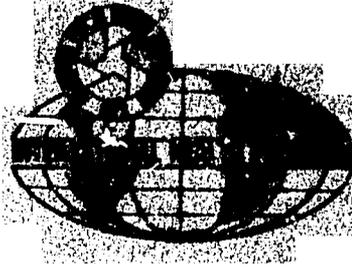


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AMERICAN PUBLIC HEALTH ASSOCIATION

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WORKPLAN
FOR CLINIC-BASED
INFORMATION AND EDUCATION PROGRAMS

A Report Prepared By:
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This report describes the activities of APHA consultant, Valerie DeFillipo, Senior Program Officer, Margaret Sanger Center, during the period September 23 through October 2, 1983.

The consultant is particularly grateful to the following individuals for their support and assistance:

Aziza Hussein	President of the Board, Cairo Family Planning Association and Family of the Future
Fakhreya Kassem	Vice-President of the Board, Cairo Family Planning Association
Mahassen Khalifa	Project Director, Family of the Future
John Paul James	USAID/Cairo
Laila Stino	USAID/Cairo

The consultant would also like to express gratitude to the staff of the Cairo Family Planning Association, Family of the Future, and the Giza Family Planning Association whose assistance made this assignment most rewarding both professionally and personally.

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EXECUTIVE SUMMARY

It is a well-established fact that poor women in the reproductive age group in Egypt lack basic knowledge about their own health or have traditionally wrong concepts of health. This lack of health knowledge is especially evident on the subject of family planning.

Results of a recent survey in Greater Cairo reveal that, while awareness of the existence of a population problem or of a national family planning program has reached 90 percent of the population, only 10 percent have any real knowledge of the health benefits of family planning or of how contraceptives work.

This gap between awareness and knowledge is especially noteworthy given that family planning goals are important priorities in overall development and population policies in Egypt, and family planning clinics are an integral component of most health and human development services there.

Sporadic attempts to close this gap have generally fallen short of the mark for a number of reasons.

- The approaches to health information and education have largely depended on printed materials which are too sophisticated or not functional in a situation where more than 60 percent of the women are illiterate.
- Mass media campaigns are presented in too general a fashion and are not tailored to meet the needs of specific target groups.
- Little concerted attention has been given to imparting modern face-to-face communication techniques to the service providers who are in daily contact with the women.
- Virtually no attention has been given to developing a clinical flow system which incorporates and encourages the sharing of health information and education.

Aziza Hussein, President of the Board of both the Cairo Family Planning Association and Family of the Future requested Valerie DeFillipo, Senior Program Officer of the Margaret Sanger Center, to prepare an in-depth program plan for a pilot project to implement a model system to incorporate information, education, and communication (IEC) components in clinical family planning service delivery sites in Cairo.

Mrs. Hussein also asked the consultant to develop audio-visual health messages that could be incorporated into the design of the clinic-based educational system. The twelve audio-visual health messages were to be produced under a separate project funded by the Ford Foundation.

In response to the needs identified during the in-depth assessment, the consultant developed a prototype system to demonstrate in three family planning centers (in Cairo and Giza) a process for developing and implementing a basic family planning information/education program incorporating functionally-diversified multi-media educational packages. The system has the following characteristics:

- It increases the number of users and enhances the quality of services in the family planning centers.
- It is appropriate to the management capacity and sophistication of existing personnel.
- It incorporates four inter-related health needs of poor women in the reproductive age group.
- It can be replicated and adapted in a wide range of settings.
- It is inexpensive to design, install, and implement.

The design and success of this system is dependent on five key variables: informational content, cohesive packaging, clinical systems preparation, staff training, and feedback, analysis, and action.

The consultant developed a detailed work plan to operationalize the proposed information/education system in the three selected family planning centers. It would take one year to install the system.

