institutional Capacity chapter describes mechanisms and approaches to revitalize IEC activities at the provincial level. While most FP/IEC outputs will be centrally-designed and produced, the strategy proposes to support the Government of Morocco's decentralization effort by initiating regional/provincial communication programs in selected provinces. The central level will provide funds, technical assistance and other resources to the provinces to pay for the cost of outreach IEC activities, perhaps some print materials, and radio programming.

Morocco has ten regional radio stations which broadcast up to three hours per day of locally-produced programs. In a number of regions, ad hoc collaboration already exists where the station makes airtime to health workers at no cost. Under a future IEC project, radio/health training workshops, with hands-on exercises, should be organized at the regional level to bring together media specialists and health professionals, and to create the base for long-term collaborations in the field.

Programs at the provincial level will follow the same rigorous design and implementation standards as for the national program; after one or two pilot projects have been implemented and evaluated, program managers will decide on the opportunity of replicating these campaigns in other regions. Start-up of provincial programs should be scheduled for the beginning of the third year of the FP/IEC program. The strategy proposes allocating \$350,000 for five provincial campaigns.

f. Promoting the image and reputation of family planning users

The latest DHS shows that family planning is a very well known concept and also has a high acceptance rate in all segments of the population. The IEC program, at this stage, must focus on helping those who are still hesitant--and who have an immediate need for FP--to make that big decision and adopt family planning.

Family planning, as an integral part of the health services package offered to the population, will be thus promoted in all communication channels as a normal, healthy, desirable behavior accepted by all segments of society. Messages will motivate target audiences, urban and rural alike, by promoting family planning, specifically its beneficial effects on mother and child health and its positive socio-economic impact on the family and society.

The strategy's motivation component has a dual role; recruiting new adopters of family planning and confirming to current users that they have made a wise choice in selecting family planning as a lifestyle. For this purpose, satisfied users are the best spokespersons for family planning. Their credibility, in many cases, is higher than that of service providers. They are more believable when it comes to dispelling negative information about real or perceived side effects, and showing that normal people can make that leap from wanting FP to actually getting it. FGDs and other research carried out with the DES will help determine with precision the type of person who is the most credible and what are the most persuasive arguments to convince people to change their health behavior.

Part of the family planning promotion mix will include spots and interviews containing the testimonies of satisfied users; in radio or television fiction programs, characters projecting positive values and reaching some measure of success will be FP users. Program managers may even call on celebrities--from the world of sports or entertainment--to reveal their satisfaction with family planning and to encourage sexual responsibility among young people.

g. Promoting family planning and sexual responsibility to men.

Motivation campaigns aimed at men are increasingly becoming a feature of comprehensive well-thought out family planning IEC programs. Messages in these campaigns emphasize sexual responsibility by encouraging men to have the number of children they can afford, and discussing family planning with their spouses. Recent examples on the African continent include Zimbabwe, Ghana, Uganda and Kenya. In Morocco, men, whether they be opinion leaders or in their roles as husbands, do not appear--on the surface at least--to be major obstacles to the acceptance of family planning. Less than four percent of female respondents in the 1992 DHS reported that their husband's opposition was the reason for discontinuing the use of a FP method.

Nevertheless, the husband will always be a major factor in a Moroccan couple's decision to adopt family planning. A significant portion of the motivational effort should be aimed at

men, with radio and television as the media of choice to reach them. As is the case in other countries on the continent, it is safe to assume that men control the dials of radio and television sets in Moroccan homes. The program component to motivate men will be based on the same considerations mentioned in earlier sections: using a variety of programming formats, emphasizing the health and economic advantages of family planning, using satisfied male adopters--whether ordinary people or celebrities--as spokesmen and role models.

The mass media effort should be complemented with other types of interventions to reach men in places in which they tend to gather--posters in cafés, and billboards in sport stadiums. In addition, the *Animateurs d'Education Sanitaire* in the provinces and *préfectures* could deliver talks in workplaces.

Appropriate messages for men--with possible differences between urban and rural audiences--will be based on existing information and on formative research carried out by the DES and perhaps an outside research firm. The Direction de la Population will coordinate the design of the male motivation program, but specific activities can be implemented by other groups. The AMPF could thus rely on its past experience with the mass media to handle radio and television programming.

The targeting of men will be a prime consideration early in the F?/IEC program. For budgeting purposes, it is proposed to allocate \$300,000 to male motivation activities.

h. Promotion of public sector family planning providers

According to a number of health officials, the public's perception of the MSP health provider is not always wholly positive; in the same way, health professionals do not always feel their work is appreciated. The strategy proposes a special campaign--which could become an annual event--to promote MSP health providers as caring and available individuals who offer quality services and information.

Recognizing one's employees and their skills makes good business sense. In the United States, virtually every major corporation allocates part of its advertising budget to the promotion of its employees. In international development, the promotion of FP service providers has been tried successfully in several countries, including Indonesia and Ghana. This type of campaign is the "external" manifestation that IEC training of providers can have results. In Morocco, the campaign will promote health professionals as providers of a whole range of maternal and child health services since it is an accepted fact that most health facilities in Morocco are under-utilized and can accommodate additional visitors.

The campaigns--which should be launched only when a sufficient number of health professionals have received interpersonal communication training--will begin towards the third or fourth year of the project. It need not be too elaborate; a poster, badges/pins, a pre-tested slogan (something like "Your local health provider, a friend for your health needs"--or FP needs)

and appropriate media coverage for the "Week/Month of the Health Provider" should be adequate. In any event, FGDs with the health workers themselves will determine the actual content and most appropriate media.

The campaign will serve several purposes: a) it will enhance the reputation of health workers as competent and caring individuals; b) it will motivate health workers who will want to be equal to their reputation; c) it will be a means for the MSP to acknowledge its health professionals; d) and it will be another occasion to promote health services.

Because it is intimately linked to the MSP and its staff, and because it covers all sectors of the Ministry, it would be very appropriate for the DES to design and execute the campaign. It will provide an excellent occasion for the DES to prove that is capable of producing quality work. A budget of \$300,000 should be allocated to the promotion of providers.

i. Initiating a more pro-active approach to recruiting clients

As mentioned elsewhere, health and family planning outreach in Morocco happens through home visits, "points de rencontres" meetings and mobile units. While this has produced some definite results, the strategy proposes that the FP/IEC interpersonal communication effort be intensified with extension workers meeting potential clients where they can be found in large numbers. For instance, simple portable kiosks or booths would be set up in markets, souks, bus depots or fairs. MSP representatives or those of other organizations could provide information, steer potential clients to clinics, and perhaps sell condoms and other contraceptives. Markets are often where rumors are born and where past-dated contraceptives are sold; an official FP presence there provides the legitimate alternative.

A future activity can also pay for the production of plastic shopping bags (with a FP logo and message) which will be sold at cost to market visitors.

The extended outreach should be attempted toward the middle of the FP/IEC program, after program planners have used the full potential of the existing infrastructure and have strengthened the IEC component of the VDMS's work. For budgeting purposes, the extended outreach should not be considered so much an output as a philosophical underpinning of the program. No specific costs are thus allocated for this purpose.

3. Promote a shift in FP method mix from temporary to long-lasting and permanent methods.

While the actual number of Moroccan modern family planning adopters has increased by hundreds of thousands in the five-year interval between the 1987 and 1992 DHS, the method "mix" has remained virtually unchanged. Oral contraceptives remain the method of choice of the vast majority, accounting for four out of every five users in Morocco (the percentage is even

more significant in rural areas where it is used by 86 percent of adopters). Long-term modern methods, with the IUD the choice of 9 per cent of users and female sterilization at 8.5 per cent, have rallied only a minority of users. Injectables are currently available but only minimally used; Norplant is not yet on the market but clinical tests are currently underway.

The pill, an effective method in itself when properly used, is more expensive to distribute than other methods because the client must be re-supplied regularly through public health facilities, VDMS agents or pharmacies. In addition, the DHS have shown that the pill has a high discontinuation rate and a high failure rate when misused.

Long-term methods offer better protection and are more cost-effective because they free the client from the need of frequent re-supply of the methods, and reduce dramatically the chance of failure rate because of an improper use of the method. On the other hand, under current policy, tubal ligation can only be offered to certain women: over 30 years of age, at least four children, the youngest at least five years old, consent of the spouse, etc.

a. Special training in long-term method counseling for health professionals in hospitals, "maternités", and private sector clinics

The MSP can support a marked shift towards longer lasting-methods by first improving the quality of services, and by making the methods available in a larger number of facilities. The Ministry will also promote opportunities to increase the delivery of long-lasting methods by its partners in the private sector.

Hospitals, "maternités" and clinics account for virtually all tubal ligations in Morocco. The FP program will first upgrade the IEC/counseling component of the in-country clinical training courses attended by health professionals to learn tubal ligation, IUD insertion and, eventually, how to insert the Norplant implant. The MSP should ensure that, over time, everyone of those facilities has staff trained in recognizing suitable candidates and in counseling for voluntary surgical contraception (VSC), IUD insertion--and Norplant when it becomes widely available). Health professionals should also learn about some of the issues concerning longer-lasting methods such as their effectiveness, their safety, their good sense from an economic point of view, both for the client and the MSP, etc.

The MSP will finalize the design of an appropriate curriculum, based on the considerable amount of training materials that have already been prepared in Morocco and abroad. The one-two day sessions will be delivered in two different types of settings. It will, on one hand, be offered to health professionals attending clinical training courses. As mentioned earlier, the Direction de la Population has already taken steps in that direction in 1992 with a first IEC/session as part of an IUD insertion course. The session was facilitated by trained MSP staffers.

Once the course has been institutionalized within the current clinical training, it should quickly be offered as a refresher course to health professional who have already received clinical training, but whose IEC and counseling skills need to be honed. The refresher courses will be delivered in the form of regional one-two workshops in the major cities by the same team of MSP trainers. The workshops need to be dynamic well-planned events with appropriate teaching aids for the trainers and materials for the participants.

Because much of the groundwork has already been laid for these training sessions, it is recommended that they be implemented early in the life of the proposed IEC project. The cost of training the hundreds of health professionals who will be directly involved in the delivery of long-term methods is estimated at \$300,000.

b. Print materials, visual aids and mass media programming emphasizing long-term methods

While the family planning program will continue to offer a range of methods to allow the client to make a free and informed choice, a significant proportion of the interpersonal communication and mass media messages and activities will focus on long-term methods which offer maximum effectiveness. Information leaflets for potential clients, posters for display in health centers will part of the product mix mentioned in section 2c.

