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DEVELOPING A COMMUNITY-BASED, CULTURALLY APPROPRIATE IEC STRATEGY IN MOZAMBIQUE

Recommendations for the Primary Health Care Support Project
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EXECUTIVE SUMMARY

Scope of Work

The general scope of work of the consultant was to examine he approach and progress of the IEC (education, information and communication) component of the Primary Health Care Service (PHCS) Project, and to recommend ways that IEC can become more community based and based on conditions in Mozambique The primary method of the consultancy was to visit NGOs carrying out community based primary health care approaches in three provinces (a trip to a fourth province, Nampula, had to be cancelled due to communications problems with NGOs there)

Executive Summary of Primary Recommendations

A general procedure recommended for PHCS/IEC can be described as a series of steps

(1) compile all qualitative and quantitative studies related to (a) primary health care, family planning, AIDS and STDs in Mozambique and in neighboring countries, (b) indigenous health-related beliefs and practices ("ethnomedicine"), and (c) visual literacy, health education material development, etc in Mozambique There is much to be compiled in (a) and (b), there seems far less material in (c) Compilation must be followed by analysis and interpretation of studies and program experience (see section on Compiling Relevant Studies for details, below)

(2) make field visits to the three provinces of PHCS Project implementation, with special emphasis on Z mbesia, in order to (a) learn from the successes and failures of NGOs and government in attempts to carry out effective primary health, family planning and AIDS prevention, and (b) learn better how to support IEC and general health education efforts there--in other words, do a needs assessment and "lessons learned" related to community based approaches and IEC/health education What materials, messages, policy/program clarification, and training are needed Why are they needed? How can these needs best be met?

(3) after review of any relevant studies related to family planning, fertility, and/or reproductive health (surveys, focus groups, in-depth interviews, etc in Mozambique <u>and</u> in neighboring countries), conduct studies of a formative, qualitative nature, <u>when needed</u>, in each of the other areas of health focus for the project AIDS/STDs, child diarrhea, family planning (existing and indigenous KAP related to fertility and contraception), malaria, immunizations, growth monitoring and nutrition It may be that there has been sufficient research in the first two of these, in which case an IEC strategy can be developed from existing studies and formative research can be concentrated on the latter areas of health A decision could be made after

review and analysis of existing studies There should be at least one study in each province of PHCS implementation The purpose of the studies is not to provide measurable baselines but to provide at least preliminary insight into the beliefs, values, attitudes, benavioral patterns, etc that need to be understood in order to plan IEC and other health education strategies aimed at child spacing/family planning in Mozambique As noted, some research of this sort is already available for Mozambique, and a great deal exists on most of these health topics from neighboring countries (exceptions may be malaria and infant nutrition)

The first such study should relate to family planning A "user intercept" study is outlined below, under the Family Planning section This should be done in at least in Zambesia and Gaza, and if certain conditions can be met, in Niassa as well

(4) At this stage, a regional strategy for IEC should be developed, aimed at the provincial level The questions addressed by the strategy should be What general approach to promoting which behavior change and adoption of which technologies is appropriate for each of the three provinces, in each area of health? Does the regional or provincial strategy need to be modified and adapted to the cultural, linguistic or other requirements of districts or other areas (or groups) within a particular province, and if so, how and in what specific ways? Is there a general, national strategy that can be identified for each health area, one that can be modified and adapted to major ethnolinguistic groups within Mozambique? If so, what is the strategy and how should be it adapted?

(5) Following from (4), where there is a need for policy or program clarification, such as in promotion of cereal-based and home-based oral rehydration therapy (as distinct from ORS packets) or promotion of latrine construction from locally available materials (as distinct from imported, concrete slabs), then the PHCS project, through the IEC component but supported by other components, should (a) influence such policy, and (b) develop IEC support for the new or modified policy or program A specific example of the final step would be developing radio and print material support for promotion of cereal-based ORT, once it is clarified that it is in accord with MOH policy and programs to promote this Another example would be putting more emphasis on fidelity or partner reduction as a way to prevent AIDS and STDs This latter has "impact indicator" implications for Results Framework Development or other measurement efforts the PHCS could suggest a methodology for measuring a "baseline" number of sexual partners and then suggest that reduction in this number formally become an indicator for measuring impact of AIDS prevention efforts Incidence of standard STDs should also be adopted as a formal indicator of AIDS prevention efforts

(6) on the basis of earlier steps, develop IEC messages, materials, productions, etc appropriate to the culture, levels of education, literacy status, etc of the target audiences

(7) Once there has been production of print materials, dramas, puppet shows, dance groups, or radio/video messages, there should be evaluation research to measure the effectiveness of message dissemination, an outline of which methods are listed in the RFP for the PHCS Project The main questions to be asked are Have the messages reached the intended target audiences? Have they been understood? Can they be recalled? Are there problems of "indentfying out" because of elements locally of the message or medium perceived as "foreign" or applying to--or coming from-- somewhere else? Are any elements misinterpreted or offensive? Can any behavior change be in any way causally related to these messages? Can the messages be further adapted or "fine-tuned" to become more effective?

There should always be an open feedback channel from the target audience to those in charge of IEC (in the PHCS, the MOH, the DPS and the DDS) Therefore there should always be short, quick "continuing impact" mini-evaluations from time to time to determine if messages continue to reach audiences and seem to be having the intended impact

Many of the problems of existing IEC media, materials and messages identified in the body of the present report are the very problems identified in the RFP for the PHCS project (p 21) The RFP specifically called for redressing these problems by a process which begins with "formative research" and " undertaking sound research for message development and pre-testing AMODEFA and the contractor will also undertake more in depth and qualitative studies (focus groups interviews or other techniques) to complement survey data" (pp 21-22) This mandate is very clear and there are frequent references to family planning and to the local family planning association, AMODEFA, meaning that family planning is the one area of focus <u>not</u> to overlook (That AMODEFA seems to be engaged in many less controversial MCH activities other than family planning does not obviate the need for technical assistance in this area--it augments the need) Indeed the argument could be raised that AIDS is the area of health in which PHCS project resources could least justifiably be directed, because there has already been a relatively large amount of survey work related to AIDS in Mozambique, plus PSI is already working in this area

The RFP calls for the translation of family planning and reproductive health videos such as "Its Not Easy" and "Consequences" and/or local development of comparable materials (p 23)

The RFP also specifically calls for "developing print materials"

as well as radio messages and materials "based on the results of these data" (referring to the formative, qualitative research as well as surveys in at least three areas of health (p 22) The RFP refers to sensitivity to "cultural and linguistic differences" in the development of health messages, thus at least some of the research should be anthropological in nature Print materials should not be overlooked for many reasons, including the fact that radio does not reach a majority of the rural population of Mozambique Accordingly, the RFP specifically calls for development of posters, leaflets, family planning methods charts and other such materials--all based on research by the PHCS Project

Some of the print materials and other health education/IEC approaches envisioned in the RFP, such as drama and dance groups, puppet shows, that the PHCS Project should be developing have already been developed in the field (the best place to develop such materials) by some NGOs and other international organizations, along with Mozambican district level counterparts A great deal has been learned at this level by several organizations What is needed is to take these field-derived lessons and modify them for more general use at the provincial and national levels An example of the latter is World Vision's training manual for health workers With a bit of revision and editing, a manual such as this could be an effective tool for use anywhere in Mozambique It would not be an effective use of resources at this stage of the PHCS Project to develop a general primary health care training manual from scratch, nor is there a need to since a model exists This example underscores the value of first compiling and examining what has already been done, and making field visits to see how approaches such as this actually work with intended audiences

BODY OF THE REPORT

Background to the Greater Emphasis on Community Based Approaches

There is an assumption that Mozambique's health system in the late 1970s and 1980s was a model for Africa, "at the vanguard" of primary health care It was a great improvement over the health system for the majority indigenous population under colonial rule It emphasized rural outreach, prevention, and focus on women and children It established a system of health centers and health posts, and a cadre of village health workers known as APEs In some areas, notably potable water systems, community participation in the form of contribution of labor was encouraged

On the other hand, the system was centralized and top-down in the extreme It was unresponsive to existing health beliefs, values, felt needs, priorities, perceptions, and social organization of the "masses" There was little realization that government had anything to learn from the masses, only the belief that government's mission was to enlighten them, show them the error of their ways There was not only no attempt to understand the indigenous health system that actually guides behavior, Frelimo in fact tried to suppress the system In response, the traditional health system simply went underground and continued to take care of the needs of Mozambicans in spite of the ideology of the times Indigenous or traditional health is estimated to take care of 80% of people in Africa, the proportion must be even higher in Mozambique due to the years of civil war, disruption of health services, poor rural outreach, and one of the weakest economies in the world And since the peace accord, some millions of people who lived for years outside areas of government control have now come under government services Many of these have had virtually no exposure to Western or "modern" medicine, or to scientific education

USAID including REDSO, the World bank and other international donors are redoubling their efforts to promote a health care system in which the people take some responsibility for their own health This is as it should and must be--and as it was <u>not</u> during the sometimes-romanticized early post-independence period of expanded health services The intended beneficiaries of these services were often passive, dependent recipients at best Functionaries at different levels passed on directives from above without question, no matter how inappropriate to local need and conditions The central authorities knew what was best for <u>o povo</u>

In spite of major reforms of the health system since 1989, when for example there was a policy shift to recognize the value of traditional healers, today's health system still has many of the unfortunate features of what might be called the Frelimo system of the 1980s Government policies and programs do not change overnight, nor do beliefs and attitudes of those who work in the system FINIDA recently financed a study to measure "client satisfaction" in Manica in October/November 1995, interviewing

879 patients at health centers and health posts (83 4% were women) Preliminary results are available and they show the typical problems of clinics throughout Mozambique

Main Reasons for Current Dissatisfaction with Health Services

-people have to make long walks to the health post or clinic, or they have to pay for transportation (27%),