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ABBREVIATIONS

CFPA	Cairo Family Planning Association
FOF	Family of the Future
GFPA	Giza Family Planning Association
IEC	information, education, communication
USAID	United States Agency for International Development

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INTRODUCTION

Background

Theories of contraceptive behavior, whether proceeding from women's lack of knowledge and/or access to contraceptive skills and information or based on risk-taking behavior within a cost-benefit decision-making process, stress potential medical and biological side effects as primary determinants in the initial choice and continued use of birth control. The contraceptive behavior of Egyptian women, as reflected in the findings of a series of surveys* done in 1982, appears consistent with these theories. Major findings of these surveys are listed here:

- While 90 percent of the people had some awareness of family planning, only 10 percent possessed real knowledge of the health benefits of family planning or of how contraceptives work.
- Most respondents who were currently practicing family planning could explain how to use a method correctly; however, only a few understood how the method worked to prevent pregnancy. This gap in understanding assumes a greater significance when measured in light of the women's subsequent behavior. Many women attempted to minimize side effects by ignoring instructions for proper usage. For instance, some women reported taking the pill only when they had intercourse. Unwittingly, women were negating the contraceptive benefit of their methods and were placing themselves at risk for an unplanned pregnancy.
- Equally distressing, many women failed to use or stopped using contraception because they perceived or experienced side effects from their method. This discontinuation rate is exacerbated by lack of information. Over one-half of the Egyptian women polled** said that neither a doctor nor a pharmacist alerted them beforehand to potential problems or side effects of the methods.

Policy implications for family planning programs are clear: information/education programs must be provided as essential, integrated components of the overall service delivery network. These programs should impart an understanding of how the contraceptives work to maximize initial acceptance and continuation rates. Inter-related health messages should be incorporated in the programs to provide a fuller context for the countless individual decisions people are making in managing their fertility. If the programs are arranged systematically in a comprehensive and manageable package, an effective and on-going flow of communication will be assured.

*Reference 1, 2 & 3

**Reference 2 & 3

Purpose of the Assignment

Aziza Hussein, President of the Board of both the Cairo Family Planning Association and Family of the Future requested Valerie DeFillipo, Senior Program Officer of the Margaret Sanger Center to prepare an in-depth program plan for a pilot project to incorporate IEC components in clinical family planning service delivery sites in Cairo.

Mrs. Hussein also requested that the consultant develop audio-visual health messages that could be incorporated into the design of the clinic-based educational system. The twelve audio-visual health messages were to be produced under a separate project funded by the Ford Foundation.

Consultant Activities

The consultant participated in the following activities in cooperation with Mohassen Khalifa, the staff person hired by Mrs. Hussein to coordinate the work of both projects:

1. Identification of three appropriate clinical sites to field-test a prototype clinic-based information/education system. The sites selected are: Toffoula El Saiyida Center of the Cairo Family Planning Association (CFPA), the Mary Marcos Center of the Giza Family Planning Association (GFPA) and the Saiyida Zeinab Center of Family of the Future (FOF).
2. Completion of in-depth needs assessment through interviews with the boards, and the administrative and clinical staffs of the CFPA, GFPA, and FOF.
3. Observation of clinical flow systems at all three service sites including interviews with family planning clients.
4. Presentation of preliminary findings and a plan of action to the CFPA and USAID/CAIRO population staff.

OBSERVATIONS AND FINDINGS

Little concerted attention has been given to the adaptation of modern face-to-face and audio-visual communication techniques for use in clinic-based education. Nor has there been much concerted attention focused on organizing a system within clinics which would provide a structure for a thorough and on-going education program. This is particularly disturbing given the fact that 68 percent of Egyptian women polled stated that they felt the doctor was the best person to turn to for advice about family planning.

There is an acknowledged lack of time for qualitative client-physician interaction. Not only do the majority of physicians work only limited part-time schedules at the clinics but observation of the clinical flow during those sessions indicates that physicians spend an average of five minutes with each client. In addition, slightly less than half (43 percent) of the physicians polled felt that they have a major responsibility to provide family planning counseling, and slightly more than half (53 percent) believe physicians have responsibility only if their patients request information. Thus, it seems reasonable to conclude that the primary responsibility for information/education must be relegated to other members of the health team.