In time, when the IEC program has reached a certain level of effectiveness, the MSP will launch targeted campaigns specifically to promote long-term methods. The cost two such multi-media campaign is estimated at \$300,000.

c. IEC training for VDMS agents and other outreach workers--with an emphasis on referring potential clients to health facilities for long-term methods

Over 85 percent of FP adopters in rural areas choose the pill, a difficult method to use properly, and which requires continuing re-supply from by the extension worker. The adoption rate in rural areas for long-lasting methods has increased during the last five years, but is still less than one-fourth that of the cities for the IUD, and less than half for tubal ligation.

Given the reality of the VDMS's home or "point de contact" client encounters which last about fifteen minutes on average, and during which the VDMS agent must also cover other health topics or give some form of treatment, the strategy proposes setting up a pilot-project in a number of the provinces where the DES will be strengthened; extension workers will receive an IEC training which focuses on how to refer more potential users to a health center to obtain a long-term method.

This training--in the form of one-two day provincial workshops--will include basic theory and practical exercises on motivation and counseling (taking into account the gender difference

between the health worker--who is usually a male--and the client). In addition, simple IEC materials--such as a leaflet designed for a non-reading public or a small colorful poster for display in the home--will be given by the VDMS agent to the potential client. A study will be carried out at the end of the pilot-project to compare any difference in efficiency between the specially-trained agents and their untrained counterparts. Based on the findings, the MSP will then ascertain whether to extend the training of VDMS agents to other provinces. Should the results prove conclusive, all VDMS agents will eventually be trained in long-term method counseling.

Given that oral contraceptives will continue to have a very important role in rural areas for the foreseeable future, and that there is a need to reduce the discontinuation and failure rate for that method, the training will also allocate some time to remind VDMS how to explain accurately the use of the pill and thoroughly, including possible side effects.

The Direction de la Population which oversees the VDMS program will be responsible for setting up the training activities. The pilot-project should start as soon as appropriate materials for agents and clients are available. The cost of the actual training in long-term methods is estimated at \$150,000.

4. Promote a shift from public to private service delivery of services and products.

a. Promotion of pharmacists as FP service providers

There are some 1,500 pharmacists in Morocco, most of them in urban areas. A large proportion of them are women. They are respected, trusted high-profile members of the community. The 1992 DHS revealed that they play an important role in family planning. More than 80 percent of the private sector service delivery is through pharmacists; they service three out of every ten FP adopter in the country. The DHS also revealed that pharmacists would be the first service delivery choice for people who have not yet decided to adopt FP. Pharmacists offer an excellent alternative for people who are willing to pay for FP services, but who do not go to health centers or to a physician.

The MSP has cost control and the gradual transfer of service delivery to the private sector as objectives. In this context, the strategy proposes to launch--in collaboration with the pharmacists' association and union--an initiative to promote these health professionals as a competent source of supply and advice on contraceptive methods, with the objective of increasing the share of contraceptive delivery handled by pharmacists.

The marketing of providers and clients to thank them for their support is a sound business practice regularly used in the corporate advertising world. Pharmacists in Morocco already have a good reputation and a strong client base; they can help the MSP divest itself of some of its service delivery responsibility and allocate the resulting savings to other health needs. As mentioned earlier, collaborations with pharmacists have been successfully tried in the past,

notably with the *Protex* condom social marketing program which is now being expanded to include the marketing of oral contraceptives at a low-cost to clients. Should the MSP decide to give more importance to injectable contraceptives, pharmacists can become a source for both the product and the injection.

The specifics of the campaign can be determined at the time of its design. An illustrative list of activities includes posters to be displayed in pharmacies and elsewhere, radio spots, and gadgets such as key-holders or pins for the pharmacists. The program will also include the launching of a "pharmacist's day" and a series of short half-day information sessions--with the possible sponsorship of drug manufacturers. The sessions will provide recent updates on health/FP technology and give some advice on how to explain method use quickly to clients, information that, ideally, pharmacists will transmit to their assistants.

The DES, with the input of a professional advertising agency, will be responsible for the implementation of this activity to be scheduled after the campaign to promote MSP service providers has been launched. The strategy proposes to allocate \$150,000 to the promotion of pharmacists.

b. Promotion and support of private physicians as quality FP services providers

In a number of countries, national family planning programs work with professional corporations or medical associations to promote private physicians as providers of top-of-the-line FP services. Promotion campaigns "position" the physicians' services for that segment of the population which has the means to pay for the services or which is willing to sacrifice in order to obtain the best care available.

Morocco's private physicians represent an untapped potential for the delivery of the IUD and Norplant in urban areas. A prerequisite, of course, is that they be adequately trained for that purpose. Discreet promotional efforts, through a newsletter or information sessions, would then motivate the physicians to include contraception in the range of services they offer and will offer useful hints on how they and their staff can provide proper FP counseling. In mass media messages, physicians will regularly be mentioned in the list of providers available to a client. A promotion of private physicians will also have favorable repercussions on service delivery in the public sector. Physicians often have postings in hospitals, while maintaining a private practice. The MSP, through its Division de la Population, will be the initiator of activities with the physicians.

The promotion of private physicians is not a priority at this point, and should be undertaken when other FP/IEC components are well established, and it is judged that the promotion effort can add significantly to existing activities. At this stage, the strategy suggests allocating \$50,000 for the marketing of private physicians.

c. Reinforcement of AMPF's capacity as a provider of quality FP information and services

As mentioned earlier, the AMPF, along with the MSP, is one of the two major players in FP/IEC in Morocco. The Association has generated, over the years, most of the FP/IEC activities in the country, much of it of commendable quality. It has reached out to all segments of society, from women of reproductive age to underserved groups such as men. It has also carried out work with opinion leaders and has kept close and regular contact with the press. With its small, dynamic and motivated staff--working with a network of volunteers and private sector collaborators, AMPF is a flexible organization which has produced materials and activities for all media: print, radio and television dramas, song contests, campaigns, etc. The AMPF has the necessary experience and resources to provide IEC advice and technical assistance to other components of the national FP program.

The present strategy proposes that USAID renew its collaboration with AMPF, under a revised form of project management, and provide the Association with funding to produce some of the high-profile FP/IEC outputs of the strategy such as some mass-media campaigns or the above-mentioned radio drama series.

FORMATIVE RESEARCH AND EVALUATION OF FP/IEC INTERVENTIONS

Evaluation is a weak link of the FP/IEC program in Morocco. Although it is possible to get some idea of how the IEC program is doing from the media coverage and an examination of service statistics when they are available, there is no on-going mechanism to verify to what extent IEC activities have any influence on people's behavior, and what communication channels are the most effective. The strategy proposes to reinforce the research/ evaluation component in order to guarantee the quality of IEC interventions and measure their impact. This component should include the following:

Baseline and Evaluation Data

Baseline data at the beginning of any major future IEC initiative will help paint a picture of the FP reality. At this date, many data are available--such as the information from the 1992 DHS--or will eventually be available through the *Evaluation project's* situation analysis that will be carried out under the SEATS project.

In addition, the strategy proposes an initial survey with a limited number of questions with a representative sampling of the population to help gauge specifically the impact of IEC interventions: are messages being remembered? Are they being understood? Are they accepted? Do people recognize the logo and its meaning? Do people discuss FP with their spouses? Do they intend to adopt FP? Do they actually follow through? What are the impression of services and information provided? Their level of satisfaction with the chosen method? Would they recommend FP to a relative or friend?

The same survey will be carried at mid-point and at the end of the project, using the same criteria; the comparative findings will be the gauge for the FP/IEC program's success, and will allow program managers to chart the next phase of the FP/IEC program. Every effort will be made to ensure a quick turn-around time for the surveys; results and findings will be geared primarily toward helping program managers, and will be shared in information sessions or seminars, and published in user-friendly reports to be distributed to all interested parties.

The next DHS which will probably be carried out when many of the proposed FP/IEC activities are in full progress, should provide valuable additional information on the project's effectiveness. Specific questions linked to project interventions could be incorporated into the design of the DHS questionnaire.

Research and Evaluation will, at first require considerable outside technical assistance. Over time, however, the institutional capability will exist within the MSP--at the Institut National d'Administration Sanitaire (INAS) and the DES---to carry out these activities.

Qualitative research

Focus Group Discussions (FGDs) will be one of the principal tools used to implement the strategy. FGDs are an effective and low-cost means for managers of getting a better targeting of their audiences, to learn what motivates people, to get the feedback of health professionals, decision makers and opinion leaders, to design more effective messages, to pretest ideas and IEC materials before they are produced, and to get a feel of how their program is doing. Qualitative research will at first be carried out with the help of outside firms, but the DES should eventually have the capacity and the resources to handle most of this responsibility.

Systematic pretest of all IEC/FP messages and interventions

Pretesting, an essential element of any communication program, is a well-understood concept in Morocco, but it is unfortunately not always put into practice. All FP/IEC activities should be verified--for attractiveness, accuracy, understanding, relevance and credibility--with sample target audiences, before their production or dissemination. The strategy proposes that DES personnel be trained in pretesting methodology, and be made responsible for guaranteeing the quality of all IEC outputs.

Evaluation of IEC Training

In-service training--workshops, seminars and conferences--for health professionals represents one of the most expensive components of an IEC program, and one where it is often difficult to measure the full impact of the intervention. Pre/post tests at the time of the training session area a temporary indicator of how much the participants have learned, but it is no guarantee of how well they will perform when they return in the field.

"Mystery client" surveys can provide important information in this regard. In this type of survey, researchers ask a person to show up at a health facility, claiming to be a prospective client who wants FP information. This mystery-client has previously been trained to check certain objective criteria: the reception, waiting time, whether a choice of methods was offered, if visual aids were used, if side effects were explained, etc. Researchers interview the client after the visit and note down all useful comments. The same process is repeated in a number of FP centers. The main purpose of this technique is to compare counseling and overall service between facilities where staff have attended workshops and those facilities where staff have received no IEC training.

Examination of Service Statistics in Health Facilities

Morocco's Health Statistics could prove a useful instrument to measure the effectiveness of the IEC program. Program managers should be able to compare usage and dropout rates between centers with IEC-trained and untrained personnel. It will also be possible to note any increase in attendance that can be linked to specific IEC interventions such as mass media campaigns.

The proposed global budget envelope for Research and Evaluation is \$500,000.