-people have to wait a long time to be seen (16%),

-the health worker doesn't take the time to listen to them (they are probably thought to be ignorant peasants),

-there is no examination (this not necessarily listed as a complaint--just something measured by the survey for FINIDA interest),

-nothing about their health problem was explained to them,

-they did not trust the health worker,

-women patients did not like being seen by a male worker,

-the facility was out of medicine, or the patient was simply not given any treatment,

-even when drugs are available, they are too expensive

-the facility did not open when it was supposed to

It is not surprising that "demand for services" are low, service is poor or non-existent These problems are by no means unique to Manica province or even to Mozambique Recent USAID-funded studies of client satisfaction in neighboring countries have found most of the same problems [1] Clearly, there need to be major changes to raise demand in Mozambique But what would this take? More staff, more and better facilities, better geographic outreach, better trained staff, better paid staff (so that under-the-table charges become less likely), more motivated staff, better drug supply, better drugs (e g , new antibiotics to overcome antimicrobial resistance), better cold chain capability--in short, more of almost everything What would the cost implications be? The GRM cannot afford the current system, which is heavily subsidized by foreign donors

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[1] Helitzer-Allen, D , and H Allen, "Focused Ethnographic Study of sexually transmitted diseases in Thyolo, Malawi Results" Arlington, Va FHI/AIDSCAP, Nov 16, 1992, Green, E C and M Nzima, "The STD Targeted Intervention Research Study in Zambia" Lusaka Morehouse/Tulane AIDS Prevention Project, September 5, 19.5

What would happen if health educators were successful in motivating hundreds of thousands of Mozambicans currently outside the system to all of a sudden become users of government health facilities? Service would deteriorate even further since the same resources would have to go much further The same health personnel and facilities would have to cope with a great many more patients

All this argues for trying something different and far less costly, at least until Mozambique develops further economically It argues for promotion of preventive and even curative actions that people can take for themselves, in their own communities The MOH and donors must think further about the implications of IEC efforts whose only aim is to increase service utilization Even the community based "popular mobilization" efforts of the Mozambique Health Committee seem to be aimed primarily or exclusively at this

It is true that there are interventions better taken care or--perhaps only taken care of--in "modern" health facilities There needs to be a better system of triage whereby more serious cases are taken care of in clinics, along with those prevtive activities such as immunizations that are also dependant on trained health staff in a fixed or mobile clinic But there are also actions and activities whereby people maintain their own health in their own communities These indigenous, practical, health-maintaining practices should be discovered, reinforced, and built upon--for example as Save the Children did in the psychosocial treatment of war-traumatized children through its Children and War program in Mozambique [2]

There are also preventive interventions that, once translated into behavior change and rooted in local communities, can alter permanently the health and survival status of children and to some extent, mothers These interventions include using rather than discarding colostrum, adoption of cereal based ORT, adoption of child spacing practices and overcoming fears of modern contraception, responsible sexual behavior so as to prevent AIDS and STDs, adequate breastfeeding, use of enriched porridges made from locally available foodstuffs for malnourished babies, and receptivity to immunizations These are all interventions that can be--in fact, can better be--taken care of at home than in a health facility PHC and supporting IEC efforts should be re-directed to actions that can be taken at home and in the local community, and away from messages like "Bring your child to the clinic for an ORS packet "

Community based, participatory development has hardly begun in Mozambique, in fact there is a strong tradition and mind-set against it Yet some NGOs and international organizations have already shown that it can be done, at least under certain conditions The question is can Mozambican health services implement and sustain programs such as those developed by NGOs

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[2] This approach has been successfully replicated in Angola

such as World Vision and Save the Children? Economically these low-cost, community based, low technology approaches are more sustainable than anything that leads to an increased use of health facilities And to the extent that sound health practices become rooted in local communities (in addition to any positive indigenous health practices), health status would improve even if the MOH were to vanish completely

In any case, the system of decentralized, community based, participatory, culturally-sensitive primary health care now being promoted by donors such as USAID and UNICEF is as new to provincial and district health workers as it is to the masses (An exception to this is self-help in the form of labor contributions See water and sanitation section, below) Entrenched patterns supported by attitudes and assumptions are slow to change (examples rural people are ignorant about health, traditional health systems are crude expressions of magical thinking or worse and they only stand in the way of progress)

But there has now been enough experience in Mozambique to show that community based, participatory primary health care can work Local communities can be--and have been--mobilized to take better care of their health and that of their children Relatively simple, low-cost interventions can be rooted in local communities and quite easily taught to people with minimal or no formal education Communities are willing to take responsibility for their health, in fact they have been doing so up to now under the prevailing indigenous health system In fact Mozambicans are unusually self-reliant in health and other matters, due to this country's special problems before and since independence Health programs promoted by government and NGOs must be careful not to undermine this self-reliance by focusing too much on the message that everything needed is done in a health unit by a trained health worker--in other words by an outsider away from the local community

Fortunately some NGOs and international organizations have proven able to work with local government health workers and officials in ways that promote local responsibility and self-help NGOs like World Vision and Save the Children (UK and US), and UNICEF in at least Manica are working effectively with MOH colleagues at district (DDS) and provincial (DPS) levels in highly participatory community based approaches As a result, villagers have proven willing to mobilize themselves into, for example, health, water or sanitation committees They are willing to repair water pumps, use local cereals to rehydrate dehydrated children with thin porridges, work in partnership with NGOs and local government workers--even come up with scarce cash when it is put to a purpose in line with local priorities <u>and</u> they have full control over its safekeeping until it is spent Success of this sort depends largely on how communities are approached, the type of partnership that is developed, and the quality and quantity of ongoing contacts with outside partners

The Primary Health Care Support (PHCS) Project can help this process by

(1) supporting local or regional IEC efforts by the production of appropriate print, electronic and other messages and materials,

(2) consolidating the lessons of what works at the community level, as well as what does not work and why, and using these principles to develop national and regional IEC strategies, messages and messages, to support both local/regional health programs, and to support the project's efforts at decentralizing management and decision making "What works" refers both to general principles such as self-help, village health workers, and appropriate technology, and to IEC approaches and materials developed (or adapted) at the local level,

(3) policy clarification when needed

There has been enough experience in Mozambique and elsewhere in Africa that the elements that contribute to successful, community based primary health care can be identified Some of these key elements are illustrated in this report in the context in which they were found to be operating during field visits to provinces and districts They can be found in the sections to follow on ORT, family planning, water and sanitation, infant nutrition, and working with and through existing structures

Ethnographic Note on Bantu-Speakers in Southern/Eastern Africa[3]

There are some who argue that developing health education in a manner that takes language and culture into account is a loosing proposition in a country like Mozambique due to its considerable cultural diversity It is therefore worth examining this question, we may do so by a consideration of both the cultural diversity and homogeneity found in Mozambique

The Bantu are a major sub-group of the Niger-Congo language family This is the numerically largest and geographically most widespread group in Africa, covering most of sub-Saharan Africa except for the Horn and central portions of the Sudan The Niger-Congo grouping relates the Bantu-speaking peoples of the Congo basin and southeast Africa historically and culturally to the dense population of West Africa, from which area the former group migrated, beginning a few centuries before Christ Noting the common heritage, historian E Murphy observes, "The Bantu-speaking peoples share with their West African cousins common fundamental attitudes about God, religion, kinship, the nature of the world, and life" (1972 179)

There are three major sub-groups of Bantu in Mozambique the

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[3] This is taken from G P Murdock's seminal work, Africa its People and Their Cultural History (1959), and my own summary in Green, E C , Heat, Darkness and the Shadow of Death Indigenous Understanding of Contagious Disease in Southern Africa (London Intermediate Technology Press, forthcoming)

Central Bantu, the Shona/Thonga clusters and the Nguni, although the last accounts for only the few Zulu and Swazi in the extreme south

Murdock divides the Central Bantu speakers into 7 "clusters" the Kongo, Kimbundu, Kwango, Kasai, Lunda, Bemba, Maravi and Yao The last three are found in Zambia and adjacent parts of Zaire (Bemba), Malawi and western/northern Mozambique and adjacent coastal Tanzania (Maravi and Yao)

The Maravi cluster includes the Chewa, the Nyanja, the Nyasa, and the Sena, among others The Yao cluster includes the Macua, the Lomwe, the Makonde and the Yao, all found in Mozambique

The Shona/Thonga sub-group consists of two clusters of many "tribes", including the Shona and Thonga, and it occupies a geographical position between the Central Bantu to the north and west, and the Nguni to the south (part of Maputo province)

This is not the place to describe diversity and similarity between subsistence modes, kinship systems, social organization, and other aspects of society and culture among the societies of these clusters and linguistic sub-group But it is important to observe that <u>health and spiritual beliefs</u> and practices are quite homogeneous among all the societies in Mozambique and in neighboring societies along a strip of southern and east Africa extending at least from the southern cape of South Africa (Xhosa) to Tanzania in the north A leading medical anthropological authority, John Janzen in fact suggests this strip may represent a meaningful cultural area, somewhat distinct in health beliefs and ritual practice from other Bantu-speaking areas [4]

We turn now to the lessons learned from field trips in Mozambique

<u>Oral Rehydration Therapy</u>

During a field trip to Nicuadala District, Zambesia (2/13/96) we observed a "demonstration" (as distinct from lecture) at the District Direction of Health (DDS), where World Vision does routine health education with mothers who bring their babies to the hospital It concerned cereal-based ORT The World Vision volunteer (an <u>activista</u>, chosen by his/her village, who meets minimal criteria of reading and writing) began by silently demonstrating the boiling of so much water with so much farinha, then adding so much salt He asked the women what they saw The mothers described accurately what they had been shown, and said they thought it was a treatment for diarrhea and for "lack of

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Janzen, John, "Health, Religion, and Medicine in Central and Southern African Traditions " <u>in</u> Caring and Curing Health and Medicine in World Religious Traditions L Sullivan, ed New York MacMillan, 1989, p 243

water" Yes, said the demonstrator, it is for the latter, and this condition results from diarrhea that persists A child with lack of water is like a tin can with a leak, all the water you put in just falls out A sunken fontanelle and sunken eyes are signs of the same condition--these are danger signs that the child with diarrhea might die And this remedy is something the women can prepare in their own homes The World Vision activista asked if they have already done this

No, they had only made porridge, but not the watery kind for use as a medicine A woman asked if she could use rice Yes, any kind of cereal, millet, even manioc In fact, coconut water is just as good if its available, and it doesn't require preparation The demonstrator (who used the local Chuabo language throughout) told the women that they should bring their babies to the clinic after restoring the child's water (energy?)

