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## *Implementation Plan, Mali: 1991-1992*



**HealthCom**

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# **I. Introduction**

## **SUMMARY OF HEALTHCOM'S ROLE IN MALI**

In Mali, HEALTHCOM supports the central information, education, and communication (IEC) team that is the communication arm of the Integrated Family Health Services (IFHAS) Project. IFHAS has the responsibility for strengthening the ability of the Division of Family Health (DSF) of the Ministry of Health (MOH) to deliver quality integrated maternal and child health and family planning services in the pilot district of Bamako and in nearby Koulikoro region. HEALTHCOM works closely with the DSF/IEC team to increase its capacity to support the newly integrated activities with effective communications. IFHAS works with the 15 clinics in the pilot area that are being reorganized to support the newly integrated services.

HEALTHCOM also works with the Malian Association for Family Planning and Protection (AMPPF) in support of increased family planning acceptance.

## **DEVELOPMENT OF IMPLEMENTATION PLAN**

The implementation plan was developed in discussion with the chief of DSF, the IEC team, and the USAID Mission. The goals, objectives, messages, and draft indicators were developed with the IEC team in a planning workshop.

## **OVERALL STRATEGY AND GOALS**

Several common themes emerged during the analysis of the problems and constraints for each of the four interventions included in this project: the Expanded Program on Immunization (EPI), Control of Diarrheal Diseases (CDD), nutrition, and family planning. These more general needs will be addressed under an umbrella strategy designed to strengthen IEC skills of the DSF/IEC team and the health providers in the clinics. A stronger IEC structure will in turn provide more effective support to the four intervention programs.

The health center structure provides IFHAS/DSF with an excellent opportunity for providing training in interpersonal communication and consistent support of program interventions. Capitalizing on this opportunity will require greater focus on priorities and organization at both the central and the health center levels.

Specific goals of the HEALTHCOM Project in Mali are:

- To strengthen the ability of the central IEC team to develop, manage, and monitor IEC activities at the health center level.
- To strengthen DSF/health structure in supporting interpersonal communication for the four intervention programs.
- To assist in the rationalization of the IEC team role in overall DSF planning.

## II. Strengthening the Health Communication Structure

### APPROPRIATE USE OF HEALTH CENTERS

#### ■ Problem Identification

Target populations do not use the services of the health centers appropriately. That is, mothers do not come to the centers for vaccinations; prenatal, delivery, or postnatal visits; family planning; or nutritional counseling. Several factors have been identified that interfere with clinic attendance. Other factors that discourage attendance will be the topic of further research during the first year. The following will be addressed during the first year:

- The concept of preventive service is not well understood. Clients come to the clinics primarily for urgent cases of illness or accident.
- Many have had or have heard of bad experiences with the agents. For example, they fear to bring children for vaccinations because agents can make them feel ignorant if they have missed what is still for many a mysterious schedule.
- Clients have often had to wait long times for indifferent service. While both factors are improved in the reorganized centers, the image remains an impediment.

#### ■ Objectives to Address the Problem

**Improving Communication Skills.** Agents will use improved communication skills in encounters with the population. Training in effective interpersonal communication skills will be provided in the next quarter for all health workers in the target areas. A series of observations of health worker health education skills has been made in each of the 15 pilot centers. Training will reflect needs identified during these visits as well as those identified by the target groups and by other providers.

**Supportive Supervision.** Agents will receive supportive supervision in using their new IEC skills. During the training, health education agents in each clinic will be trained in the same IEC skills and in providing support to the IEC efforts of the agents; for example, they will be trained in giving and receiving positive feedback. Simple behavioral checklists will be developed and used both for the training and for the supervision. These will be based on the norms for IEC already developed by IFHAS.

All new behaviors will be practiced through role plays during training until agents feel confident and appear credible in their clinic work.

*Improved Outreach Skills.* Community social workers will use improved communication skills in outreach to the community. These workers will be trained in IEC skills and in simple messages for each intervention.