Recapitulation of proposed family planning IEC expenditures

The list that follows summarizes the proposed expenditures described in the family planning strategy. An additional line item has been added to cover the cost of in-country technical assistance. This budget estimate does not include the cost of project management or external technical assistance. These costs are mentioned in the Strategy's Management Section.

. IEC training of AES, VDMS workers and clinic based health workers	\$ 600,000
. Production/purchase of FP/IEC materials for health providers	550,000
. Production of FP/IEC materials for clients	1,125,000
. FP/IEC Mass Media	1,500,000
. 5 provincial level IEC campaigns	350,000
. Male motivation program	300,000
. Promotion of public sector health providers	300,000
. Campaigns to promote long-lasting methods	300,000
. IEC training in long-term method counseling for VDMS workers	150,000
. Promotion of pharmacists as FP providers	150,000
. Promotion of private physicians as FP providers	50,000
. Formative research and Evaluation	500,000
. In-country technical assistance	<u>500,000</u>
TOTAL IN-COUNTRY PROPOSED EXPENDITURES FOR FP/IEC:	<u>\$6,500,000</u>

CHAPTER 5

MATERNAL AND CHILD HEALTH

Health Background

Despite Morocco's important progress in lowering fertility (from 5.9 children per woman in 1979-80 to 4.2 in 1992) and infant mortality (from 88 deaths per 1000 live births in 1978-82 to 57 per 1000 in 1992), many areas in MCH need attention. The areas discussed below are those in which USAID plans to invest in IEC programs.

According to the 1992 Demographic and Health Survey (DHS), only 16.5 percent of children with a recent case of diarrhea were treated at home with oral rehydration solution (ORS). Reasons for this low usage were not covered in the DHS report, but discussions with MSP staff and informal observations suggest that it is a problem both of supply (limited access to ORS packets) and demand (information about CDD, including ORT, is not widely and clearly disseminated). The DHS also revealed a decrease of hospital mortality due to dehydration and fewer cases presenting, yet diarrhea remains the first cause of death of children in Morocco.

Other statistics from the current DHS relevant to maternal and child health show that few women have deliveries assisted by medically trained personnel (physicians, nurses or mid-wives), specifically, about 63 percent of urban women and 14 percent of rural women. The DHS shows that attended deliveries increase with increases in women's level of education. About 20 percent of illiterate women have attended births compared to 65 percent for women with a primary education. These findings may be confounded by the fact that women in urban areas have easier access to education and medical facilities.

Because so many births take place outside health facilities, documenting maternal mortality is difficult. Indeed, no national statistics are available based on a direct measure of mortality during or after delivery. Mortality statistics from regional hospitals collected over several years from the mid 1970s to early 1980s, indicate 586 maternal deaths per 100,000 live births in Oujda, 406 maternal deaths per 100,000 live births in Marrakech, and 257 in Rabat.

The implementation of a structured program for pre-natal care began recently in 1987. This explains in part why use of these services is low. Indeed, only 48 percent of urban women and 13 percent of rural women received at least one pre-natal visit and 30 percent of urban women and 4 percent of rural women received 3 or more visits. Reasons for these low figures are cited in the national strategy for safe motherhood as, inaccessibility, lack of information, socio-cultural constraints, and lack of integration of pre-natal care in other health interventions. In contrast to these low figures, over half the pregnant women in both urban and rural areas receive a neonatal tetanus vaccination. This means that many have contact with the medical system but do not use it for care during pregnancy and delivery. Many women do not see pregnancy as a medical issue.

As for breastfeeding practices, the DHS shows that 96 percent of infants from 0 to 3 months are breastfed of which 62 percent are breastfed exclusively. By 10 to 12 months, breastfeeding drops to 70 percent which is still relatively high. Nevertheless, a closer look at breastfeeding practices from population based surveys done in 1985 and 1987 shows that 46% of urban women introduce the bottle at 2 months versus 11% of rural women. More women in the middle (44%) and upper classes (64%) use the bottle than do poor women (13%). Stated reasons for stopping breastfeeding among urban women were most notably: insufficient milk (28%), mother's illness (24%) and normal weaning age (21%). Rural women stated: pregnancy (35%), normal weaning age (27%) and mother's illness (18%). The studies also showed that although health professionals report a positive attitude toward breastfeeding, no professional category is responsible for promoting the practice among women. In addition, health professionals were not aware that breastfeeding is declining in Morocco.

Major Issues for the DPES in the Ministry

Within the DPES, the Division de Santé Maternelle et Infantile (DSMI) is responsible for programs including diarrheal disease control (CDD), breastfeeding and maternal health. The DSMI has produced a variety of IEC materials for health workers and mothers in the areas of CDD and breastfeeding. The DSMI has also been involved in the production, distribution and promotion of Biosel, the locally produced packets of oral rehydration salts. UNICEF funds activities in immunization and CDD, and has started the "baby friendly hospital" program. The Catholic Relief Service (with USAID funds) has been working with staff in nutrition to develop an IEC strategy for the promotion of breastfeeding. This support will end in December, 1992. Because other donors have been large contributors to DSMI activities and USAID has been the major donor to support family planning, USAID's involvement to date in maternal and child health activities has been limited. It will be important for new USAID support for IEC programs in MCH to build upon the work and planning already in progress in the various program areas and to reinforce the move toward integrating services and IEC activities in the provinces.

The DPES will need to address the health issues cited above through both systems and policy changes and IEC programs. Even well designed and executed IEC programs will not have much impact unless they are supported by favorable conditions in the health care system and health policy areas. Two important concerns in systems and policy emerged during discussions with MSP staff and others that need to be addressed in MCH in conjunction with work in IEC: a) integrating services at the patient contact level both at fixed facilities and with itinerant workers, and b) in CDD, increasing the availability of ORS packets by making packets available through sources outside of the health care system.

The DPES is working to improve the integration of services and health education in dispensaries and health centers. Currently, a woman bringing in an infant for diarrhea may not get family planning counseling, or the child's immunization record may not be examined. It will be important that the MCH and FP program areas continue to work towards better integration

both in treatment and in health education. This is reflected in the recommendations throughout this report.

A major policy issue is that packets of ORS are considered a medicine and therefore are available to the public only through medical facilities, itinerant nurses, mobile units and pharmacies. Women in rural areas are not able to obtain packets when needed because they cannot reach a pharmacy or the medical system easily, and they are given only enough packets to treat single cases of diarrhea. The MSP, especially the DPES, should take the lead in changing policy and addressing the management of packet distribution in order to strengthen the current distribution system and to create a controlled distribution program outside the health system. The DPES should engage the pharmaceutical profession in this process since the industry has a major role in current practices and has much to gain or lose with wider distribution of packets. In these meetings with the pharmacists, the DPES should find answers to the following questions: What policy issues need to be addressed to allow both wider distribution and safe administration of ORS in the home? What can pharmacists do to improve the distribution of packets to retailers and improve the education to purchasers? What strategies can pharmacists suggest to make packets more accessible to rural women--in places where there are no pharmacies or dispensaries? How can mixing instructions be reliably and accurately given with purchases?

Programs in other countries have been designed where distribution to other retail outlets ("depot villageois") is done by the pharmaceutical company's own detailers. They sell supplies of packets and provide a simple countertop display unit for small retailers. The retailers buy more supplies according to the demand. The detailers can be trained to show retailers how to explain mixing and administration of ORS from the packets. Another possibility to create better private sector supply of packets and CDD information is to model distribution after the approach used by family planning in Morocco. The approach uses contacts in the community such as tobacconists, hair dressers, small retailers in souks to supply contraceptives and family planning information to their customers. The MSP animateurs (AES) could briefly train similar types of people in CDD issues and provide them with a supply of packets, teaching aides and a plaque which would identify them as the ORS packet and information source in the community.

During document review, interviews with DSMI staff and observations in two provinces, the following issues directly related to IEC emerged which have helped to shape proposed IEC strategies in CDD, breastfeeding and safe motherhood:

1. Reaching widely dispersed and difficult to access rural populations where health status nearly always lags behind that of urban areas is a high priority. Service availability and quality, cost effectiveness, logistics, credible communication channels, and health policy issues must be confronted when designing appropriate communication strategies to help rural populations improve health.

2. In CDD, although the DSMI has developed and distributed a set of norms for home therapy of diarrhea, no research has been done to document how effectively health workers

communicate this information to mothers and how well mothers follow through at home. Little is known about how well they give liquids, food and breastfeed during diarrhea, mix and administer ORS, and know signs of worsening diarrhea/dehydration to prompt referral to a health facility. In the provinces observed, health workers did not deliver these messages clearly.

3. As stated earlier, few women give birth in health facilities, especially in rural areas. In urban and periurban areas, pre-natal and birthing services are often under-utilized. An IEC program, working in conjunction with service improvement could promote these services. In rural areas, these services are frequently non-existent or inaccessible, and alternatives to assure safe motherhood need to be found. This dictates creative IEC strategies to lower high risk pregnancies and to increase the number of safe births at home in isolated rural areas. In localities where a referral system for high-risk pregnancies is in place, an IEC program could promote its use.

4. Traditional birth attendants are a possible channel of communication to rural pregnant women. Nevertheless, TBAs are a heterogeneous group of women who are not easily identified. An individual TBA may help in only 4 or 5 births a year and is often in contact with a pregnant woman only at the time of delivery, so the design and implementation of a communication program using TBAs as intermediaries needs further exploration.

5. While many women breastfeed in Morocco, most introduce other foods or liquids early. Urban women employed in the formal sector have difficulty breastfeeding exclusively for the recommended five months. The DSMI has recently conducted a study to review hospital practices and policies on breastfeeding. When available, these results will help shape IEC strategies for medical personnel. In addition, UNICEF is launching its "baby friendly hospital" program and IEC strategy development should take these activities into account.

6. With current funding patterns, the DSMI has not been able to develop a communication program with appropriate research and pretesting. Usually, the DSMI does strategy and message conceptualization itself, and then when funding is available, it moves quickly to production of materials. It has also been unable to implement a phased communication campaign with a series of messages over time and through integrated channels (eg. radio spots repeating the same messages as health workers).

Given these issues, the following IEC strategies are proposed for maternal and child health.

Rural Strategy

Reach isolated populations with radio messages specially designed to help families improve the health of children and mothers with little or no access to health services or supplies.