The World Vision leader began a song which summarized the value of cereal-based watery porridges for babies suffering from "lack of water" Most of the mothers soon joined in

The teaching approach we witnessed is described in World Vision's training manual for health workers as teaching by the inductive method (I would add the word participatory to this) With this approach, something is first shown or demonstrated without explanation in lecture or any other form Then a series of questions are asked What did you see or hear? Does this happen in this community? What might be the cause? What can we do to make this not happen?" (see p 4 of manual) The method requires that the audience not be passive but instead participate in a step by step learning process It allows questioning or disagreement at any step where anyone in the audience does not understand or agree, or has an alternative explanation

The health workers' manual has sections on child and infant nutrition and cereal-based ORT, as well as family planning, AIDS/STDs and many other topics The ORT section also explains and illustrates the options of ORS packets and home-made sugar/salt solution It uses the unwatered, drooping plant illustration add water and soon the plant is firm, upright and healthy Then "Plants need only water The human body also needs salt "

We later discussed the relative advantages of cereal-based ORT over ORS packets with World Vision and DDS staff There was agreement that packets are simply too difficult to distribute They are something alien, something people don't understand nearly as readily as adding salt and extra water to porridges already in use, even as remedies for diarrhea and other childhood illnesses The MOH policy a few years ago was to promote only ORS packets, because, among other considerations, people in rural areas lacked sugar and salt and therefore could not make their own sugar/salt solution at home Nowadays people are said to have salt but often cannot afford sugar Sugar is not needed in cereal-based ORT and potassium is also provided by the cereal Plus the cereal-based solution stays in the child's stomach

longer, so it is biologically superior to ORS The chief of Community Health at the DPS saw these advantages and said that they have been promoting cereal ORT for a number of years now

I asked both the World Vision staff member, the activista, and the DDS Chief if cereal-based ORT could be simply and effectively promoted by radio They all thought so Had anyone present ever heard this promoted on the radio? No, never, they thought [5] Here is another example of where the PHCS Project, through its IEC component, could discover what works best at the local level, then see that cereal-based ORT rather than ORS packages is promoted through radio Songs in a few key local languages could supplement the teaching part of the spot

Jaime Morais of World Vision guessed that much less than half of households in Zambesia have a radio (Jose Romero guessed about 30% Other estimates I heard were less than 20% for some other provinces) Clearly radio is not the only channel that should be used in health education

To avoid confusion over whether ORS or ORT is a treatment for the symptom of diarrhea (some Mozambican health education messages actually made this mistake a couple of years ago), the proposed remedy must be directly linked with symptoms already familiar to mothers, such as sunken fontanelle, and the name for this in the local language must be used (tomela in Chuabo, chikahara in Shona, etc)

Another point for PHCS/IEC World Vision is successfully using a culturally-appropriate, participatory "demonstration" process in its health education, while in other parts of the same district health center, nurses are giving lectures in the old manner--even though they apparently know they are not effective Why do formal lectures persist? The Community Health Chief said that, well, demonstrations require materials such as pots and pans and some cereal flour, yet "The DDS has nothing " Putting aside ways to remedy this, here is another issue for health education and IEC--the need for materials, especially culturally appropriate print materials The best materials Save the Children/Zambesia has found come from Malawi Why not from RES in Maputo, and from the PHCS Project?

There are doubtless other reasons for the persistence of the lecture mode Old habits die slowly Current health staff was trained to give lectures and many continue to do what they were taught, even if what they were taught does not work, or work well Again, this touches upon a crucial decentralization issue what is needed to change outmoded procedures? Policy statement from above? In-service training for mid-level health officials where they learn how to get and use feedback from the communities

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[5] See below, discussion of the PHCS radio spots There is mention of "rice water" in one of these From questioning about this, it is not clear that "rice water" is understood in many parts of Mozambique

where they work? New written materials for health staff and teaching materials? All of the above?

Recommendation The PHCS project should do a systematic needs assessment of district-based and community based IEC, starting with those who work effectively at the community or DDS level, and then working upwards--rather than from the top down Materials, policy/program clarification, and perhaps training are needed

Recommendation There has been effective promotion of ORT in the form of cereal-based porridges in Zambesia, Gaza and probably elsewhere But success may be constrained--if no longer in Zambesia then elsewhere--by murky policies or business-as-usual MOH programs Former policy related to ORT was to promote only ORS packets Government health workers in some if not many areas would benefit from such policy clarifications as these What has happened is that NGOs and other international organizations have shown district and possibly provincial health colleagues that different approaches and technologies can be far more effective than ones in use There may be an understanding that concessions to "appropriate technology" and the like may be alright in certain districts and/or under circumstances of working with NGOs or foreign organizations Yet to be effective on a larger scale, and to be sustainable, there should be discussion at higher levels (provincial, national) and articulation of supportive policies

Family Planning

The PHCS Project is intended to support preventive and health promotive efforts in three main areas of health family planning/child spacing, maternal and child health (MCH), and AIDS/STDs Of course child spacing is an integral part of MCH, but project documents treat this somewhat separately because in countries like Mozambique it is easy to put emphasis on other, less controversial elements of MCH and leave out family planning altogether To minimize the chance of this, the IEC Advisor was to work in and with the family planning association and IPPF affiliate, AMODEFA, according to project design However, for various reasons, this did not work out and the IEC Advisor was moved to the health education unit (Repartação de Educação de Saúde, or RES) of the Ministry of Health It seems that there may be some question about IPPF's continued funding of AMOFEDA because of the latter's reluctance to focus on family planning AMODEFA is working more in AIDS, STDs and maternal and child health (MCH)--all areas that are less controversial than family planning

Is it possible for the PHCS Project to promote family planning in Mozambique at this time? Some notes from the consultant's fieldwork in Gaza (accompanied by USAID General Development Officer Laura Slobey) are instructive

2/27/96

In aldeia Julius Nyerere (where SCF has worked since 1988), we visited a clinic run by a nurse-midwife After the usual discussion and tour, we asked about family planning The nurse showed us her supply of contraceptives pills, injectibles and condoms She said about 20-30 women per month come for family planning services We later had a discussion with the provincial director of health Sr Naiene as well as the provincial medical director, Dra Ligia Masia We asked in a general way what they thought about family planning Both directors mentioned all of the right things the need for responsible child spacing to better ensure maternal and child health and survival, the constraints on development caused by high fertility rates, etc The provincial director said that there is already quite a bit of demand in town and peri-urban areas although demand is in a very early stage of developing in the rural areas There is some "cultural resistance", especially from men in rural areas He said the process of acceptance would be slow but that it has definitely begun There is a "need to sensitize people through IEC"

We asked if there were any policy or related constraints at the district, provincial or national levels that would constrain family planning initiatives Both he and the medical director thought that there were none It might be argued that these two particular officials might be unusually progressive or enlightened Indeed it may be that some of their counterparts in other provinces are not supportive of family planning However, it seems that there are no serious policy constraints to implementing a program in family planning in Mozambique at this time--even if this may have been true in the recent past

To test this hypothesis at the grassroots level, we raised the subject of family planning with a group of volunteer village health workers in Nhacutse, a village of 16,000 population about an hour's drive northwest of Xai-Xai These VHWs are locally known as <u>activistas</u> They have received two weeks of initial training in promotive and preventive primary health care (as well as some environmental sanitation and water) under the sponsorship of Save the Children/Gaza Even though this village is one of the last communal villages in Mozambique, and one might expect that it would be difficult to recruit general volunteers in such an environment nowadays, these <u>activistas</u> seem to be the real thing they consisted of traditional birth attendants, the odd traditional healer, and other mature women and men (about 90% were women, reflecting in part the demographic imbalance of the village and region) <u>Activistas</u> work without pay or other direct compensation other than rewards of prestige and recognition Some have been working this way since 1992 One thing they requested of Save the Children in our presence was an ID card so that people would know that they are really health <u>activistas</u>, including when they venture away from their immediate community This demonstrates the

value and power of what we might call prestige rewards It should also be mentioned at this point that supervision, resupply (in the case of using curative kits), and regular if not frequent contact with health workers and/or NGOs or outside organizations seems to be an important factor in accounting for why village health workers may actually operate under these circumstances when the government APE program has largely failed [6]

To return to family planning, we asked these VHWs about family planning and no one seemed at all surprised about the question or uncomfortable in discussing the subject Basically they said that they promote child spacing and help women obtain contraceptives Some husbands in the area are afraid that this will lead to promiscuity of their wives if they are away working, and there seems to be some association between contraception and prostitution, but nevertheless family planning goes on The activistas seemed aware of the health benefits of child spacing

To summarize the family planning findings in Gaza, we found evidence that programs are operating and that there are no policy or other constraints other than the usual resistance one finds in rural Africa in at least the early stages of such programs

In later discussions with World Vision, it was disovered that WV has managed to persuade several district health directors in Tete to allow it to experiment with CBD of contraceptives in communities located more than 15km distance from a health post WV hopes to show that the pilot program has worked and to build upon this, hopefully influencing national policies and program on family planning