Education provided by clinic staff, while meeting the immediate informational needs of women, is not sufficient to reassure and support continuous contraception. The second most utilized and trusted source of information, as reported by Egyptian women, is the social milieu: friends, neighbors, and relatives. It is these individuals who corroborate information, compare experiences, and in general, function as support systems.

Thus, it is critical to build within an information/education program a mechanism to convert a cadre of community residents to be informal but nonetheless acknowledged and trained information-givers.

A two-pronged approach, utilizing both clinic staff and community residents, represents an optimal way of integrating information/education activities into overall family planning programs. Initiating information/education programs at the clinic level

- builds on established and credible patterns of communication in a medical facility;
- maximizes utilization of scarce auxiliary health professionals;

- uses modern communication techniques on the preferred one-to-one basis; and
- encourages the participation of community residents in the educational process, thereby creating an informal but responsible group of educators.

RECOMMENDATIONS

In response to the needs identified during the in-depth assessment, the consultant recommends the following prototype system for incorporating IEC components geared to poor women in the reproductive age group in clinical service sites.

The design and success of this system is dependent on five key variables: informational content, cohesive packaging, clinical systems preparation, staff training, and feedback, analysis, and action. These five variables are presented in overview below. However, it should be noted that refinement of this prototype system and steps for its adaptation would be primary tasks of the project itself.

Informational Content

The content of the information/education program will be derived from four inter-related health concerns: i.e., family planning, reproductive health, family health, and female circumcision. From each health concern, three specific topics or health messages will be selected for development into educational modules. These topics will be selected based on assessment of stated needs of the women attending the centers and the recommendations of a panel of medical, media, and anthropological experts who are being brought together expressly for this purpose. An example of the type of message which may be selected is the importance and benefits of self-breast exam. This message would fall under the general category of reproductive health.

Cohesive Packaging

Multi-media resource packages will be produced. These are portable, multi-purpose groupings of educational aids, resource papers, instructional pamphlets, demonstration models, and audio-visual messages developed in the Ford Project, all of which are linked by a common theme. Each health message has a corresponding resource package. Specifically, the resource packages will contain, as appropriate:

- Resource materials for staff and volunteers. These materials will provide a full and detailed explanation of the health topic and will be inter-disciplinary in approach. These materials will form the basis of the technical knowledge to be acquired by staff educators.

- Educational formats for assisting staff in summarizing the technical material and in translating technical information into colloquial language. These formats will contain checklists of essential information to be shared and illustration of possible analogies or reference points to be used in explaining the subject material.
- Demonstration models and materials to be used as educational aids. These will vary in number and type according to the health topic. For example, through practice with a rubber model of breasts, women could learn what a breast tumor feels like. Whenever possible, materials which are a part of the women's everyday life will be used.
- Audio-visual messages will be developed under a separate project funded by the Ford Foundation. One of the tasks of this project is to incorporate these audio-visual messages into the resources package. These messages will be broadcast on the radio and simultaneously be used in clinic-based educational activities. In the clinics, they will be used to reinforce the health message as well as to stimulate discussion and learning.
- Instructional pamphlets for consumers. These will be primarily pictorial in format with minimal written instructions. The pamphlets will be reviewed with the women before they are distributed and taken home for educational "recall" when necessary.
- Posters to replicate in bold pictorial and print form the information contained in the instructional pamphlets.

Clinical System

The system is designed to be flexible so that the resource packages and non-formal learning skills can be applied in a variety of situations and be functional given changing realities of clinical operations. The system, in whole or part, is appropriate for use in participatory, non-formal educational groups; individual education and decision-making counseling sessions; home visits; and individual learning activities.

The system can be readily updated, revised, or expanded based on participants' feedback and changing program goals. It is also designed to be used by three different categories of educators.

Staff Training

The key educators are, of course, staff from the clinical health teams. They will lead discussion groups combining didactic and participatory methodologies. Their presentations will be short and concise to ensure communication of essential information. The staff will function primarily as facilitators encouraging discussion and participation of the women in the learning activities.- They will begin the process of identifying women in the group who appear to be "natural educators." The staff will use the resource packages and communication skills various circumstances so they become fully conversant and at ease with all aspects of the education process.