- a. For hard to reach and sparsely populated areas, regional radio is probably the most cost effective medium to promote health practices. (The DHS reports 80% radio ownership in rural areas.) Radio programs should focus on what mothers, families and communities can do themselves to maintain the health of children and women. As health services become available locally, radio programming can encourage the use of these services in addition to home treatment.
- b. This regional radio programming would cover all MCH and FP areas and would be developed initially as part of the provincial IEC pilot program described in the Institution Capacity Building chapter of this report. Core IEC teams from selected provinces would work with central DES, SMI and FP programs to develop a package of basic radio spots to cover priority health behaviors to isolated audiences. The teams would then adapt the spots to their own local conditions, culture and language.
- c. The core teams would design programs and messages which emphasize
 - prevention of disease, malnutrition and high risk pregnancies,
 - home treatments for childhood diseases and delivery, and
 - community support for prevention and home treatment.
- d. The core teams would also work with provincial radio personnel to ensure airing of programs and spots
 - at the appropriate time of day for target audience,
 - at the appropriate season for best prevention and care,
 - on a regular basis over the course of a year, and
 - at the lowest cost possible.

Diarrheal disease control

The major IEC activity in CDD until 1990 was the promotion of ORS packets. This was done under the ORS social marketing project. There has been no direct evaluation of the effect of these communication efforts, but the recent DHS showed 16% of respondents actually used ORS (packets and home mix) for the most recent case of diarrhea. Since 1990, the DSMI is doing more than promotion of Biosel. Research suggested that case management of diarrhea could be improved, so they are emphasizing training health workers in better case management and interpersonal communication about home therapy and appropriate referral of severe cases. The rationale is that better service delivery will increase demand as well as lower mortality.

Indeed, the quality of information and treatment skills health workers transmit to mothers is questionable. Discussions with MSP personnel and (informal) field observations revealed the need to strengthen health workers' interpersonal communication skills and review the content of their messages. As mentioned in other sections of this report, these IEC issues are part of a larger systematic problem of how cases are handled in health facilities. The move to a more holistic and comprehensive treatment of cases would give health workers a better opportunity to

give appropriate health messages while clients are visiting the facility. Before investing heavily in communication skills training of health workers however, the MSP should investigate to what extent working conditions and supervision of health workers contribute to unsatisfactory communication with mothers. USAID should support both the skills training of health workers as well as the training of management and supervisory skills of other health personnel to achieve sustainable quality performance of front-line health workers.

The following are recommended IEC strategies in CDD. All strategies would be implemented centrally and in the provinces through the general structure outlined in an earlier chapter. Thus, provincial activities in CDD suggested below would be part of the core teams' needs assessment and provincial IEC action plan, and then carried out in conjunction with the local health system, radio and community. Central level activities would be designed and implemented or coordinated by both the DES and CDD.

Increase the use of health facilities and pharmacies as sources of CDD information and ORS packets.

a. In sites where services exist (in provinces selected for the IEC provincial pilot project), conduct a small observational research study to identify what are remaining problems in mothers' practices such as: i. how well can mothers mix ORS? ii. do they know how to administer enough ORS to a sick child? iii. what are feeding practices (including BF) during/after an episode? iv. can they recognize signs of serious dehydration? What do they do when these signs appear? The study would also identify what are mothers' knowledge and attitudes about diarrheal disease, its treatment and why they do not use ORS. The same study would also observe health workers' practices: Does the HW demonstrate ORS mixing, get the mother to practice mixing and administering, discuss feeding strategy, signs of severe dehydration and appropriate action?

This research will serve three purposes. First, it can serve as formative research to help design messages for mothers, second, as a skills assessment to design training for health workers, and third, as a baseline measure of practices. When the communication program in CDD has been implemented in this locality, follow-up observations can be made to measure the program's impact on practices of mothers and health workers as well as to what extent the demand for ORS has changed.

b. Based on the above research results, review CDD messages and materials for health workers. Revise as necessary. If the research shows deficits in health worker communication skills, design and implement training in CDD counseling skills.

c. At both central and provincial levels, CDD should work with other program areas (FP, breastfeeding, safe motherhood) to increase the integration of services and messages at the health facility. Develop a counseling aid for health workers that reflects the integrated approach.

- d. The CDD should work with the ORS social marketing project to assure that women buying packets in pharmacies are instructed in how to mix the solution correctly.

Increase the proper treatment of diarrhea and dehydration in the home.

- a. To combat diarrhea in general in Morocco, home treatment of diarrhea must be promoted. This can be done if mothers have BOTH the supplies and skills to mix and administer ORS. Thus, even before ORS packet access is improved, messages to promote proper use of ORS should be promulgated. These messages should be integrated with the overall messages about home therapy and appropriate referral to the health system for severe cases. To combat diarrhea in rural Morocco, special messages encouraging use of home available fluids should be designed for those areas where home available fluids are the only feasible rehydrants.

Animateurs should utilize communication channels working the best in their province to reach mothers: radio, women's associations and foyers feminins, health workers, or other community members. As mentioned above, the central level DSMI would work in conjunction with the DES to devise standard messages that provincial animateurs could adopt to local conditions and medium of communication.

- b. The DES and CDD should develop a series of instructive messages on home therapy for regional radio. These would be part of a more comprehensive health package for regional radio stations as described above.

- c. In the fourth year of the project, design and conduct research to evaluate the combined impact of interpersonal and radio communication activities on mothers' actual treatment of diarrhea in the home.

Safe Motherhood

In maternal health, the DSMI has a brief IEC strategy included in its general national strategy for safe motherhood. The IEC strategy's primary goal is to increase demand for pre-natal services (in concert with improving those services), using health workers as the primary communication channel. It also suggests testing the use of community leaders to address certain traditional practices during pregnancy that put mothers and the fetus at risk. The strategy also lists the following as target audiences: women already visiting health facilities (either for themselves or for their children), women who have access to health facilities but do not use them, women of childbearing age and those women who influence them (eg. mothers-in-law), and lastly, school children and men. A secondary audience would be those who attend deliveries at home. Messages would be specifically targeted to improve their practices and to teach them to identify high risk pregnancies early on.

With funding from UNFPA, the DSMI is currently working in four southern provinces to upgrade dispensaries, renew supplies, train personnel in case management of pregnancy to increase use of pre-natal services. Despite these efforts, the dispensaries are still under utilized for pre-natal visits. Some reasons are that much of the staff is male, who have not mastered effective interpersonal communication. Health workers tend to focus on the technical execution of a pre-natal exam and do not use the opportunity to communicate with the pregnant woman. In addition, women are not informed of pre-natal services when they come for other problems. UNFPA plans to continue its support of these four provinces and is working with DSMI on an action plan. Peace Corps, working closely with DSMI, will be placing health education volunteers in these same provinces in 1993 and 1994.

Part of the Safe Motherhood national strategy is to provide mothers with information about the risks of pregnancy and to discourage certain traditional practices which put pregnant women at risk. Research needs to be done to identify what these practices are. Careful analysis of these practices would help identify how they can be modified or what new practices could be introduced to replace them. Communicating these messages could be done through channels described above: regional radio, facility-based health workers, TBAs and could be combined with other programs in maternal and child health and family planning.

Despite having a national strategy for safe motherhood, the DSMI has expressed the need for further research to identify more clearly the KAP of urban and rural women about pregnancy and childbirth. Such a study would be the basis for a more detailed IEC strategy than that included in the general national plan. This research should be done before the proposed project's start up in 1994. Until this work is done, however, it is premature to recommend specific IEC activities.

One of the most difficult questions to answer in safe motherhood is how to identify pregnant women and get them in contact with at least an information source if not medical services. Since many women do not believe that pregnancy is a medical issue (it's a normal function for a woman), moving the source of information about safe motherhood outside of the medical system should be considered. Research could identify respected sources of information in the community concerning pregnancy and childbirth. Messages over provincial radio would reach many women not reachable through face to face channels or through health facilities. As stated earlier, messages would need to emphasize self-identification and self-help during pregnancy and delivery as well as avoiding a high risk pregnancy. These sorts of messages have worked in other countries where women's mobility is limited due to rugged terrain or Islamic traditions.

Increase demand for pre-natal services by improving the quality of information and communication.

- a. Select sites (from SEATS research findings or in provincial pilot areas) where adequate prenatal services are under utilized. Animateurs should conduct focus groups with health facility staff to have them identify what they could change in facility

procedures and their own behavior to make visits less aversive and more informative to pregnant women. Focus groups with women from the target groups mentioned above would also shed light on where improvements could be made. These suggestions would be part of the needs assessment and action plan conducted by the core IEC team in the province.

b. Offer a motivational scheme to women who complete two prenatal visits and are vaccinated for neonatal tetanus.

c. As part of the regional radio programming for health and FP, promote the new, improved prenatal services.

d. A community based referral system should also be strengthened by working with TBAs. Begin with research on the feasibility of using TBAs as communication channels for reaching pregnant women. Some of the complexities of working through TBAs were outlined above, but training activities should be piloted at a few sites that would modify certain practices and teach signs of high risk patients needing referral to a health facility.

Increase the number safe deliveries of rural women not reachable by health services.

a. Conduct survey research on pregnancy and child birth KAP of rural and urban women birthing at home.

b. Inform women of risks of pregnancy, when and where to receive help, how to avoid high risk pregnancy, and how to maintain a healthy pregnancy. These messages could be incorporated into the package of messages developed for the regional radio program on SMI and FP.

c. Modify traditional practices harmful to pregnant women. Use channels for these messages such as community leaders, mothers and mothers-in-law of pregnant women, and TBAs.

d. Work with TBAs to improve birthing conditions and practices in the home. Another strategy (tried in other countries) is to teach pregnant women directly to set up proper birthing conditions themselves in their own home.

Breastfeeding

The DSMI has been working with Catholic Relief Services to do research, develop an IEC strategy, produce print materials and train health workers to promote breastfeeding. The IEC strategy is based on survey research done in Morocco in 1987 and 1985.

Major conclusions from these results are the following:

1. Giving the breast soon after birth is not widely practiced whether giving birth at home or in a medical facility.
2. New mothers have a negative attitude about breastfeeding and are often frustrated by not knowing how to do it.
3. Women are not prepared during their pregnancy to breastfeed.
4. Women generally do not know the value of colostrum.
5. Women stop breastfeeding for a variety of reasons which could be addressed through better information.
6. Constraints associated with returning to work and work schedules encourage urban women to abandon breastfeeding prematurely.
7. Premature and abrupt weaning are common practices in Morocco.