Recommendation Operations Research How should the PHCS project approach family planning? As recommended above, formative, qualitative research in this important area--perhaps the area of health least researched in Mozambique--should be undertaken without delay The first study might be a "consumer intercept" study in which current users of contraception are located at clinics, then interviewed with a semi-structured questionnaire at a later time [7] The purpose of the study is to assess current "demand" for contraception (child spacing, delay of pregnancy) and to obtain a profile of current users, with a view toward better meeting their needs, and expanding the number of users The "intercepts" of users should be done in clinics such as the

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[6] See recent evaluations of the APE program, funded by the Swiss Development Cooperation

PSI has just done a study of this sort in Mozambique to establish a user profile of Jeito condoms users For description of intercept methodology, see Green, E C , "A Consumer Intercept Study of Oral Contraceptive Users in the Dominican Republic " Studies in Family Planning Vol 19, No 2, 1988, pp 109-117

one described in Gaza that have at least 20 users per month The preliminary study should be done in two provinces (Gaza and Zambesia), with a suggested minimum "sample" of 100 users per province Questions to be asked of users of any method include, What is your reason for using method X? What other methods, if any, did you use in the past? Name some advantages of this method Name some disadvantages of this method Does your partner know (and approve/disapprove) of your use of method X Have you or do you now have difficulty in obtaining method X? Where did you learn about method X? The study should establish a profile of age, gender, number of children, residence, level of education, etc

A third province, Tete, could be added if additional resources are available This would allow inclusion in the study of remote villages where World Vision has been promoting and supplying contracpetives in a pilot CBD effort An "outside" evaluation of this pioneer effort would be a very useful first step in influencing the MOH to adopt a policy supporting CBD nationally Such a policy would be an important milestone in the development of family planning in Mozambique

Recommendation General Approach to FP The general approach to family planning taken by World Vision in Tete Zambesia illustrates a good way for the PHCS Project to proceed This approach can be seen in World Vision's training manual for health workers Education in this area begins--as it should--with the observation that families in Mozambique and most of Africa used to practice spacing of births so that each child could receive adequate care, the mother could rest, etc An illustrated metaphor is used of planting carrots too close together, such carrots cannot grow properly But they can be fat and healthy when planted--or spaced--some distance apart Note that the traditional birth attendants (TBA) training manual produced by the MCH section of the MOH uses a similar metaphor and graphic representation, only using maize instead of carrots

This seems to be the best initial way to approach family planning with both health workers and the general population in Mozambique, and with health workers in the MOH An additional approach that might be used to help convince sceptical health workers is the relationship between having some control of one's fertility and the betterment of Mozambican women This was one of the centerpieces of Frelimo ideology and major social engineering was done in its name, e g , banning polygamy and bride payments Family planning can be presented as a new or additional way to empower and emancipate women This approach would also have the advantage of linking newer, Western-appearing approaches to health with earlier Frelimo approaches to health care and social development It builds upon one of the strengths of the old system

One would probably not use the emancipation of women approach with men at the village level In fact, one would want to discuss this general approach at various levels of the MOH before using it at all

Infant Nutrition

This section comes from both World Vision/Zambesia (Nicuadala field visit) and UNICEF/Manica

The first is based on field notes from a demonstration to a fairly large group of mothers (with their babies) about how to prepare and use "enriched porridge" This went much the same way as the cereal ORT demonstration put so many liters of water in a pot, add flour, add peanut flour, add dried fish meal, add pulverized pumpkin leaves, add a bit of oil, etc Mothers were asked to describe what they observed They did The trainer then explained the various functions of each food group represented in the ingredients (fruits and vegetables to protect against illness,[8] fish or other meat and peanuts to build baby's bodies, oil for energy, etc) Examples were given of other foods that can substitute when the particular ingredients used by the activista are not available Fruits for example have the same protective power as vegetables

After the enriched porridge was ready, everyone was given a bowl and mother and babies all tasted it All seemed satisfied (One particularly active, rock-wielding toddler who managed to focus a lot of attention on himself gobbled up the gruel gustily He couldn't have been a better advertisement for the porridge) There ensued questions and answers as well as discussion about how to store the ingredients, the difference between fresh and dried ingredients, etc

A UNICEF program of infant nutrition in Manica province is also instructive, in large part because it illustrates the value of working with and through existing structures UNICEF realized through its community based work in Manica that the Catholic church in this area is the only organization with good organization and grassroots outreach, as well as both credibility and acceptance among large numbers of people UNICEF accordingly began to work with church volunteers in an infant supplemental feeding program The program promotes a porridge made of crushed beans with cassava or papaya leaves UNICEF taught interested church members he rudiments of child nutrition and showed them how to measure the circumference of an under-three year old's upper arm with a color-coded cloth (red means danger and to take to clinic, yellow means a warning sign, green means the child's nutritional status is alright)

As the program has grown, so has the number of volunteers--another sign and measure of success in community based programs (witness the Children and War program of SCF in Mozambique in

[8] Pumpkin leaves are high in iron, and anemia is a leading cause of infant mortality in malarial parts of Mozambique such as the Zambesia littoral

1992-3) [9] This church-based program now has a training center whose scope has come to include income generation projects, sanitation, and literacy training as well as nutrition
It took some time to involve government health workers from the local DDS in this program In additional to the usual problems of per diems and transportation (there was a recent controversy over whether full per diems should be paid if workers are out for a couple of hours only), there was an attitudinal problem in Manica For many years the Mozambique government disapproved of churches as counter-revolutionary forces Therefore some government staff was and is suspicious of the church Moreover, there is no precedent to work with any church Yet working with church volunteers through existing church networks and structures has proven a good way to reach the grassroots and to mobilize support

Community Based Approaches to Water and Sanitation

An interesting finding jumps out of two recent USAID evaluations of water and sanitation projects in adjacent northern provinces Both projects are based on health education, IEC, self-help, and a participatory, community based approach After all, why build wells or latrines if people see no need for them and won't maintain them?

The World Vision/Zambesia evaluation reports that water and health committees are functioning as they should The water committees actually repair well pumps when they break down, and even find scarce money to pay for spare parts It seems the wells and latrines are appreciated and are considered the responsibility of the villages--essentially everyone in the village

The recent evaluation of the MCD/I water and sanitation project in Cuamba district, Niassa, suggests that some of the same things are found as in Zambesia, but that only about 20% of a village, on average, is mobilized for at least water matters--usually those living closest to the wells

Why 20% mobilization in one district and 100% in another district, both in the north of Mozambique?

I asked MCD/I Chief of Party if the characterization of 20% was fair He thought mobilization for water maintenance might be about 20%-50% I asked one of the Mozambican project assistants the same question, he did not disagree with the 20% estimate At least no one was claiming more than half of Cuamba villages was mobilized

I asked Ed Vosotros of World Vision/Zambesia, who is in charge

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[9] This could be a formal indicator for USAID, not of any specific area of health, but of the effectiveness of, and popular support for, community based approaches

of water and sanitation, what contributed to the success of his project He used the language typical of those who are serious about implementing a community based approach "We spent a lot of time to talking to village leaders such as chiefs and traditional healers we keep in touch regularly we did a lot of education I myself learned so much from the people in the village [10]

It seems to me that other factors are that Mr Vosotros has a great deal of experience in Mozambique Moreover World Vision sent him to learn from one of its water and sanitation projects in Malawi prior to implementing in Zambesia And World Vision has taken steps to ensure a sound community based approach from the very start of its Mozambique program--no matter that much of what they were doing earlier was classified as emergency relief

MCD/I was also committed to this approach when it began implementation in Cuamba in 1993 However the original IEC Advisor was not committed to--perhaps not even really understand--the related concepts of self-help and community based, participatory development Even though this is how the project was designed, the IEC Advisor found herself working with "animators" from Agua Rural (the branch of government in charge of water issues), who presented themselves as interested in working from MCD/I as soon as it was recognized that a new organization had appeared with funds to hire people

A number of such animators were hired from Agua Rural, prior to the Needs Assessment and contrary to the plan in the project design It was intended that animators come from the villages they were to work in, and be selected by the villagers themselves--as in Zambesia under World Vision Thus the IEC/community based approach component got off to a poor start It seems the IEC Advisor actually took sides with ex-Agua Rural animators who thought that people should simply be given wells and latrines without having to contribute to their construction I witnessed and reported candidly on these problems at the time [11]

Now, more than two years later, a Mozambican project assistant told me that villagers received a mixed message the IEC Advisor and some animator allies promoted the old dependency-creating approach, while the project director (an engineer) and others promoted self-help The district government in Cuamba was no help since it was for the most part still immured in the old ways of

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[10] In my years of evaluating USAID and other projects, hearing a spontaneously comment about learning from villagers has correlated with finding a successful community based project

[11] Green, E C , "The MCD/I Water and Sanitation Project in Niassa Province, Mozambique Preliminary Information Needs and Findings USAID/Mozambique and Medical Care Development/ International, Wash D C Dec 1993

doing things and did not really support self-help (another example of how the PHCS project IEC and decentralization technical assistance could have helped--and could still do so Niassa is one of three provinces of focus) Some villagers took self-help to be some kind of rebuke or punishment from the government, "and so they stayed away in their planting fields when the well-building was going on," the assistant reported As could be anticipated, those who were involved in construction are the same people who later maintain the wells and feel a sense of ownership The rest of the village feels no such responsibility

According to some in Pronar, there were also problems in the style in which self-help was introduced in Cuamba In this view, it seemed to many villagers and some in Agua Rural that the MCD/I vision of self-help amounted to exploitation of unpaid labor, and that there was insufficient initial discussion and planning with villagers to learn what they wanted