Of equal importance are the community residents who are clients of the family planning center. Interested clients will work as co-facilitators of the discussion groups. These "natural educators" will have been identified by the clinic staff as being particularly interested in the subject matter or as being willing and eager to participate in group education. The "natural educators" will be trained through individual consultation with the staff, direct observation and practice. The purpose of this feature is not to "free up" staff time but to involve women from the community in the educational process. They will function as role models teaching skills of self-reliance in health matters and, it is hoped, enhancing the quality of information shared in the non-formal networks.

The third group of volunteers will be recruited from the Ministry of Social Affairs' social work graduates. They will be trained as a group at the beginning of their year of internship according to the model developed in this project and will assume the major responsibility for on-going group education. This will allow the clinical staff to focus their attention on individual consultations and development of expanded educational modules. The interns will also accompany family planning clients back to their neighborhoods to disseminate information on the availability of educational and medical services. These outreach activities will form the foundation for a sound community out-reach program -- one which is linked to on-going clinical services.

All members of the service provider team will be trained in the skills and methodologies on non-formal education. Monthly schedules will be posted detailing staff assignments and health topics. Both the assignments and topics will be rotated daily to avoid staff burn-out and to ensure program diversity. Maximum participation of the staff in the development of these schedules will be encouraged to provide the staff with a sense of ownership of the program and continuously to incorporate participants' feedback. The information/educational work does not represent an additional layer of responsibility superimposed on on-going clinical activities but is rather a revamping and re-direction of existing work expectations.

Feedback, Analysis and Action

The ongoing success of the information/education program will depend to a large degree on the strength of the internal evaluation system. The program administrators and the clinic staff must become aware of the need for evaluation and be assisted to identify and initiate evaluation approaches which improve decision-making and program operations. To be effective, the evaluation steps must be easy to initiate and conduct. Otherwise, the staff will be unlikely to accept evaluation as an ongoing part of their regular responsibilities.

PLAN OF ACTION

The proposed work plan involves four intervention phases which are implemented over a twelve-month period. The plan addresses all necessary activities with the exception of the production of printed materials for non-readers, which has a separate timeline.

It should be noted that throughout this process persons from the collaborating centers will be involved as much as possible in all aspects of designing, implementing, assessing and refining the information/education system to their needs. Country personnel have been and will continue to be interviewed to assess their ongoing needs and objectives. A coordinating committee will review and approve all workshop and technical assistance plans and objectives. The workshops themselves will be participatory in nature, with participants gaining hands-on experience and practice in educational methodologies, and program planning and design. Finally, an in-country project director has been designated who will work closely with a consultant project director in all phases of project implementation and design, including coordination of technical assistance, and who will provide a training and technical assistance resource both during and after completion of this project. It is hoped that this strategy of involvement, will make it possible for health center personnel to design, implement, and utilize information/education systems themselves, so that further reliance on outside consultant expertise will be unnecessary or minimal. The discrete program activities which are required to meet the goals of this project are discussed below.

Phase I Program Activities Planning and Design of Support Structures

Formation of Coordinating Committee. Representatives from the board and staff of each collaborating family planning association will be identified. Representatives from other organizations, as appropriate, will be asked to participate. The specific role and functions of the committee will be delineated.

Determination of Specific Health Messages. The recommendations of the Coordinating Committee along with a review of available literature and the stated needs as perceived by staff and attendants will form the basis for several focused discussion groups. From these discussions, the list of messages to be incorporated into the information/education system will be compiled.

Planning and Design of Workshops. Preliminary planning and design of workshops to take place in Phase III will begin. Initial steps include:

- identification of in-country co-trainers for each health message segment;
- identification of international consultants with expertise in evaluation and communication techniques in non-formal education to co-train with Egyptian counterparts;
- determination of workshop site and logistics;
- specification of support services including translators, interpreters and copy facilities;
- presentation by the consultant project director of preliminary workshop objectives and design for review and approval of Coordinating Committee; and
- development of a needs assessment instrument to determine the skill level of participants.