The IEC strategy identifies new mothers, urban working women, and mothers at home in "suburban" areas as primary target groups. Secondary target audiences are health professionals who are in contact with women such as OB-GYN, midwives, TEAs, pharmacy assistants, heads of foyers feminins, certain PVOs and medical schools.

There are well thought out IEC and training activities for each of these target audiences described in the strategy plan. It is difficult to gauge where DSMI will be in implementing these activities when the present project begins in 1994. Nevertheless, during USAID's planning phase, funds can be earmarked for breastfeeding activities and the specific activities can be identified in 1994. This will allow better coordination of these activities with other MSP IEC programs as well as with other USAID funded projects. For example, the IEC strategy targets urban women working in large factories and businesses. The support and informational activities identified can be incorporated into AID's private sector project. Working with foyers feminins on breastfeeding promotion can easily include information on safe motherhood or family planning. As integrating care and health education in health facilities progresses in the proposed project, breastfeeding information can be added to the healthworker's routine.

The one aspect of communication not mentioned in the breastfeeding IEC strategy is pretesting materials before finalization and evaluation of the impact of IEC activities on the practices of women and health professionals. The DES can help to pretest materials and work with DSMI to produce appropriate materials for each target audience. Not all activities can be evaluated for impact, but one study of health workers' practices and one of mothers' practices after an IEC intervention should be undertaken (possibly by INAS students) and funded.

This report recommends considering one or all of the following as priority objectives of a USAID funded strategy in breastfeeding.

Improve practices of women currently breastfeeding, prepare first-time mothers for breastfeeding, and engage health professionals in supporting the practice.

- a. **Select and support activities described in the DSMI's IEC action plan. Begin with necessary KAP research with a selected target audience.**
- b. **Evaluate at least one activity described in the DSMI's IEC action plan targeting mothers and one targeting health professionals to measure the degree of behavior change.**
- c. **Work with the DES to support provincial IEC programs in SMI with materials and training.**
- d. **Prepare breastfeeding messages for the regional radio program.**

Proposed Financial Allocation for Implementing MCH IEC Strategy:

Workshops with provincial radio personnel and health education animateurs	\$ 40,000
Diarrheal Disease Control	\$800,000
KAP research (mothers and health workers)	
training of health workers in CDD counseling	
developing radio spots and programs for provinces	
developing print materials for health workers, pharmacists and other distributors of ORS packets and information	
evaluation research of IEC efforts to modify IEC program in general and update radio messages in particular	
Safe Motherhood	\$600,000
Focus group discussion research	
Clinic-based motivational scheme for pregnant women	
Radio spots and programs for provinces	
Research on traditional birth attendants (TBAs)	
Development of messages and training for TBAs	
Breastfeeding	\$560,000
KAP on breastfeeding (and its constraints) of women in a particular target audience	
Evaluation research of impact of IEC efforts with mothers and with health providers	
Radio spots and programs for provinces	
Development of materials and training for <u>provincial</u> IEC programs	

CHAPTER 6

AIDS EDUCATION

Introduction and Analysis

Morocco is currently less affected by AIDS than many other countries of Africa with a total number of only 121 cases reported. Nevertheless, the concern for the more rapid spread of the disease has prompted Government authorities to follow WHO/GPA guidelines and create a National AIDS Commission (NAC), to begin to take aggressive actions to protect the blood supply, to plan for the care and treatment of an eventually much larger AIDS patient population, and most importantly to begin vigorous efforts to educate the public about the disease.

Recent studies done in Morocco have shown that the proportion of heterosexually transmitted AIDS has increased from 20 percent between 1986-1989 to over 54 percent between 1990-1992. Although because of the exceedingly small number of reported AIDS cases no confirmation of this trend can be made, it appears likely that heterosexual transmission will be more and more the principal means of transmission. At the same time, KAP studies have shown that there is only a vague and incomplete understanding of disease transmission, treatment and lack of cure, risk factors, and means of prevention. Particularly disconcerting is the lack of understanding of the increased risk of transmission through sexual contact. Recent documents have concluded that while AIDS prevalence is low, efforts now to increase awareness and understanding will pay distinct rewards.

The AIDS program in Morocco officially began in 1988 with the creation of the NAC and the creation of the Programme National de la Lutte contre le SIDA, located in the MSP Direction de l'Epidemiologie et des Programmes Sanitaires. Shortly thereafter epidemiological surveillance studies were undertaken, steps to protect the blood supply instituted, the training of community and professional leaders begun, and IEC programs initiated.

Over the last four years since the program's inception PNUD and WHO have been the principal donors to the program, contributing the bulk of both financial and technical assistance. AIDSCOM, a centrally-funded project funded by USAID also provided technical support, primarily for the production of radio and television spots.

The AIDS IEC program, effectively begun early in 1991 with the arrival of the current Chief of IEC programs, Dr. Bezaad, has been characterized by the following major activities:

1. Materials production:

- a tri-annual Information Bulletin distributed to higher-level health professionals and other national and local leaders

- A Guide for Health Professionals on AIDS and one for sexually transmitted diseases (STDs)
- A series of brochures, leaflets, stickers, and other popular print material for public distribution
- A series of posters on AIDS
- 2 Radio spots and 1 television spot on AIDS (in preparation)

2. Sensitization and Training

Through the offices of the AIDS Commission - a body comprised of officials from a variety of governmental, private, and non-governmental organizations, the AIDS program has carried out a series of seminars, workshops, and roundtable discussions on AIDS in various settings. The variety and extent of this training component has been possible through the participation of resource persons - professionals identified by the AIDS commission and the AIDS program to organize and offer sensitization/education courses to their clientele, assisted in technical matters by representatives from the MSP.

While no quantitative data concerning the number of sensitization/education sessions that have been held were obtained by the IEC strategy design team, the ambitious effort has been noted - particularly the way in which the limited number of MSP AIDS program staff have enlisted the support of other agencies and other ministries.

Training is also considered an important goal of the AIDS program. The training of trainers - that is those who will discuss AIDS with their own client groups - has been begun and must continue.

AIDS IEC program goals have been equally ambitious, with the goal of reaching national and community leaders, the public at large, and high-risk groups of the population. In its relatively short life the IEC program has succeeded in developing basic informational materials for the general public and perhaps more importantly in providing training/sensitization workshops in a variety of sectors.

The needs of the IEC program as stated by the AIDS IEC representatives are as follows:

1. Evaluation. According to representatives of the AIDS IEC program, the first priority is the evaluation of all educational efforts done to date. Since no such evaluation has been done, no conclusions can be drawn concerning the print materials, the mass media productions, or the seminars and workshops, and no meaningful modification or re-orientation of the program can be effected.

2. **Materials reproduction.** Although a number of materials have been produced, resources have permitted a reproduction far less than the demand.

3. **KAP studies for specific audiences.** Although the AIDS program wishes to reach a variety of different audiences - youth, married couples, prison populations, prostitutes, etc. - they are unable to do so because of the lack of detailed information about the attitudes and sexual practices of their clients. There is a particularly noteworthy lack of detailed information about the beliefs and attitudes of health providers towards AIDS and the various policies and programs that are associated with it.

The Grandes Lignes du Plan d'Action IEC prepared by the MPS AIDS program identifies the following priority target groups:

- Health professionals
- Traditional practitioners (circumcision; tattoos; ear-piercing; traditional birth attendants)
- the public at large
- Youth; and
- and individuals at particular risk.

Recommendations

Given the active participation of other international donors in the national AIDS program, it is recommended that USAID focus its investment in reaching three specific groups of the population of which two have the highest priority:

1. Populations of highest risk and likely highest seropositivity (e.g., prostitutes, prison populations, the military).

2. Youth - a population perhaps now seronegative, but in high risk of infection.

In addition, the project, through its IEC interventions at the clinic level, can play an important role in engaging women in a dialogue about AIDS - particularly about their perceived risk and the most appropriate contraceptive for their risk group.

The specific interventions to be funded by USAID would be:

1. **KAP and Operations Research on youth and high-risk populations:**

a. KAP research on risk-related sexual practices and habits of particular groups including the large major categories of sexually active men and women in traditional marriages and unmarried men and women; and more specific categories such as prison populations, military recruits, prostitutes, and gay populations.

b. Operations Research to identify those groups of youth and high-risk individuals which can be reached most easily and effectively; and similar research to determine the best means to provide this information (i.e. interpersonally, through print materials, video, etc.). While this work has already been begun by the AIDS program, it has not yet been able to carry out the in-depth exploration necessary to fully understand and characterize each subgroup of the many target populations identified and to determine how best to reach them. Ways to reach prostitutes, for example, are not immediately evident. Although efforts have been made to present prison populations with AIDS information, more needs to be known about how to present this information in the vernacular, with striking and graphic illustrations designed to motivate even more hardened criminals;

2. Strategic planning and campaign development. Strategic planning is required to take the information provided in the research outlined above and to develop programs and campaigns to reach specific audiences. Such strategic planning requires attention paid to: priority - some groups, such as prostitutes and prison populations, while small, represent a disproportionate threat to the population at large. Prostitutes' contact with the general public multiplies geometrically the risk of AIDS as does the sexual contact provided by returning prisoners; timing - some frank messages should only be discussed in interpersonal forums, while more general messages on the threat and danger of AIDS to youth, for example, can be presented in the mass media. As public interest and tolerance increase, more and more direct and graphic representations can be presented more widely; media - each target group has particular media needs. Youth, for example, may more appreciate a hip MTV image and treatment, with the participation of popular stars; prison and military populations may respond to far more graphic and realistic images; theme - some audiences may best respond to a direct, if not shocking approach to the disease; others may need a more expository approach; others an up-beat presentation of the ease of protection and the peace-of-mind it fosters.

3. Materials and media production. Careful attention should be paid to: cost-effectiveness - general information provided on radio, television, and glossy posters for youth may help to raise general awareness, but at what point does their generality render them ineffective. Careful study must be carried out to determine how to progress from the general to the specific in media programming; targeting - brochures and leaflets are relatively inexpensive given cost-per-material in large printing runs. However, they can be wasted if they are directed to the wrong audiences.

4. Training in planning, management, and training. While the AIDS IEC program staff has worked efficiently to date with its donor partners and with the AIDS Commission, as the program expands rapidly to include more diverse groups, more diverse media, and more time-consuming conferences and seminars, the management demands of the program will increase. Defining terms of reference, work plans, performance criteria, program objectives, etc. will

become of even more importance. Training in these and other management skills will be critical. The training of trainers is another important element in the AIDS IEC program. One of the particularly positive elements of the AIDS program is their use of resource persons to participate in the education/training of target groups. Yet, few of these resource persons have been trained in communication skills - how to communicate to a particular audience. As indicated above, the message, theme, and didactic approach of each encounter will differ according to audience characteristics and the training of trainers should reflect that. Appropriate training materials should also be included in any training program.