Steps were later taken to remedy the problems with the project's IEC component (which incudes community participation), but it is crucial that proper foundation work be done before construction The March 1995 project evaluation notes that a constraint to sustainibility was that " local people were not required to contribute to prior projects (of this sort) that were considered emergency relief" (p 21) Pronar denied this in discussions with me, saying that labor contributions have always been part of construction of water systems But even if true, this only means it was even more critical for both the project director and the IEC Advisor to promote participation and self-help, to speak with one voice This evaluation goes on to recommend a "new/renewed campaign of village awareness " to remedy the problems in the first year

Hopefully lessons learned from this project (and a great many like it elsewhere) can help ensure that self-help, participatory projects lay the right foundation at the outset, and that demonstration of a willingness to participate is made a prerequisite for construction of facilities

There are many important lessons to be learned here The foundation of participatory, community based, self-help efforts must be established at the outset, as it seems World Vision did in Zambesia This approach must be continuously reinforced with leaders of the communities involved Parallel efforts must be made to foster change in thinking and attitudes as well as standard procedures at the provincial and district levels of government, in order to sanction and reinforce this approach Ministries, NGOs and donors must <u>learn at the local level</u> what works and what does not, and then suit policies, programs, and a decentralization strategy that builds upon this Certain NGOs are currently at the forefront of this learning

There must be adequate health education, using effective approaches, to convince people unused to wells and latrines that these can hep prevent a number of serious, local health problems

And self-help must include participatory planning--and perhaps some compromise between outside agendas and local priorities and needs--and not be reduced to labor contributions alone

Recommendation USAID should require that anyone implementing a self-help based water and sanitation project should spend some time with a mature project in the same sector, one that is successfully fostering self-help and the other elements that go along with a community based approach

Before leaving the subject of water and sanitation, World Vision/Zambesia has also been successful in promoting construction and use of latrines, according to the external project evaluation and discussion with Ed Vosotros To achieve this, World Vision had to prevail in a struggle over appropriate technology for latrines As has happened in neighboring African countries, the Mozambican MOH--at least the DPS in Zambesia, felt that only concrete latrines met minimal standards of quality World Vision argued that latrines could and should be made from local materials such as wood and bamboo According to Ed Vosotros, anti-termite treatments are even locally available World Vision was eventually able to demonstrate that simple, effective, easy-to-construct latrines would last and could be promoted more easily than concrete-floor latrines

Thus we see yet another ingredient in successful community based programs to the extent that technology is involved, appropriate technology is best Other things being equal, it is better to choose that which is simple, low-cost, locally available, familiar, and easy to repair and/or discard and replace

(See also UNICEF/Manica's community based approach to water and sanitation, described in Annex A, below)

Flexibility and Adaptability

Other elements that emerge as factors in successful community based programs are flexibility and adaptability When something is needed, ways are improvised to get it If information about ethnomedical beliefs and practices are needed, or if a visual teaching aid needs to be assessed for local comprehensibility, these programs do what they can with the resources at hand They do not simply wait until a highly-qualified, expert consultant can be brought in From the description of the activities that SCF/Zambesia has gotten into in the broader interests of children and their health, staff members have had to do mini-environmental and social soundness analyses on the spot (You want to raise goats? Have you thought about the depletion of bushes and what this might mean for firewood availability in later years?") SCF welcomes all outside help but does not count on it, they manage to improvise Much of what they do, they say, is common sense And they always, it seems, seek consensus and feedback from those whose behavior they are trying to influence, whether on the community or government side

Flexibility and adaptability has certainly been needed to deal

with the addition of thousands of Mozambicans who formerly lived under Renamo control The general perception used to be that health care consisted only of what traditional healers and TBAs provided We now know that there were "health workers" of a sort who also provided "modern" health care to a degree Some were nurses, técnicos de saúde or other personnel who had some GRM training and later found themselves in Renamo areas Or they were Mozambicans with only a little formal (primary) education, but at least more than others, and somehow received a little health training and/or medicines from NGOs, churches or other sources One of the constraints to acceptance of government health services in Zambesia is that health workers and other local notables stand to be left out, or become subservient to government (in their minds, Frelimo) health and government personnel Those who took care of formal, "modern" health care for years have often become disempowered since their areas have come under government health services This is one of many factors making the work of foreign NGOs particularly important and delicate, since they may be in a position to assist this transition process in ways that minimizes stress Are they trained in reconciliation of former combatants? Probably not, but they do what they can

Compromising on Health Priorities

Another element of sound community based PHC is seen in UNICEF/Manica's program Staff quickly realized that what the DPS is promoting and what local people want out of the health system are not the same thing One of the highest priorities locally is treatment for bilharzia (Shonas understand the Nguni term umthundungazi, blood-in-urine, for S haematobium and use it as one of two local terms for bilharzia) The DPS promotes simple preventive/promotive health "technology" such as ORS and condoms, while local people want help with bilharzia which traditional healers admit they are not good at treating UNICEF therefore tries to accommodate this felt need by bringing bilharzia pills to villages where they work promoting the DPS and UNICEF health agenda This in turn creates good will, confidence and respect, after which it becomes much easier to promote ORS and condoms or whatever the MOH and DPS want

Again we see that program staff are flexible and willing to move into areas beyond what was planned in order to meet the felt needs of the people they are trying to influence and serve This of course implies that the program will take the time to find out what it is the local people want Because they took the trouble to do this, the UNICEF/Manica community based program has expanded into income generation, wells and sanitation, etc We see exactly the same thing with World Vision/Zambesia and Save the Children in Zambesia and Gaza All programs have expanded into broad, integrated, community development, and now work in income generation and agriculture-related projects as well as all areas of health, family planning, potable water and environmental sanitation Such expansion has been in response to needs expressed by the people they work with SCF/UK reasons that the health and survival of children depends on more than simply

preventive health care, water and sanitation People need to grow food and have some income to buy things All these programs are stimulating sound, community based, integrated development aimed at health but of necessity becoming broader than the organizations had in mind at the outset

It seems that such expansion of activities need not necessarily get out of hand as far as demand on technical assistance and other resources as long as technology is kept very simple and locally-available, with a view toward affordability and sustainability And as long as the community is doing the great part of the work and the assisting organization is primarily providing encouragement, "low tech" help, and pointing people to appropriate outside resources

Linkage Between PHCS and the GEMT

Health behavior in Mozambique is influenced primarily and overwhelmingly by indigenous knowledge systems of health [12] It is probably fair to say that 95% of what the average rural Mozambican does related to health is influenced by a "traditional" or indigenous model of health, and 5% is influenced by the biomedical model promoted by the MOH and by science teachers in schools Yet almost all health-related research is aimed at discovering only what Mozambicans know about biomedicine (questions like, "How is AIDS transmitted?"), leading to the conclusion that rural people are ignorant Meanwhile researchers have failed to ask about what people do know--the 95% of their health knowledge that is indigenous, or "traditional"

The reasons for this myopic research approach are important to understand, but cannot be discussed here Suffice it to say that in countries like Mozambique, health interventions including health education and IEC are based on assumptions that people know little or nothing about health--because they get low scores on KAP surveys that ask them only about an alien health system Why not do research about indigenous knowledge systems, about the health beliefs and assumptions that actually guide behavior?

As it happens, the Mozambique MOH has come to appreciate the value of this very approach Since 1991, the Gabinete de Estudos de Medicina Tradicional (GEMT) has been carrying out "ethnomedical" research, that is, research into the indigenous system of health-related knowledge, beliefs, attitudes and practices The GEMT's current program is funded by the Swiss Development Cooperation, which happens to also be the lead or coordinating donor for the MOH The GEMT's focus of ethnomedical research also happens to be on child diarrheal disease and

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[12] There is a large and growing body of literature on the value and specific practical uses of indigenous knowledge systems (IKS) in international development, especially related to health and agriculture It was pioneered at Iowa State University (with AID support) A number of universities worldwide now have IKS applied research centres, including Cape Town University

sexually transmitted disease, including AIDS, two of the major foci of the PHCS Project

What does the GEMT do with its research findings? It seeks to identify any common ground that already exists between indigenous and "modern" medicine It builds upon this by finding the "fit" between what exists and what the MOH wishes to promote in the interest of public health The approach is to build upon existing beliefs and practices, rather than ignore or confront them (as some of the effective NGOs like World Vision are already doing at the local level) Next, the GEMT develops a communication strategy that embodies these elements and that is aimed at traditional healers of a particular major ethnolinguistic group (e g , Tsonga, Macua, Shona/Sena) in order to communicate essential health concepts and enlist these healers (through regional workshops) in joint efforts to improve public health

But these research findings and this approach have much broader relevance than to educate and influence health behavior through the good offices of Mozambique's ubiquitous traditional healers (of whom there are some 80,000, so this in itself has high impact potential) This research and the resulting communications strategy approach can also go a long way toward developing a culturally-meaningful, community-based strategy for health education including IEC, at the regional and even national levels

Recommendation There should be strong and continuing linkage between the IEC component PHCS Project and the GEMT The GEMT has a fund of highly-relevant research data on indigenous health systems throughout Mozambique, yet lacks the resources to translate these findings into a national IEC strategy and the development of accompanying materials and messages The PHCS project has many of the latter resources but lacks the research findings and perhaps the expertise in translating these into something that could become a national (provincial, district) IEC program It seems a marriage made in health education heaven With linkages between them, the PHCS and the GEMT could each help the other better carry out its mandate And two lead donors in health could work in an even more synergistic and coordinated fashion

Should the PHCS Project become directly involved in community based PHC?