Phase II - Program Activities: Technical Assistance

This segment will consist primarily of technical assistance provided by the consultant project director to the project staff. The consultant project director and the country project director will work hand-in-hand with the co-trainers and resource people identified in Phase I. Specific activities will include:

- design and development of individual components of the multi-media resource packages for each health message;
- design of clinical flow patterns for each family planning center to allow for more efficient delivery; of services and to prepare for the introduction of the information/education system;
- development of a preliminary format for management information analysis and evaluation;
- review and updating of administrative procedures so they are consonant with the new systems; and
- finalization of workshop design and logistics.

Phase III - Program Activities: Training and Implementation

Training Workshops. The training workshops, which will last approximately twelve days, will train the participants in the content and use of the resource packages. Didactic sessions and practice of skills and knowledge will be the predominant methodologies. Two international consultants with expertise in non-formal education and evaluation will assist in the training process.

Preliminary suggestions for workshop topics are:

1. Family planning update including anatomy and physiology, sexuality, contraception, and well-woman health care.
2. Communication skills.
3. Philosophy of non-formal education.
4. Evaluation techniques.
5. Content of health messages.
6. Practicums.

On site application. Immediately following the workshops, the consultant project director and the country project director will accompany the teams back to their centers to operationalize the clinical flow and information/education systems. The purpose of the on-site application is to provide support and assistance, as appropriate, in the initial presentations and use of the resource packages.

Phase IV - Program Activities: Program Monitoring and Intervention

The final phase of the project will consist of two technical assistance interventions scheduled approximately three and six months after initial implementation. It is crucial that the teams in the field are provided with consistent support in the early stages of program activity both to ensure compliance with agreed on performance goals and to solve administrative and programmatic obstacles. These technical assistance visits are, of course, only a back-up to the on-going site visits of the country project director.

Production of Printed Materials for Non-Readers. A separate timeline will need to be developed for the production of printed materials for non-readers. Culturally responsive support materials, when provided in combination with adequate educational services, provide reassurance and support in the daily use of contraceptives.

However, the development of nonverbal materials is more complicated and requires much more time than the development of comparable verbal materials. The proposed clinical group education sessions provide an excellent format for visualization and small-scale testing of these materials. Therefore, these materials will need to be slowly incorporated into the resource packages. A viable projection of implementation can only be presented after the responsible country resource person has been identified.

REFERENCES

1. Hussein, Aziza The Egyptian Family Planning Program As Seen
By A Volunteer. Paper presented at the
Symposium on Population and Family Planning
in Egypt. Egyptian State Information
Service and Social Development Center,
Chicago.
Cairo, February 17-21, 1980.
2. Family of the Final Report:
Future. Pharmacy - Intercept Study,
February, 1982.
3. Family of the Final Report:
Future. Physician - Pharmacist Survey,
November, 1982.

Appendix A

List of Persons Contacted

1. CAIRO FAMILY PLANNING ASSOCIATION

Aziza Hussein	President of the Board
Fakhreya Kassem	Vice-President of the Board
Samira Hamza	Treasurer of the Board
Sabet Salib	Executive Director
Soad Fouda	Coordinator of Training and Education
Ramsis Amin	Field Supervisor
Aziza Kamel	Coordinator of Female Circumcision Project

2. FAMILY OF THE FUTURE

Effat Ramadan	Executive Director
Mahassen Khalifa	Coordinator of Health Projects
Abdel Bari	Director for Media and Research
Elham Fateem	Assistant Director for Media and Research

3. GIZA FAMILY PLANNING ASSOCIATION

Evon Nashid	Treasurer of the Board
Mounir Mohamed Ibrahim	Executive Director
Cynthia Myntti	Program Officer-The Ford Foundation Office for the Middle East and North Africa
John Paul James	USAID/Cairo
Laila Stino	USAID/Cairo
Samiha El Katsha	Senior Research Assistant Social Research Center American University in Cairo