5. Monitoring and evaluation of all activities.

These activities would be undertaken as follows:

1. A careful review and assessment of the two primary target audiences for the project - youth and high-risk groups - should be undertaken to determine which subgroups of these populations should be targeted initially - i.e. during the first two years of the campaign. While youth is a large category, it must be broken down by age and socio-economic status, the corresponding AIDS risk, the different levels of receptiveness of each of these groups, etc. While there are many high-risk populations in the country, such as those suggested above, given the classic transmission routes in other countries and disproportionate role of prostitutes in that transmission, this group might be the one most deserving of early attention. While reaching prison and military populations offers institutional structure and largely captive audiences, certain policy factors may militate against such interventions: USAID may have regulations restricting US funds channeled to foreign military establishments; discussing AIDS in a prison context requires a more open admission of homosexual activity than heretofore acknowledged publicly.

This review and assessment would be undertaken by the PNLs (Programme National de la Lutte contre le SIDA) in collaboration with subcontracted agencies (NGOs, private research groups, universities, etc.).

2. Once a determination of which subgroups of the two major target groups are to be reached in the first phase of the project, detailed KAP studies should be carried out of these groups to determine as much as possible about sexual knowledge, attitudes, and practices. These KAP studies will also be undertaken in collaboration with NGOs, private research groups, universities, etc.).

3. Simultaneously, operations research should be carried out to determine the best ways of reaching these audiences: who among the many possible interpersonal agents available (teachers, social workers, health workers, AIDS patients, teenagers, etc.) would have the most impact on the populations targeted? Which of the many public and private institutions in the country - government agencies, NGOs, etc. - can play the most effective role? An NGO such as ALCS, for example, may be best placed to implement a prostitute and/or prison IEC program, whereas Ministry of Education staff may be more appropriate for dealing with youth.

Reaching youth in a country where relatively few children attend high school will present problems. While this problem may be addressed by working primarily in major urban centers (where the risk of AIDS would be highest), it cannot be avoided. Thorough investigation must be carried out to determine how, outside of the formal educational structure, youth - both male and female - can be reached through existing institutions. Peer group support is thought to be particularly important in AIDS education. Assessing one's own risk and confronting it, and learning to deal with the subtle changes in sexual interaction that come about in an AIDS environment, requires the support of one's friends and associates and the presence of a trusted teacher or social worker.

This aspect of institutional identification is particularly important, given the currently limited staff of the AIDS program and its reliance on collaborators. How can the target groups be organized so that they can be reached in a regular and continuous way? What kind of media would be most appropriate for these populations? This operations research will be directed by the PNLs, but will be undertaken under subcontract with public or private agencies, as above.

4. Once Steps 2 and 3 have been carried out, a strategic IEC plan can be developed by the AIDS Program staff - one which indicates who is to be reached, with what means, with what frequency, over what period of time, and at what cost. Particular attention should be paid to what specific messages are transmitted. Given the relatively low risk of AIDS in Morocco now, what should be told to youth? Even if a general message on the threat of AIDS and the importance of protection is broadcast on the radio, interpersonal counsellors will have to offer specific advice: that a condom must be used at all times? Only under certain conditions? Only during illicit encounters? Will Government policy permit such frank discussions?

The issue of frankness on homosexual sex in prisons has been raised above.

5. Once a strategic plan has been developed key activities can begin:

a. the training of trainers - those key agents in the military, the prison system, the social welfare system, the Ministries of Education and Youth and Sports, NGOs, etc. This training would be done by AIDS Program staff who will have been trained by the project in TOT skills;

b. the development of media programs and materials. This production will be done by the AIDS program;

c. the implementation of both the interpersonal and media components of the program;

d. supervision, monitoring, and evaluation. Given the limited staff of the PNLs, most monitoring will be undertaken by the individual organizations participating in the program, but the PNLs will provide them with monitoring guidelines to measure the performance of their programs. To the degree possible, the PNLs will also participate in monitoring, but largely through periodic supervisory visits to schools, prisons, military installations, brothels, etc.

In addition to these program interventions to reach youth and high-risk groups, it is recommended also that AIDS and Family Planning be increasingly linked in all communication efforts. While it is acknowledged that this is still a politically sensitive issue, it is felt that some basic steps should be taken in the implementation of the Provincial IEC programs and in the Family Planning IEC programs, discussed elsewhere in this document.

Improved clinic- and VDMS-based interpersonal IEC activities can promote AIDS education as follows:

1. If history-taking and record-keeping at fixed clinics can include questions on HIV/AIDS risk, then proper referral and counseling can occur.

2. Family planning counseling can and increasingly must include questions on HIV risk. If a woman defines herself at risk, then she and her husband/partner must use the condom alone or in addition to other methods of contraception. Since clinics in most areas are staffed by women nurses, such intimate counseling can occur.

3. AIDS counseling for men in rural areas, perhaps now those least affected by AIDS, but likely soon to be affected, can be important in slowing the introduction of the disease. Since VDMS outreach workers are almost exclusively men, they are in a particularly advantageous position to discuss a sensitive topic with their male clients. In home-visit situations in particular, men at risk can be identified and be given the proper counseling. At rural contact points in areas which are in proximity to high AIDS risk areas (such as the areas surrounding Morocco's major cities), special discussions can be organized concerning AIDS prevention.

4. The training of both clinic-based and VDMS outreach personnel should include modules on AIDS education - particularly how to elicit information from clients on their HIV risk and how to introduce the subject of AIDS.

Secondly, the FP/MCH project of USAID can help to promote positive policy shifts to include AIDS prevention in family planning in two ways:

1. To identify women as important, if not major targets for AIDS education. Even though it may be men who are and will continue to be the primary vector for the spread of AIDS and to whom the most aggressive campaign of protection is to be directed, women must realize the importance of their insistence on protection. An official policy of the Department of Health indicating the right of women to protection and the inclusion of them as an important IEC target group will be important.

2. To establish a clear policy that if a woman does identify herself at risk, that she be instructed in ways to protect herself. While no one denies that this is will be a difficult task in Morocco as it has been in other countries (requesting of one's spouse the use of a condom is tantamount to admitting suspicion), if men's sexual peccadillos are tolerated even to a certain degree, that is a basis for at least beginning the discussion.

3. To establish a clear policy that in areas of high risk, promotion of the pill or any other contraceptive method be accompanied by the promotion of the condom.

While these measures may not be considered important now, because of the relatively low incidence of HIV and AIDS, they will certainly be even more germane by 1999-2000, the approximate years of the end of the proposed new project.

While no additional budgeting needs to be envisaged for this proposed AIDS project, nor any special line item in either the family planning or institutional development components of the project, the AIDS-family planning link should be strengthened wherever possible and appropriate.

To assist the PNLS in the execution of the above-described activities to reach youth and high-risk, likely seropositive populations, the project will provide the following:

1. Short-term technical assistance in the following areas: research (needs assessment, KAP, and Operations Research); training (TOT, the development of training and course materials, etc.); strategic planning; media and materials development and production; management, supervision, and monitoring and evaluation.

2. Financial assistance for: research; training; materials development, production, and dissemination; supervision; and monitoring and evaluation.

Budget guidelines for this AIDS education component of the project are as follows:

1. Research - Preliminary Assessment of Prime target groups; KAP studies of two groups; OR @ \$25,000 ea	\$100,000
2. Training of Trainers: 10 Courses @ \$4000	\$ 40,000
3. Interpersonal IEC costs: 200 per year @ \$100 x 4 years	\$ 80,000
4. Media production: TV, radio, slide sets projection equipment, videos, brochures, posters	\$400,000
5. Supervision @ \$ 20,000 (vehicle), \$2500/yr operations x 4	\$ 10,000
6. Office equipment	\$ 5,000
7. Short term consultants: 3 mos. per year x 4 years @ \$10,000	\$120,000
8. Evaluation	<u>\$ 25,000</u>
TOTAL	<u>\$780,000</u>

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ANNEX A

ESTIMATE: IEC PRODUCTION/DISTRIBUTION AND TRAINING COSTS IN MOROCCO

The cost estimates that follow are based on actual bids, information provided by local advertising and marketing professionals, and the team's experience working in Morocco.

Prices do not include Morocco's 19 percent Value Added Tax (VAT) which is sometimes tagged onto the production costs of IEC materials. There is some discrepancy as to whether the VAT needs to be applied to health education materials. Any major USAID-funded health/FP IEC initiative should thoroughly investigate all possibilities for tax breaks on health communication expenses, and avail itself of any opportunity in this area. In addition, as mentioned in the strategy, there appear to be no clear standards for the cost of health advertisements. The possibility of obtaining favorable rates and time slots in the public sector mass media should be discussed at the highest levels between the Ministers of Information and the MSP.

1. **Television spots--production.** In the context of Morocco's economy, advertising and mass media are expensive. Prices quoted for the production of a 30/60-second spot were in the \$40,000-\$50,000 range. The Casablanca-based agencies have high-priced expatriates on staff, and much of the television post-production is done in France. It should be possible, however, through a competitive bidding process, and by relying on local production capabilities, to produce satisfactory television spots for half the price.
2. **Radio spots--production.** Advertising radio spots for campaigns are usually produced in series. It is estimated that three quality 30/60-second radio spots could be produced for approximately \$5,000, using the type of agency talent mentioned above. Prices could be higher if original music is used, etc.
3. **Television and radio spots--broadcast costs.** A prime-time 30 second spot on national television costs approximately \$1,000, and a 30-second radio spot costs \$250. The cost of 60 second spots can be estimated at \$1,700 for television and \$400 for radio.
4. **Radio and television programs--production.** Costs vary enormously, depending on the type of programming. An interview or round-table discussion format will cost a fraction of a scripted soap opera program with actors, exterior locations, etc. For planning purposes, production of an interview/discussion program should be estimated at \$100/program for radio and \$300/program for television. This would be for preparation materials, simple visuals and honoraria for guests if applicable. In addition, there could be lump sum payments from time to time during the project for the purchase of simple materials such as blank tapes or small tape recorders for field interviews. The cost of scripted series of drama/comedy programs (26-39 episodes) could be pegged at \$2,000/episode for radio and \$8,000 for television programming broadcast on the national network.