Prior to the present consultancy, there was discussion about the PHCS Project actually implementing some community based PHC programs at the local level, in Zambesia This seems neither necessary nor the best way to use PHCS resources. However, the IEC component of PHCS project can learn much from NGOs and DDS counterparts in Zambesia who are already successfully implementing participatory community based primary health care programs--and not simply those that aim at clinic utilization

Recommendation The IEC Advisor should spend some weeks making field trips within Zambesia, Niassa and Gaza to learn from the

experience of NGOs such as World Vision and Save the Children who are effectively implementing community based approaches with their DDS counterparts The purpose of the trips should be threefold

(1) to make a needs assessment of health needs and services at the village and district levels,

(2) to learn from the successes and failures of NGOs and government in their attempts to carry out effective primary health care,

(3) to learn how policies, modification of national programs and specific IEC can support programs and general approaches found to be successful at these local levels

The IEC Advisor has already visited these provinces to train and gain cooperation in the AIDS survey, but this would be to gather information and to learn Discovery and learning ought to precede training

Compiling Relevant Studies

Part of this learning process involves compilation as well as analysis and interpretation of research and other work that has already been done A guide to this activity is provided here

The single best data base for searching the published literature (and some of the USAID-funded unpublished literature) related to fertility and family planning is POPLINE AIDSLINE and MEDLINE are also useful for AIDS/STDs, MCH and other areas of health SOCIOFILE and HRAF [Human Area Relations File] contains abstracts of anthropological and sociological literature CD-ROM discs as well as necessary software/hardware are available in the Mozambique MOH library, searches of at least a few of these data bases can therefore be done locally

USAID maintains its own computerized data base Key word searches and limiting parameters (such as "Mozambique", "health, "family planning", "fertility", "malaria" "nutrition", etc will yield relevant article/chapter abstracts, after which the USAID library at 1601 N Kent in Rosslyn will copy and send by pouch all original papers requested

Repositories of ethnographic and health-related studies in Mozambique include

-the library of the Gabinete de Estudos de Medicina Tradicional (GEMT), Maputo (essential for indigenous health beliefs and practices in Mozambique, especially related to primary health care and AIDS/STDs),

-the National Archives, Maputo,

-the Ministry of Health Library, Maputo 'in addition to the CD-ROM data bases, this library has made an attempt to

obtain and archive copies of all health related research studies pertaining to Mozambique),

-the British Council Library, Maputo,

-files and holdings of various NGO and international organizations in Mozambique (UNICEF, WHO, USAID, Save the Children, etc Unfortunately, many studies--even good ones--do not circulate beyond a very narrow circuit,

-the Anthropological Museum Library, Nampula,

-at the regional level, some NGOs keep lists of studies as well as the studies themselves pertaining to that province, e g , the library files of the Mozambique Health Committee in Chimoio MSF used to maintain such a library for Niassa Phone calls to various NGOs would reveal which keep--or know of--clearinghouses or libraries pertaining to health

-INDE (Instituto Nacional do Desenvolvimento da Educação) has recently conducted some anthropological-type studies related to socialization, gender, sexuality, marriage, family, sexually transmitted disease, and other topics relevant to family planning and AIDS prevention There is a published series of these studies, apparently with UNFPA and UNESCO support

Problems with Surveys in Mozambique

A KAP survey related to AIDS was conducted under the IEC component in recent months It appears to exhibit many of the pitfalls of sample surveys carried out in Africa, especially when designed by foreigners--or by educated urbanites from the same country An example of a finding that is probably non-valid the causal connection between sexual intercourse and STDs is alleged to be poorly understood And in one area a significant minority are said to not see the causal connection between sexual intercourse and pregnancy Findings such as these are probably due to question wording and the formal, somewhat intimidating atmosphere of the one-time interview process

Qualitative research as well as surveys with validity checks show that Mozambicans in fact have well-developed indigenous theories about sexually transmitted disease--their causes, preventions, treatments, etc The qualitative research that has been done in Mozambique (and neighbouring countries) over the past few years suggests that it is highly unlikely that Mozambicans would not know the sexually transmitted disease are causally connected to sexual intercourse However it may be necessary to use native terms for sexually transmitted disease, rather than the Portuguese terms for syphilis and gonorrhea Use of Portuguese disease terms implies the Western, biomedical model of these diseases, models with which many rural respondents are unfamiliar--so it becomes easier to simply say, "I don't know"

Formal surveys like the AIDS/STD KAP test what Africans know

about the Western, biomedical model of health, and seem to make no attempt to uncover the indigenous ethnomedical model that actually guides behavior in a country like Mozambique Respondents feel they must give the "right answer" expected of them This leads to non-reliable and non-valid results For example, 13% of adults in Zambesia are reported to use condoms "all of the time " The figure offered for Gaza is 9% If true, this would mean condom prevalence in Mozambique, where condom promotion is relatively new, is already four times higher than the prevalence accepted in countries like Uganda, Zambia, and Tanzania which have much higher HIV seropositivity and have had 10 years of intense condom promotion A recent prospective study in a rural area of Tanzania showed a 42% reduction in HIV incidence as a result of improved STD case management in a rural district, even in the absence of condom use, which after two years of promotion was only about 2 5%--or less, if regular partners were included [13] Other recent, specific studies could be cited, suffice it to say that the Mozambique KAP findings are way out of line with other studies in Africa

If the purpose of the PHCS KAP survey was to collect baseline data against which to measure project impact, and 13% becomes an accepted baseline, the PHCS project as well as PSI and the national AIDS program might end up looking ineffective in the future when a condom prevalence survey using more validity and reliability checks produces findings more in line with actual behavior The PHCS IEC Advisor defended the findings of the AIDS KAP survey on the basis of having done a pre-test of the instrument The Advisor also mentioned a number of factors that may have led to a slight exaggeration of the prevalence figure such as a 20% non-response rate and the fact that a number of respondents in Zambesia had lived in Malawi Yet it seems unlikely that the factors offered can account for findings so different from other condom prevalence surveys in Africa There were probably significant reliability and validity problems in the survey--as there have been in other surveys in Mozambique AIDSCAP or another organization with global and African experience with such surveys could be asked to review the methods and findings of this study if another opinion is needed

As it happens, Population Services International (PSI) conducted an AIDS baseline survey itself and also arrived at a high condom prevalence figure 14% of respondents claimed to have used a condom during the last act of intercourse PSI Resident Advisor Clayton Davis does not trust this figure since it is so much higher than prevalence figures elsewhere in Africa He admits that there were a number of problems with many aspects of the survey, from question wording and conditions of interviewing through analysis of data He did a quick estimate suggesting that

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[13] Grosskurth, H , F Mosha, J Todd, et al, "Impact of Improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania randomized controlled trial " The Lancet, Vol 346, August 26, 1995,, pp 530-536

some 100,000,000 condoms would need to be circulating in Mozambique for 14% of the survey "universe" (men and women of sexually active age) to be using condoms on a regular basis (100 condoms per year is accepted as a "couple year protection" for condoms) This is far more than the number of condoms estimated to be in Mozambique

When in Nicuadala, Zambesia, this consultant had some discussion about AIDS, STDs, and family planning with the Community Health Chief of the DDS He commented that sexual fidelity is hard to promote but condoms are even harder A "few urban men might use them" They are very rare in rural areas " I tried to get the Chief to make even a wild estimate of what percentage of men overall--or even in Quelemane--use condoms He just shook his head and said he couldn't say Fernando from the PHCS project asked if any of the Chief's friends or acquaintances ever used condoms The Chief said he didn't know and seemed a bit embarrassed We got the feeling he might not know anyone who used them Again, it seems unlikely that 13% of Zambesian men use condoms "all of the time"

There are some checks and safeguards that can be built into sample surveys that can help minimize problems of validity Some of these are to (1) talk with researchers with experience in-country and find out what factors are known or suspected to have compromised validity and reliability in past surveys, (2) learn what has been done to overcome these problems, (3) review all relevant, prior research findings, along with methodologies, before designing new research, (4) conduct informal, qualitative research to first discover the patterns that can be expected to emerge through survey research Qualitative research should as a rule be done <u>prior</u> to survey research It is appropriate

> (a) when we don't know much about the subject area We would not know what questions to ask in a survey, let alone how to ask them Nor would we have a framework for understanding any resulting answers
>
> (b) when the information sought is of a sensitive nature, such as when it relates to private, highly-personal behavior such as sexual intercourse, fetal or child loss, or bodily excretion

Survey research is appropriate when patterns are already quite well established and we are ready to measure aspects of these patterns It is not good for discovering these patterns

There may be pressure from funding agencies to produce a measurable baseline or other quantifiable data Fine, but qualitative research should come first and maximum safeguards should be built into the survey design and instrument(s), in order to minimize error (especially the many things that can go wrong that are grouped under "response error") A pre-test of the survey instrument cannot insure a later survey against validity error, since the same systematic bias can enter both the pre-test and the "test" undetected

Recommendation The recommendation that formative, qualitative research be carried out in order to design IEC materials and messages has already been made Another recommendation is that the Demographic and Health Survey (DHS) should be advised to take the precautionary steps advised here in order to avoid the pitfalls of survey research in Mozambique Since it was the intention of USAID/Mozambique that the PHCS project work with data from the DHS, and that research under the PHCS project might serve as a basis for adapting the DHS instrument to the special conditions in Mozambique, it seems appropriate for a PHCS consultant to make this recommendation Moreover there is still time for the PHCS project to conduct formative research in family planning prior to the DHS The experience and findings from such research could help in the adaptation of the DHS instrument and design to Mozambique

It is instructive to note that PSI found little or nothing in its KAP to use in the design of its social marketing program, according to Mr Davis It obtained the information for its program design from formative research of a qualitative nature

AIDS and Condoms

An AIDS KAP study of truck drivers passing through Manica province was conducted in 1995 Allowing that self-reported behavior may well be unreliable, only 16% said that they had changed their behavior in the past 2 years Of this group, a greater number had changed behavior in the direction of fidelity or abstinence (17, most of these citing fidelity) than in the adoption of condoms (14, 7 of whom only say they use them "some of the time", even though condom use may have seemed to be the answer expected of them [14]

This makes one question whether "demand for condoms" should be the primary impact indicator by which to evaluate AIDS prevention programs It also suggests that promotion of fidelity or partner reduction ought to have at least as much emphasis as condom promotion in an AIDS prevention program in Mozambique [15] There are a number of reasons supporting these suggestions beyond these limited survey results