*Improved Image.* Once IEC skills are improved, a new and better image of the worker and the clinic will be conveyed to the population. Outreach activities will include stories, songs, etc. portraying agents as caring, credible sources of preventive health. Images congruent with Malian values will be tested and used to "humanize" agents' image and increase their credibility.

Videos, outreach, and other media will present concepts of preventive care in traditional and positive terms, along with the role of the agent in providing these services.

*Motivation of Agents.* Agents will be motivated to continue using new skills for effective contact with the community. Many agents suffer from burnout and discouragement. In addition to teaching skills that work and providing supportive supervision, the project will search for sustainable incentives valued by the agents, such as certificates and awards. We are discussing, for example, a newsletter to be produced by the National Center for Health Information, Education, and Communication (CНИЕCS) addressed to agents, with updates on communication issues, questionnaires about counseling and educational supports needed, and morale-raising topics such as "agent of the month" awards. A newsletter would also strengthen the visibility and coordinating role of CНИЕCS.

## **SUPPORTS FOR HEALTH AGENTS**

### **■ Problem Identification**

Agents need supports to increase the effectiveness of each level of their contact with the population: outreach visits to the field, small group discussions, and one-to-one communication. Supports can be used to assure that the "key points" are covered, to remind the agents of the correct technical content, to assist them in making things clear to the clients, to encourage client participation in discussion, and to persuade clients to adopt new behaviors.

Currently, health education is neglected in nonreorganized centers. In reorganized centers, health "themes" are established for coverage each month, but there is no guidance on key points that should be made consistently in each encounter and each center. Consequently project records show how many women took part in health education sessions, but we do not know what messages were presented to them.

### ■ Objectives to Address the Problem

*Memory Aids and Materials.* Memory aids and materials to encourage discussion and to help persuade will be tested with both agents and clients and will be provided in at least three of the four interventions during the next two years.

Materials will be pretested with agents and the public, and a system for monitoring their use and impact will be put in place. A form for pretesting and monitoring materials has been developed and will be tested before finalization.

*Development of Key Points.* Key points will be developed for at least two of the four interventions and presented as technical reminders to the center staff. These will be used in health talks and face-to-face encounters. Other key points will be developed for outreach and community workers. By taking greater advantage of the potential of the interpersonal channel the centers provide, the DSF can increase the impact of all interventions.

Collaboration has already been established with several important local resources for development communication, such as the Audiovisual Production Services Center (CESPA), Audio-tech, and DNFLA (Direction National Alphabétisme Fonctionnel et Lutte contre Analphabétisme). These organizations have agreed to help develop supports for health and social affairs workers.

## TAKING ADVANTAGE OF PRENATAL VISITS

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### ■ Problem Identification

Opportunities provided by prenatal visits are not being used to full advantage for promotion. In 1990, attendance was improving in Bamako (83 percent) and mothers there were beginning to deliver in the maternity centers (87 percent). Koulikoro figures at that time were 35 percent and 36 percent respectively. These encounters can provide an excellent means of developing trust, introducing topics such as vaccination and family planning, and identifying high-risk cases and high-risk family situations.

■ **Objectives to Address the Problem**

To capitalize on this opportunity, key points will be developed and used in prenatal and postnatal encounters. Developing these integrated messages will be a major challenge in the next year.

**CONSTRAINTS TO PRENATAL VISITS**

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■ **Problem Identification**

Outside of Bamako and Koulikoro a minority of mothers attend prenatal clinics. Health workers feel mothers see pregnancy as being natural and do not have the habit of seeking help from medical personnel. They do not understand the tests and instruments, and these therefore make them nervous. Research will be needed to further define the constraints against attending the prenatal sessions.

■ **Objectives to Address the Problem**

A strategy to encourage attendance in pre- and post-natal sessions will be developed. Outreach can help to encourage attendance by appealing to popular themes (to be developed) as motivation and by providing caring service when they attend.