Prices can vary significantly, depending on how much the State radio and television network will want to contribute at little or no cost (technicians' salaries, facilities, promotion, etc). Normally, there should be no charge for broadcasting ready-to-air radio or television programming on the State network, whether it be at the national or provincial levels.

5. **Print materials.** Because of the heavy competition among printing companies, competitive bids are essential to obtain the best deals possible. Factors that will influence prices include: the quality of the paper, the quantity printed for each item, and whether one is producing four-color or black/white materials. A simple four-color two-fold brochure printed at 500,000 copies will cost \$0.06-0.08 per unit. A four-color 8-page brochure will cost about \$0.25-0.30 per unit for a print run of 25,000 copies. A four-color poster can cost about \$0.50-\$0.75, for an average print run of several thousand copies. In all cases, the cost per unit will go down as the print run increases. These prices do not include creative/design costs which, to be on the safe side, should be estimated at \$3,000-4,000 per item. This includes the cost of texts, artwork, photography, typesetting, proofs, etc. It does not include pretesting expenses.
6. **Local in-country training.** Here again, there are many variables. For planning purposes, \$45-50/day per participant should be budgeted for training; this includes, participant per diem, pro-rated cost of local trainers, coffee breaks, transportation, room rental and workshop materials. It does not include trainers' preparation time or curriculum development. The cost of training participants could diminish significantly if USAID and the MSP agree on reducing or eliminating workshop per diems, as has been discussed in the past. Per diems are, by far, the single largest training expense.
7. **Third-country training programs.** The cost of a short-term three/four week training seminar in the United States is estimated at \$11,000/participant. This includes tuition, return airfare from Morocco to the United States, travelling expenses and per diems in the U.S. The cost of long-term participant training in the United for an advanced degree is pegged at \$25,000-\$30,000/year..

ANNEX B

Field Trip Summary

R. Parlato
E. Murphy

November 11-12, 1992

Following is a summary of major points covered/discovered during the recent field trip to Larach and Tanger Provinces:

1. The Centres de References - family planning clinics only which are set up one per province throughout the country - appear to serve little useful purpose now that IUD insertions can be done at Health Centers by women nurses. The one we visited in Tangiers was large, well-equipped and staffed by 4 nurses who had an average of one client per day.

2. Female nurses can now do IUD insertions.

3. There are currently very strict rules governing sterilizations - a woman has to have a minimum of 4 children, be over 35, have the youngest child over 5, have her husband's consent, etc. It is not clear whether or not these are official written rules or unwritten rules, but they appear to be in force.

4. The lack of a good Management Information System at the clinic level is a major obstacle to IEC counseling. Although information is collected on patients, it is recorded by intervention. That is, there is no one patient record that can be consulted on arrival. A unitary recording system is important to know a child's diarrheal history, a mother's family planning history, etc., regardless of the reason for which she came in. Only with this kind of tracking can counseling begin at the moment of clinic entry and continue through the referral system.

5. The norms for ORS dictate that no ORS packets be distributed to mothers other than the three required to complete treatment of the current episode. Although this is apparently not a problem in urban areas where mothers in principle can return to a health facility whenever her child has diarrhea, it is a major problem in rural areas where the maximum contact with a health agent is once a month at a contact point or mobile team meeting place and a child's diarrheal episodes may not coincide with these visits.

Moreover, and equally important, there is little education of mothers on how to recognize cases of severe diarrhea requiring treatment at a health center. The case of ARI is similar: there is no systematic instruction of mothers on how to recognize a case of severe ARI requiring medical attention.

6. The VDMS system - including home visits, points of contact, and mobile teams - is really an extension of the fixed dispensary. That is, when an infirmier itinerant goes to a contact point or accompanies a mobile team, it is primarily to see patients. Little time, it appears, is allocated or programmed for education. Given the infrequency of the contact point and mobile team visits and the apparent demand during those days of service (similar to a fixed clinic on souk day), even the opportunity for counseling is limited. Since the recruitment of new staff is unlikely (lack of government funds, IMF strictures, etc.), then either the time spent in each point of contact must be increased (and people previously visited at home encouraged to come to the points of contact for services) or the frequency of contacts increased, or the number of personnel present at each contact point or mobile team visit increased.

7. The so-called Animateurs of SMI, MST, Family Planning, etc. are not educators but program managers. The term animateur is a misnomer - even by the admission of provincial staff. Thus, one cannot count on a cadre of actual health educators at the provincial level.

8. The Health Education Animateur is the only such person with a particular health education brief and there is only one animateur per province. Yet he does not have specific terms of reference and operates on an ad hoc, a la demande basis, serving the needs of the other animateurs when needed. Among other responsibilities should be the supervision of VDMS personnel in matters of IEC, the development of long-term radio programs; training clinic staff in IEC counseling, etc.

9. There appears to be strong coordination among different sectors at the provincial level. Roundtable meetings with representatives of all sectors in both provinces visited showed a degree of mutual awareness of programs and cooperation that was encouraging.

10. Representatives of both provinces stated that they rarely if ever see representatives from either DES or the technical divisions from Rabat.

11. In Tangiers, provincial officials stated that they had a good, continuing relationship with the local radio station, but that they had not developed a medium- or long-term plan for radio used. They indicated that they needed to develop such a plan.

12. Both provinces recognized the need for modifying the VDMS program to make it more effective and to include more counseling. In Tanger the delegate had already taken the step of reducing home visits and increasing the number of points of contact and mobile team visits, but was still not entirely happy with overall efficiency.

13. Both provinces agreed that additional community action - such as that provided by AMPF would be ideal to close the gaps in points of contact (once a month on the average). In order to increase the utilization of ORS particularly - that is to provide the continuing demonstration and education needed to promote better ORS use - continuing education and perhaps stocking of ORS is required. A suggestion was made to create a small depot villageois

where ORS is stocked and a volunteer, perhaps provided an incentive by the local commune to provide health and family planning information as well as distribute ORS.

14. Everyone interviewed emphasized the need for widespread and more profound training of health personnel in IEC; these people receive little or no training in communication. At the same time the interviewees mentioned that the people -- particularly the rural people -- must also receive a greater sensibilisation for PF and other preventive health measures.

15. Very few IEC materials were seen on the trip in any health establishment and these were largely those of AMPF. This indicates a need for more materials and a strengthened cooperation with outside agencies, such as AMPF. No conclusions were drawn, however, on the type of additional materials that would be needed, given high illiteracy levels, overall high awareness of family planning etc., but one of the first OR activities to take place would be one to review existing materials and to recommend how they can be supplemented or replaced.

16. There was an avowed interest on the part of the staffs of both provinces to extend the reach of health education beyond the boundaries of the public health service and into the community. There was a willingness to explore ways in which community groups could become increasingly involved as well as other ministerial agencies.

17. The attitude towards AIDS varied widely among the health professionals interviewed. One high-ranking provincial medical official met on the visit insisted that no condoms should be given to prostitutes because it would likely encourage prostitution. Others had no such objections. The question: "Would you automatically give a supply of condoms to a young male with an MST?" was answered either positively, tentatively, or negatively. It appeared clear that investigations to determine the degree of support for various policies and programs is needed.

18. Most of the above observations have been made by other evaluators. Most notable is the document of the UNFPA PRDS exercise in which the above points have been raised. The issue, therefore, is not necessarily bringing new items to the attention of the GOM, but developing projects which can directly and appropriately address them

ANNEX C

Recommendations for IEC FP/MCH Bridging Activities

Although not part of its official scope of work, the IEC strategy team would like to recommend the following activities for possible funding and implementation during the bridging years 1993-1994.

1. Training in IEC planning, design, and management for heads of Divisions of health education (DES), maternal and child health (DSMI) and Population (DP) if the individuals occupying these posts have not yet received such training. In the case where they have, an appropriate person in their division (e.g., head of CDD or Safe Motherhood) should be designated.

The training should be the type offered by the Western Consortium for Public Health, Santa Cruz, CA: "Information, Education and Communication Program Management" or by Population Communication Services at Johns Hopkins in Baltimore, MD: "Nouvelles Orientations de la Communication pour la Santé".

2. The research described in the MCF and AIDS sections of this strategy document can be undertaken during the bridging years. Specifically, they include:

- a) observational - KAP research in CDD of both mothers and HWs
- b) feasibility of using TBAs as a communication channel with pregnant women.
- c) constraints to breastfeeding for specific groups targeted in the DSMI's IEC action plan
- d) research on the KAP of and credible communication channels to reach specific high risk groups for AIDS.
- e) KAP study on pregnancy and child birth among urban and rural women birthing at home.

3. Bridging activities for family planning are specifically mentioned in chapter 4 of this report. They are recapitulated here:

- a) expanded dissemination of the family planning logo
- b) improved coverage of FP issues in the media
- c) production of FP cue cards for health providers
- d) short-term training of AES in the provinces
- e) production and distribution of a FP/sexual responsibility song.

Annex D

Detailed analysis of operational elements of the Provincial IEC system

There are a number of issues in the provincial health education program which must become the focus of renewed DES activity:

1. The counseling system at provincial health establishments is such that very little counseling on any of the above health issues (i.e., Family Planning, ORT) is done on a systematic basis. The reasons for this are as follows. First, activities at health centers are still reactive, rather than proactive. Women who come to the health center for family planning, vaccination, diarrhea treatment or other MCH problem are treated - given the contraceptive method they desire; provided with ORT; or given the vaccination called for. Unfortunately, at the time of the provision of these services, little routine tracking of these clients for other medical problems is apparently done, largely because there is no uniform MIS system - no one form on which a client's recent family planning, vaccination, diarrheal episodes, or ARI history is recorded. Also there is little indication that more informal but perhaps equally well-organized system to organize and consult existing records exist.

As a result persistent health problems are not always routinely discovered, family planning dropouts not always identified, and referral to the proper clinical service not always made.

Second, many of the health activities undertaken under the MCH/FP system are clinic based and do little to encourage patient responsibility and self-care. The case of ORT is illustrative: Current MSP policy is to require all mothers to bring their child to the clinic whenever they have a case of diarrhea. If dehydration is present, they are shown how to mix the ORS solution and sent home with two packets after receiving the first dose. If dehydration is not present, they are sent home and told to give copious liquids and to return if more serious diarrhea occurs. No systematic attempt is made, however, to carefully and thoroughly educate mothers on how to distinguish between a serious and non-serious case of diarrhea. As a result, many cases of severe diarrhea are seen by medical staff far later than they should have been.