1 Condom failure rate in vivo is high, especially in Africa

2 10 years or more of vigorous condom promotion in the African countries with the highest seropositivity (Uganda, Zambia, Tanzania) have produced prevalence rates of only 2-3%

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[14] Black, J , A Cesar, F Manejo, "Conhecimentos, Attitudes e Práctícas dos Camionistas de Longo Curso em Relação ao SIDA, na Província de Manica, Moçambique Chimoio, Mozambique Provincial Direction of Health, 1995

[15] It is good to discover that PSI, in its social marketing program, is promoting partner reduction along with condoms

3 A recent prospective study in Tanzania proved that AIDS seropositivity can be reduced by 42% by STD control alone, even when condom prevalence is only 2-3%

4 The Zimbabwen Minister of Health was recently quoted as saying, "In Thailand they are shocked to find that although condoms were heavily promoted (there) long before AIDS hit, the condom has not been effective in preventing the epidemic "

5 STD rates have declined significantly in Uganda and Zambia since about 1994, yet condom prevalence remains at the same low levels It appears that more men are choosing fidelity or at least partner reduction Fidelity, rather than condoms, appears to be what churches and possibly traditional healers are promoting in these countries (This last is based on the most preliminary evidence and must await systematic measurement before any real conclusions about motivation can be derived)

Therefore it may make sense for programs in Mozambique to put more emphasis--or at least emphasis equal to that of condom promotion--where there seems to be better payoff treatment and prevention of standard (treatable) STDs and promotion of partner reduction or fidelity Looking at the Guidance Cable on Results Framework Development from AID/Washington, the measure for effectiveness of AIDS prevention seems restricted to demand for condoms

Recommendation The PHCS Project should develop additional indicators as measures of AIDS prevention impact These should be adopted by USAID and PSI, if not the National AIDS program The specific indicators are

(1) STD incidence decline (these data should be part of a health information system already), and

(2) KAP type measures (even retrospective) of behavioral changes toward sexual partner reduction and fidelity (or abstinence)

IEC Accomplishments to Date

IEC accomplishments to date seem to be radio spots in malaria, ARI, EPI, ORT, and AIDS/STDs Listening to these, the consultant's initial critical reaction is that none of the spots promote self-help or any form of direct participation in one's own health maintenance, or that of one's child The message is invariably that the mother should take the child to a clinic There is no suggestion that the mother or anyone situated in the community can do anything herself There is an implicit assumption that centuries of African culture have produced no useful, practical health knowledge The mothers are depicted as knowing nothing while the (somewhat Brazilian-sounding) nurse is presented as all-knowing The nurse must enlighten the mother with the missing information The underlying message is that the locus of responsibility is outside the mother, the local community, the village It lies only with the health unit

Are these spots much different than the message of the MOH throughout the 1980s--take your child to the clinic? Perhaps it can be argued that they are a bit better because they feature dialogue and music But there is much room for improvement

In the malaria spot, the wise friend makes an instant diagnosis of a fever as malaria and tells her friend the mother to calm down--there is a treatment if she takes her child at once to the health center What if there is no functioning, medicine-equipped clinic within reachable distance? Is it useful to suggest that any and all fevers are malaria? Is there nothing the mother can do for her child in the absence of formal health services? What about existing, traditional theories of malaria--does this spot fit in any way with these? Regarding the last, the IEC Advisor believes there has been no research in Mozambique in this area Then why not do some quick, qualitative research to discover KAP related to this disease of major morbidity and mortality?

In one of the diarrhea spots, when the mother asks what kind of liquids to give her child, the nurse mentions "rice water" as one of the appropriate liquids to give This seems on the right track--it is one of the rare mentions of an action or remedy that can be taken at home or in the local community But even here, it is not at all clear that Mozambican mothers or others know what the MOH means by rice water Someone working in provincial NGOs also raised this question (This is the kind of question that should be answerable in focus group dicussions

It seems that the existing KAP we want to build upon is the practice of giving <u>porridges</u> to babies This is suggested by ethnomedical research and observation of community based programs such as that of World Vision in Zambesia and Save the Children in Gaza

Finally, the dialogue in the spots seems a little forced and artificial ("Hello neighbour!" -How many Mozambicans address each other this way?), the dialogue is very rapid-fire, suitable perhaps for a young, urban audience but not for rural people, and the ORT jingle sounds like Brazilian music, not Mozambican

This "MCH mass media campaign" is the main accomplishment of the IEC component, according to the project COP It was expensive and time-consuming The spots were all pre-tested It is instructive to note that focus group methodolgy may not be able to address broader problems or issues such as how people feel about all health answers being in the clinic (this may be an issue for health planners rather than "consumers"), or how people feel about mothers being always depicted as helpless and ignorant Just as the "politeness sydrome" can enter surveys as a major source of response error, so can the same phenomenon prevent focus group particpants from being so bold as to offer broad criticism when it is not specifically asked for Probably the focus groups discussion was directed at smaller, more manageable components such as "did you like the song?" or "did you understand the word malaria?"

Recommendation At least some IEC should be directed at preventive, health promotive actions that Mozambicans can take outside of health units--in the homes and local communities There should be some recognition of existing, indigenous knowledge related to health Mothers should not always be depicted as knowing nothing There should be some research about the area of health to be addressed (e g , malaria) before developing messages in this area This refers to research beyond minimal pre-testing of messages, there should be some KAP/ethnomedical research Finally, any term used in mass media promotion, such as rice water, should be widely or universally understood in Mozambique

Recommendation Clear guidelines are needed from the MOH in Maputo about how to--or even if to--promote community based approaches in health And if this is to be the MOH's policy, there ought to be guidelines about how best to mobilize villagers in health matters This is a clear area where the PHCS Project can and should help It is in a good position to influence such a policy The lead donor organization for the MOH, the Swiss Development Cooperation, would doubtless be glad to help in this effort, if necessary (its experince with village health workers--APEs--and traditional healers would be especially relevant here) The IEC component of the PHCS Project could develop how-to-do-it guidelines, using the experience of NGOs such as World Vision, UNICEF/Manica, and Save the Children (doubtless there are others as well) who are successfully implementing this approach The PHCS Project/IEC and a group of these NGOs could come together for a few days and draft such guidelines and then solicit suggestions from the MOH, the Swiss Development Cooperation, FINIDA, and other health donors

Annex A Notes from Selected Field Visits

2/11/96 Meeting with Save the Children/UK
(Interview with Jane Gibreel)

SCF/UK has been operating in Zambesia for 10 years Until late 1994 the program was considered emergency relief, although it definitely included elements of participatory, community based development For example, its documentation, tracing, and reunification (of children displaced in war circumstances) program and its small, income-generating projects all involved careful discussion with genuine local leaders and then getting their active support in mobilizing people (this all seems like just plain common sense to many working at the village level) Since late 1994, SCF's program has moved toward sustainable development and away from emergency relief Learning about and then working with local people and their culture has become even more important

Like World Vision, SCF has been pulled into broad, integrated, community development, moving far beyond health/water/sanitation Current areas of support include income generation and projects in aspects of agriculture as well as all areas of health, family planning, potable water and environmental sanitation Such expansion has been in response to needs expressed by the people they work with, SCF reasons that the health and survival of children depends on more than simply preventive health care, water and sanitation People need to grow food and have some income to buy things

Jane commented that community development is not easy When SCF tried to explain the value of health or water committees, for example, some days of heated discussion and debate followed due to the baggage associated with words like committee and--especially--"cooperative" The latter term is associated with Frelimo's former, heavy-handed, coercive approach to mobilizing the masses Neither villages formerly under government control nor those under Renamo control want to participate nowadays in anything resembling a cooperative, or a communal village Some of the most anti-cooperative people are teachers and others who work--and worked--for the government (Later note it seems that the only place where communal villages still survive is in parts of Gaza, the epicenter of Frelimo Even here, cooperative agriculture seems not to have survived)

When SCF begins to work with a community, it meets with local leaders, notably the chief and traditional healers TBAs are trained in birthing-upgrading, they may also be locally elected to be trained by SCF as animators Jane was emphatic that animators and anyone else who works with the program is elected by the local people

In the DPS, SCF works primarily with Community Health, charged with doing health education, and preventive/promotive health They also work with teachers from MOE and animators and others from Agua Rural SCF understands well that it will not remain in

Mozambique forever, therefore whatever the constraints of working with government agencies and with particular personnel, it can't move ahead without them Thus for example there is a particularly recalcitrant, arrogant animator from Agua Rural (this type of animador is on government payroll) who finds working in villages and with villagers distasteful There are even allegations of this--or another--animator trying to control funds raised by villagers for health projects in order to profit personally Yet SCF cannot simply drop its partnership with Agua Rural, it is too crucial for sustainability in the longer run

In fact, a great many local government personnel are highly motivated to do good community based development nowadays, and NGOs like Save the Children and World Vision serve as catalysts in this Many who run rural health posts and handle other jobs at the periphery of government systems are remarkably hard-working, responsible and enthusiastic about their jobs, even if they are paid irregularly and have little support and resources from above They know what is going on in rural areas, they all speak local languages, and they want to work in ways that produce results

The problem seems to be at higher levels Officials at the DPS and national MOH level, for the most part, do not have this community based, culturally sensitive orientation The problem can be illustrated by a stand-alone poster that SCF developed After appropriate testing and discussion at the community level, and well aware that the great majority of villagers are functionally illiterate in at least Portuguese, a poster was jointly developed that conveyed the desired health message without recourse to writing The poster was sent to Maputo for approval It was tossed out and another poster replete with cartoon-like voice balloons in Portuguese was substituted Thus even when national IEC could learn from what has been developed with a representative group at the local level, it not only did not help, it set the SCF program back Here is precisely where the primary health care project IEC Advisor could change thinking and response at the national level