For example, agents can explain how each instrument and test protects mother and child. A video demonstrating an effective way of doing this has been produced for use with health workers or mothers.

Simple sustainable incentives could be tested, such as gold stars, to encourage attendance for at least two sessions during pregnancy.

### III. Control of Diarrheal Diseases

CDD is the major focus of the project currently, and also the focus of a special project, *Lutte contre Diarrhea* (LMD), assisted by PRITECH. DSF can support LMD project objectives by training health workers in IEC, developing and distributing to health workers consistent messages for mothers, developing and supplying other support materials for workers, and supporting efforts to strengthen supplies of oral rehydration salt (ORS) packets.

Communication objectives for the other interventions are also being developed. In each case, strategies will be based on increased IEC skills of workers and on key standardized and consistent messages which are to be developed in support of the specific projects. The intervention for CDD has been planned in detail and the description of those activities follow.

#### **PROBLEM IDENTIFICATION**

##### **■ Health workers**

The DSF team identified the following specific problems in meeting program objectives. Health workers:

- Tend to prescribe antibiotics and antidiarrheals instead of or as well as ORS. (Source: observation and clinic records.)
- Develop their own content for health talks at the clinics; as a result, mothers receive inconsistent messages. (Source: observation and clinic health education forms.)
- Lack simple, precise messages about each of the phases in control of diarrhea (prevention, diarrhea, some dehydration, severe dehydration, and recovery).
- Lack clear, simple messages about nutritional aspects of diarrheal management.
- Lack skills in communicating credible role of ORS to mothers.
- Fail to demonstrate mixing skills or ask mothers to demonstrate mastery. (Source: observations.)
- Do not give (in non-reorganized clinics) enough emphasis to health talks.

- Private Voluntary organizations (PVOs), which play a major role in health service and education, do not always have policies consistent with the MOH, one another, or other agencies.

### ■ Mothers

The DSF team identified the following specific problems in meeting program objectives. Mothers:

- Demand mixed treatment.
- Do not understand that oral rehydration therapy (ORT) does not treat diarrhea but prevents dehydration.
- Do not feed the child properly during and after episodes, failing primarily to provide extra foods, and do not urge the child to eat when he or she has no appetite. They give the breast or food on demand but do not offer it more often if child has little appetite during or after episodes.

### **OBJECTIVES**

Key messages for CDD will be elaborated, tested, and provided to all health centers, for use in health talks and face-to-face communication. Selected messages will be designated for community outreach.

Where possible, messages, research, direction, and materials developed by PRITECH/LMD will be used. Aspects that seem particularly appropriate for the health care structure with the personal contact it provides are (1) prevention and (2) nutritional aspects of CDD, including nutritional care during and after episodes.

### **DRAFT MESSAGES**

The following draft messages regarding CDD were developed during the DSF/IEC team workshop.

■ **For Mothers**

- "When the infant has diarrhea, give ORS continually, increasing the amount after each liquid stool. If the infant vomits, wait five or ten minutes, then continue to give the liquid in small sips."

Possible Indicators:

- The percentage of mothers who, when leaving a session with a worker, can describe correctly how to give the ORS.
- The percentage of mothers who report having used the proper method in a diarrhea incident in the previous two weeks.
- "When the child has diarrhea, continue to give the breast and easily digested foods (two examples) more than usual while the child is sick and while he or she is recovering."

Possible Indicators:

- The percentage of mothers who feed their infants during and after episodes as recommended.
- The percentage of children having diarrhea who became malnourished during a given period after the campaign compared to a similar period before the campaign.
- "ORS prevents the dangers of dehydration and is not meant to cure diarrhea."