If policy permitted the distribution of extra packets of ORS to mothers for future cases of diarrhea, and if there were a careful and systematic instruction of mothers in the proper preparation of ORS, there would be far fewer cases of severe diarrhea seen at the clinic or deaths from diarrhea. The same is true for ARI. Mothers are not systematically taught how to distinguish between serious and non-serious cases.

2. Although most health centers state that they are reasonably faithful and rigorous in their follow-up of family planning dropouts, it is not clear whether most health facilities have established a routine system for identifying these clients and following them up. Ideally, as is

	NOM ORGANISATION	PRESIDENT(E)	ADRESSE	VILLE	TEL	FAX
	23 FEDERATION NATIONALE DES ASSOCIA. MUSICALES DES JEUNES		MINISTERE JEUNESSE & SPORTS	RABAT		
X	24 FEDERATION NATIONALE DU SCOUTISME MAROCAIN		B.P. 776, AGDAL RABAT		77.93.00	
	25 MOUVEMENT DU SCOUT MAROCAIN		Av AL MAGHRIB EL ARABI	RABAT	72.75.22	
	26 MOUVEMENT NATIONAL DES ECOLOGISTES AU MAROC					
X	27 MOUVEMENT TOFOLA CHAABIA		B.P. 205 P. PAL RABAT		76.65.76	
Y	28 ORGANISATION DU SCOUTISME MUSULMAN MAROCAIN		B.P. 481 RABAT	RABAT		
	29 SCOUT NATIONAL		156 Av DES F.A.R.	CASABLANCA		
X	30 SCOUTISME HASSANIA MAROCAIN		B.P. 137 RABAT	RABAT	72.07.01	
	31 SCOUTISME MOHAMADIA		QUARTIER AL BASSATINE A No 2	MEKNES		
X	32 SOCIETE MAROCAINE DE NUTRITION	Dr M'Hamed SEDRATI	B.P. 6202 RABAT			
	33 UNION DES ASSOC MAGHREBINES DE LA PROTECTION DE L'ENFANCE	Mr HASSAN ABOUTALIB	53, Bd ALLAL BEN ABDELLAH	CASABLANCA	30.65.65	
	34 AMICALE DES MEDECINS ET PHARMACIENS PRIVES DE SALE					
X	35 ASSOC MAROCAINE DES SAGES-FEMMES			Michelle Melloufi		
	36 ASSOC MAROC. DES SCIENCES INFIRMIERES ET TECHNIQUES SANITAIRES					

X Fédération de clubs
UNESCO
avec ses clubs régionaux -

NGO's CDD SUPPORT

	NOM ORGANISATION	PRESIDENT(E)	ADRESSE	VILLE	TEL	FAX
X	1 ASSOCIATION MAROCAINE DE SOUTIEN A L'UNICEF	SAR LA PRINCESSE LALLA MERIEM	16BIS NAHDA 2 - YOUSOUFIA	RABAT	75.90.24	
X	2 LIGUE MAROCAINE POUR LA PROTECTION DE L'ENFANCE	SAR LA PRINCESSE LALLA AMINA	HAY NAHDA II ROUTE AKREUCH	RABAT	75.98.75	75.98.80
X	3 LE CROISSANT ROUGE MAROCAIN	SAR LA PRINCESSE LALLA MALIKA	PALAIS EL MOKRI, YOUSOUFIA	RABAT		
X	4 ASSOCIATION POUR LA VIE D'UN ENFANT	Pr IDRISS ALAOUI	32, Av. FAL OULD OUMEIR - AGDAL	RABAT	77.66.06	
X	5 ASSOCIATION DE L'ENTRAIDE FAMILIALE	Mme GHALLAB	RUE BENI MTIR - SOUISSI	RABAT	72.60.41	
X	6 ASSOCIATION D'AIDE ET SOUTIEN AUX ENFANTS ABANDONNES 'AL IHSSANE'	Mme BENOUCHEUD MALI	43 RUE MOUSSA BEN NOUSSAIR	CASABLANCA	27.57.93	
X	7 ASSOCIATION DES PARENTS ET AMIS DES ENFANTS ATTEINTS DU CANCER (L'AVENIR)	Pr LEMSEFFER ALAOUI	HOPITAL DES ENFANTS	RABAT	77.05.13	
X	8 ASSOCIATION DU BOU-REGREG	MR MOHAMED AOUD	RUE OUED DAHAB, MINZAH, BET TANA	SALE	78.07.87	
X	9 ASSOCIATION DU GRAND ATLAS	Mr TAIEB CHKILJ		MARRAKECH		
X	10 ASSOCIATION DU GRAND CASA.	HAIJ BOUCHENTOUF	WILAYA DU GRAND CASABLANCA	CASA		
X	11 ASSOCIATION DU MAROC ORIENTAL 'ANQAD' - OUIDA	Mr AHMED OSMAN	PARLEMENT RABAT	RABAT		
X	12 ASSOCIATION AL BOUGHAZ	Pr HAMZA OUAZZANI	16 RUE CLEMENCEAU	CASABLANCA		
X	13 ASSOCIATION AL MANAR ^{enfants} _{handicappés}	Mme LAZRAK	GOLF DAR ESSALAM Km 7 SOUISSI	RABAT		
X	14 ASSOCIATION CULTURELLE AL MOUHIT	Mr MOHAMED BENAISSA	MTRE AFF CULTURELLES	ASILAH		
X	15 ASSOCIATION DE PROTECTION DE LA FAMILLE MAROCAINE	MME ZHOR LAZRAK	43, RUE EL HATIMI	RABAT	75.28.54	
X	16 ASSOCIATION FES-SAISS - FES	Mr MOHAMED KABBAJ	MTRE TRAVAUX PUBLICS	RABAT		
X	17 ASSOCIATION HANANE POUR LA PROTECTION ENFANTS HANDICAPES		RUE MOULAY YOUSSEF BP 529	TETOUAN		
X	18 ASSOCIATION I.L.I.G.H POUR LE DEVELOP&LA COOPERATION-AGADIR.	Mr A. BOUFETASS	MTRE HABITAT RABAT	RABAT		
X	19 ASSOCIATION MAROCAINE DE PLANIFICATION FAMILIALE	MME ZOHRA DOUKKALI	3 RUE IBN EL KADI	RABAT		
X	20 ASSOCIATION MAROCAINE D'AIDE A L'ENFANT MALADE	M. Mohamed LAILOU	53, bd Allal Ben Abdallah	CASABLANCA	30.85.85	
X	21 ASSOCIATION RIBAT EL FATH	Mr ABDELFATAH FREJ	RUE MADANI BEN EL HOSNI	RABAT	75.61.08	
X	22 FEDERATION NATIONALE DE THEATRE D'ENFANT		B.P. 550 TABRIQUET	SALE		

the case in Tunisia, the file of a new acceptor is kept visible for three months - the minimum time allocated for a dropout to occur. If a woman has not returned to the clinic before three months (for the pill), her file is given to an extension worker for a home visit follow up. It is further not clear whether similar systems of tracking and follow-up are followed for borderline cases of diarrhea, ARI, or malnutrition. To do this requires weekly review of all patient records, flagging of those that need attention, and a regular follow up outreach on the part of already fully-occupied staff. As mentioned above, if the ARI and ORT programs were re-oriented to be proactive and to give individual families more education and more responsibility, this outreach might not be necessary. The point is, a program strategy must be developed to determine when client follow-up is required and for what reasons. Failing either increased client responsibility or clinic staff follow-up, proper treatment and counseling cannot be done.

3. The VDMS outreach program (done through home visits, points of contact, and mobile team visits) is largely reactive as well and puts little emphasis on preventive education. The reason for this is as follows: the VDMS system was set up to extend the dispensary to lower levels of the population. The points of contact and the mobile teams are in essence mobile dispensaries with all the positive attributes and problems of fixed dispensaries. Home visits are carried out largely to follow up cases of infectious disease, such as tuberculosis or malaria. Much less follow up on family planning drop-outs, cases of chronic diarrhea, mixed breastfeeding, etc. is done. Because the outreach activities are, by and large, extensions of the dispensary - and in so doing serve a very legitimate need - they have not been conceived of as education points. Little preventive education is carried out at points de contact or during visits of equipes mobiles. VDMS staff have not been given any recent training in IEC, nor have they been provided regular technical assistance and support by the AES in IEC.

In addition, because the time interval between visits of the outreach personnel is likely to be at least one month, and because very few communities have been organized to participate actively in preventive health programs, no continuity is possible.

A critical element of the VDMS program is personnel management. It has been noted that in some provinces, the VDMS service is losing personnel rapidly. Although the exact reasons for this high dropout rate are not known, a number have been suggested: a lack of support and supervision; an unrealistic workload and diversification of activities; a salary too low for this workload; etc. If this situation is confirmed, a prompt resolution to these management problems will improve both service delivery and IEC.

4. Although radio broadcasts are carried out at the provincial level, they are not done so systematically. No year-long programs, for example, including breastfeeding, ORT, family planning, etc. have been developed, and no real media communication strategy established. This is thought due to the predominant focus on centrally-produced radio and television programs and the relatively slight attention paid to provincial programming.

5. Few print materials have reached the provincial level, and these appear not to have been developed according to any overall strategy or campaign design. Most family planning

materials appear to have been prepared by AMPF. They are basic and generally informative but have neither been targeted to particular audiences, nor been designed to address the particular reasons why individuals have not adopted family planning, nor prepared to address priority issues, such as on myths and rumors concerning family planning methods.

6. While other ministries, such as Jeunesse et Sports, Agriculture, and Developpement Rural have been invited to work with provincial health staff to extend the range and frequency of IEC contact, such collaboration has been uneven.

7. While the community volunteer Primary Health Care system has been either a program or an issue in Morocco for many years, it is often discounted as a model for renewed community action in health because of its less than successful performance in Morocco in the not so distant past. At the same time, the modified family planning model applied by AMPF - the Association Marocaine de Planification Familiale - has not been seriously considered, largely because it requires payments from individual families for family planning services and products. Although the AMPF program accounts for only an estimated 3 percent of family planning transactions in the country, it has been particularly successful in engaging a variety of community groups such as Comites des Jeunes, women's groups, and other organizations in its family planning activities. Since payments for products and services are more contributions than fees in what AMPF considers a participatory program, the model may be politically acceptable and worth exploring as a means for extending both family planning services and IEC.