■ **For Health Workers**

Clear, simple messages similar to those above (such as the importance of feeding during diarrhea) will be developed for health workers. Examples of indicators would include:

- The percentage of agents in reorganized centers who can give three appropriate (easy-to-digest, inexpensive, nourishing) examples of foods that can be given to children with diarrhea in their region or area.
- The percentage of agents in reorganized centers who give at least three examples of appropriate foods in talking to mothers about diarrhea.

- The percentage of agents who give all points in key messages to mothers during group and face-to-face sessions.
- The percentage of agents who prescribe ORS rather than other or mixed treatments, compared to the present, as shown in clinic records.

## **PRINCIPAL ACTIVITIES**

### **■ Research**

HEALTHCOM has conducted a series of focus groups with mothers and fathers in areas surrounding the pilot clinics and has observed the health education activities in each of the clinics. In addition, substantial material is available from various PRITECH studies in Mali. Messages and technical reminders (*fiches techniques*) will be tested with the agents and the public. Further research will be needed on home administration of ORS (how, how much) and on reasons mothers do not choose to use clinic services.

### **■ Training**

Members of the DSF/IEC team will be provided with hands-on and formal training in each aspect of the HEALTHCOM methodology including research, developing communication plans, pretesting, production, and monitoring of activities. In addition, they will be trained as trainers in interpersonal communication for workers in the DSF.

Several team members have had formal communication training overseas, but the methods they learned (planning, behavior- and research-based programs, etc.) have not been translated into action. We envision that after at least two successful cycles of applying the methodology, the team will gain confidence and credibility. To provide encouragement in the first application, we have selected one of the simpler, better researched interventions (CDD), rather than one of the more difficult and sensitive ones, such as family planning or nutrition. This choice provides a simpler testing ground for the application and lowers the costs to the team of committing to the communication methods we seek.

As part of this process, the team has already assisted with focus group discussions on community perceptions of health issues and treatments. The results were introduced to the agents to familiarize them with the concept of using audience research for IEC planning.

A major two-week training activity is proposed for spring. This will be a training of trainers (TOT) for members of the IEC team and representatives of AMPPF and other selected services. Collaborators from the Nutrition Communication Project may participate. Training will focus on interpersonal communication, outreach, and support for behavioral change. Within the following two months, supervisors as well as agents will be trained in each of the 15 centers; in an adapted training session, social agents who work in the communities will also be trained.

IEC team members from Dakar will be invited to participate if agreement can be reached between the two organizations. This will permit exchange and comparison of experience as well as increase the status of the training.

Immediately after Ramadan, members of the IEC team will be invited to Dakar for training in management of IEC activities. The training will include a review of health communication and social marketing concepts and principles.

The module for the interpersonal training and IEC management was developed and pretested by HEALTHCOM in a Francophone African country and revised extensively by a skilled nurse-midwife, a social marketing trainer, and experienced HEALTHCOM resident advisors (RAs). The module will be adapted to the Malian situation and provided to Malian training institutions if desired.

The training team can, if desired, provide these same training sessions to regional training teams who can train health workers nationally. Additional formal training will be provided as needs are identified. It is envisioned that there will be at least two other one-week training activities in methodology for the DSF team. Topics under consideration include use of various research methods, and monitoring and evaluation. In addition to the training in country, we propose that selected members of the team be elected to attend the French language training in communication provided by Johns Hopkins University (JHU) each year. This training will be held in Baltimore in September 1992.

The proposed training schedule for the IEC team is:

- One week (in Dakar, to be shared with the Dakar HEALTHCOM team) in management of IEC activities.
- Two weeks TOT in interpersonal communication, and health communication concepts.

- At least two weeks of training in another health communication topic to be identified as a priority.

The proposed training schedule for health care workers is:

- One week in interpersonal skills, provided by JEC team.
- Training for health education officers in supportive supervision of health education activities in their clinics.
- Training in use of materials and supports as developed.

### ■ Print and Broadcast

In phase one, materials already available in Mali have been inventoried and evaluated against program goals and requirements and are being reworked or edited where needed and pretested for future DSF use. These materials will relieve some of the pressures on project staff and providers for support of communication activities. Where unmet health worker needs have been identified, new videos have been prepared to illustrate communication content and skills. Workers have been trained in use of these materials. These activities result from the collaborative relationships established with other development communication organizations in Mali. A system for monitoring the use and impact of these materials has been developed and put in place.

Future materials will include videos, songs, and theater to support outreach and key messages.

### TIMELINE

Phase one materials review and reworking	December-January, 1991
Production of CDD materials	March-July, 1992

(At least two other interventions will be the focus during 1992-1993.)

Training in IEC management late	April 1992
TOT in interpersonal communication early	May 1992
Training of health workers	May-June 1992
Meeting in Washington	March 1992

## **MONITORING AND EVALUATION PLAN**

Baselines will be drawn for selected indicators and will be measured for progress. Where possible, data drawn from clinic data will be used, such as treatment records of health workers. A consultant will have to work with the team when they have completed their list of objectives for client and agent behavior change, to develop the evaluation plan in more detail.

## **IV. Institutionalization**

### **TRAINING**

The team has experience in planning and running focus groups and observations and has presented the data to a workshop of health providers and other development communication organizations to develop priorities and constraints. They have worked in another HEALTHCOM workshop to design messages and indicators based on research data. It is expected that they will continue to play a leading role in each future step in the methodology. Several of the team members have had training in Santa Cruz and elsewhere in health communication, and they have more skill than they are using. It is hoped that the experience of seeing the approach succeed will encourage them in making the necessary effort in the future. The training planned for this team, and the experiences they will share with the Senegal team, will help to increase the credibility and the status of the approach.

### **PLANNING**

A major problem facing the IEC team, and in fact the entire DSF division, is difficulty in planning activities in a time- and objective-based manner. The current approach results in daunting lists of tasks without a clear rationale or method for prioritizing or measurement. Consultant de Guzman was effective in working with the IEC team members to improve their IEC plan for the next two years. It will be difficult, however, for the IEC team to rationalize or focus its role within the DSF unless the larger body itself develops methods to arrive at more easily achieved plans.

To strengthen the central planning structure so that effective planning can occur and be carried out, we propose technical assistance as soon as possible for the DSF in health planning. The consultancy would help them to develop realistic, objective-based time and task commitments. Doing so would encourage sensible time and resource allocation. This is a particular problem for the IEC team, for they are overcommitted in an often unforeseeable pattern, and they have no planning document that allows them to set priorities or limits on their own resources.

Part of our responsibility is to help this team define its role. It now seems that a realistic plan will need to be in place so that the IEC team can play a realistic role. The technical assistance in planning will focus on the process rather than on the content of the

planning; that is, on helping the DSF achieve its own goals, rather than advocating specific goals or directions.

## **JOB DESCRIPTIONS**

Another institutional need is for job descriptions and responsibilities for individual members of the IEC team and for the team itself, so that their commitments and resources are managed more systematically.

## **COMMUNITY PARTICIPATION**

HEALTHCOM has been asked to use our research and creative strength to test a community participation role in selected pilot health centers where community support, including financial support, will enable the community to influence service quantity and quality. This is an exciting idea that could, if successful, offer a model for improving the responsiveness of the health system to client needs and concerns in the Sahel. A proposal for such a pilot will be developed for the second phase of this project.

## **V. Management Plan**

### **ADMINISTRATIVE PLANS**

The RA will continue to manage the imprest fund and the log for the vehicle once it has been acquired. Once air-conditioned office space is available, he will hire a secretary to assist him in many of the reporting and other tasks that he can delegate. This secretary will assist other members of the IFHAS team with project duties as well.

### **TECHNICAL ASSISTANCE**

Technical assistance will be provided, if desired, to the DSF to help them develop a monitoring and evaluation plan. When final behavioral objectives are completed for CDD (and in the second year for the other interventions) baselines will be collected in the 15 clinics.