Decentralization

Regarding decentralization, it is often more a matter of abdicating rather than delegating responsibility, Jane observed National and provincial level officials do not really support lower level personnel There is still a lot of the old, ideologically-dictated, highly centralized, top-down mentality, as well as fear of letting go of control, at higher levels In fact, to the extent that villages organize and mobilize to form the likes of health or water committees, they become empowered They might make demands for health, water and other services from the government This "demand for health services" is exactly what USAID and other foreign donors are promoting But some (many?) in the middle- and higher levels of government are afraid of this And with good reason the system barely functions now, with a surge of new users, it could collapse altogether (see discussion of radio spots, below, for more on the wisdom of

creating greater demand for services at this time)

This appears to be a crucial issue in decentralization and certainly in the PHCS Project The PHCS Project should work to understand all nuances and aspects of this problem and then go about finding ways to overcome what must stand as a major constraint to health decentralization Have donors only secured (nominal?) commitment to decentralization at the very top of the MOH and other ministries? Do we even have that, or do government spokesperson only agree with whatever the latest interest of the donors happens to be, in order to keep the aid funds flowing? Or have they not really thought through all the implications and ramifications of decentralization so that they do not really know what they have formally agreed to, in which case advisors at the national and DPS levels need to explain the process better The SCF spokeswoman said that a great deal of education and re-training of GRM personnel is needed Certainly there is a need to balance demand for more services with self-help, participatory primary health care that can be carried on outside of health facilities--in the local community

In a later discussion with Fernando and Laura Slobey about decentralization, Fernando said he thought the process might be easier to implement at the district level and harder at the provincial level In the latter case, decentralization might seem like sticking your neck out--and it could be chopped off if you make a mistake And decentralization seems like more work--you have to make decisions that were once made for you At the district level, you get quick, positive feedback when you start following a culturally-sensitive, community based approach This is less likely to happen at the provincial level, where staff may be further removed from the people they cover

If this observation has any truth, it argues further for learning about decentralization and IEC and community based approaches at the lowest level, and then taking those principles up the chain of command Effective decentralization strategies <u>for Mozambique</u> cannot be dreamed up in Maputo, they must be developed in response to lower level needs and realities, and be based on what has actually been found to work

[Later note after visiting the Gaza DPS and talking with World Vision staff about its experience in several parts of Mozambique, it should be noted that some district and provincial health directors see decentrailization as an opportunity to make decisions without interference from above, decisions more in line with the realities they face in their areas A telling example is the willingness of several district health directors in Tete to allow World Vision to experiement with community-based distribution of contraceptives in communities located more than 15km distance from a health post The piot program seems to be successful]

<u>Training in Zambesia</u>

In this regard, at least one person in Zambesia felt that the scope of work of the PHCS Training Advisor was too broad and spread out to be doable There seems to be enough training need in Zambesia, with its three training institutes With the Advisor popping off to two other provinces, the Advisor may be spread too thinly to be effective in Zambesia

The Centro de Recaclagem has great potential, in fact it is able to generate and keep its own funds earned from providing training But it seems not to be fulfilling its role well It needs direction and other forms of technical assistance That appears to almost be a fulltime job in itself, yet the PHCS project Training Advisor had/has duties in two other provinces as well as this

(See body of report for section on how SCF and World Vision in Zambesia exhibit flexibility and adaptability)

A question of how the MOH in Maputo could help NGOs working at the local level arose in a discussion in Zambesia One thing they are busy with at the moment, it appears, is converting all computer programs to work on the Windows platform--the new Windows 95 if possible This of course will require new computers with larger hard drives, as well a great deal of time to learn new procedures Mozambique wants to be up to date, to have the latest software, our discussant noted wryly

Imagine how this priority seems to those in the government and their NGO partners toiling in the trenches of community based development (When I went to visit a colleague in the MOH two weeks later--sure enough, he was busy struggling to learn Word for Windows He commented that it would take a long to time to master this alien program, and he had just spent a lot of time learning Word Perfect for DOS)

How High a Priority is (formal) Health Care?

I met with Ragner Hansen (from a Danish NGO, IBIS) and his Mozambican counterpart at Obras Públicas This Public Works program involves the rehabilitation of infrastructure such as schools, health posts, bridges, and whatever else is needed Yet there are lessons here for PCH/IEC, and USAID health programs generally The P W Ministry together with its NGO partner have found that when local communities can be mobilized to assist in the building of facilities, those facilities become something that are thought to belong to the village There is a sense of ownership, of responsibility The facilities will be maintained Accordingly, the Ministry has a "Self-Construction" program in which Ministry/NGO advance people go into a local community and ask people which type of facility they want most In virtually all cases, the answer is schools There are many implications here, including that "modern" health care provided by government is apparently not a high priority need USAID is right in recognizing the need to create some increased "demand for health services"--yet only some services, and this must be balanced with

community based approaches to primary health care See discussion above)

In fact, returnees and other villagers typically build schools out of local materials, using local technology, in the hope of getting a teacher and whatever supplies are needed IBIS and its provincial public works partners then use radio to reinforce the desire for a school, agreeing with people's observation that it is the gateway to useful knowledge, literacy, future jobs, betterment, etc, and setting up a time and date for a team to drive out from Quilemane to meet with village leaders Note the radio is here being used effectively as a "bush telephone" for communicating with rural people, for setting appointments (which must be kept or credibility is quickly destroyed), for motivating people, for explaining the superiority of a sound structure over an improvised hut-like school that does not last beyond a couple of rainy seasons, and for explaining the partnership required for a self-help construction project When the team arrives, this last is explained even further IBIS and partner will supply the technical know-how and the cement, the village will supply the burnt bricks and the labor Once the team actually sees the bricks (evidence of motivation), the school construction can begin

This has worked out well The only problem is that some other NGOs continue to provide schools (or other facilities) for the village, and actually pay local people to build it This of course undermines the spirit and goals of self-help, and underscores the need for coordination of policies and approaches among NGOs working in the same areas and sectors

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3/12/96 Meeting with World Vision/Zambesia (Veronique Kollhof, Jaime Morais, etc)

The World Vision program in Zambesia sounds very similar to that of SCF integrated rural development with a good community based approach Work is all priority areas of health, including water systems and environmental sanitation As a USAID-funded project, it seems to have more documentation requirements and it has undergone more evaluations World Vision has also been more systematic and formal in its information-gathering, having conducted several KAP surveys over the years It has also used informal, qualitative methods to gather information

As it happens, I spent a couple of hours in 1991 learning about the WV/CSP (child survival project) community based approach from Bernie (last name?) who, I think, was the first project director, at least in Zambesia As with SCF/Zambesia and other successful community based programs, World Vision began with careful elicitation of who the local leaders were, discussed project goals as long as was necessary to gain understanding and cooperation, improvised ways to learn about locally perceived needs and priorities, learned about indigenous health beliefs and behavior, etc

In order to assess the degree of World Vision staff awareness about indigenous health beliefs and practices, I enquired of the Mozambican staff how people understand STDs and diarrheal diseases in the Sena and Chuabo areas where WV is working They said that child diarrhea is often attributed to children's cutting their first teeth or to children picking up "dirt" in a variety of ways [16] Also as elsewhere, if a man has sex outside the marriage and then touches his child before some sort of ritual cleansing (or purification, as anthropologists would say), the child will get diarrhea I tried to determine what--if anything--is actually transmitted to the child to make it sick Heat, darkness, "dirt", shadow? (These are all elements of contagion in parts of Mozambique) It seems something is transmitted, called veriga in Chuabo This term seems to refer to "jumping", as in jumping or violating a social rule (against adultery?)

There is an idea of a snake or worm in the stomach, but it seems to resemble the Mihaco idea of the Macua rather than the nyoka belief of the Shona In other words, it refers to helminthic infections--it is not a more positive and highly-developed belief in a force that protects the human body against the introduction of impurities Mihaco (the Chuabo word is something like this) is something deleterious rather than beneficial to, or protective of, health

Regarding STDs, those illnesses considered local or traditional may be attributed to having sex with a widow or a menstruating woman, that is, to becoming contaminated with death or woman's reproductive fluids, a widespread belief in Mozambique and elsewhere in the region [17] The World Vision staff said that STDs may also be attributed to sorcery, but that there is "naturalistic" thinking behind theories of STDs, diarrhea (and probably other contagious diseases if Zambesia is like Manica,

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[16] This is similar to elsewhere in Mozambique Cf Green, E C , J Marrato, M Wilsonne, "Ethnomedical Beliefs and Practices among the Macua of Nampula " Maputo Mozambique Ministry of Health and Swiss Development Cooperation (Berne), Aug 1995 (English and Portuguese versions available), Green, E C , A Jurg, and A Dgedge, "The Snake in the Stomach Child Diarrhea in Central Mozambique " Medical Anthropology Quarterly Vol 8, no 1, 1994, pp 4-24

[17] Green, E C , A Jurg, an A Dgedge, "Sexually Transmitted Diseases, AIDS and Traditional Healers in Mozambique" Medical Anthropology Vol 15, No 3, Spring 1993, pp 261-281, Marrato, J , E C Green, M Wilsonne, "Crenças e Práticas Tradicionais Relativas às DTS/SIDA, Doenças Diarréicas Infantis e à Saúde Mental na Província de Nampula Relatório de Pesquisa e Estratégia de Comunicação " Mozambique Ministry of Health, Department of Traditional Medicine, Aug 1995

Nampula, Gaza, and Inhambane)

Jaime told me that the WV staff talk frequently to traditional healers in order to learn about existing health beliefs (the next day we had such an interview) This is to be highly commended, since it is rare and yet highly useful

Can sensitivity to, and awareness of, traditional health beliefs such as these help in shaping appropriate messages to the people in Zambesia? The WV Mozambican staff think it can First of all, they explained, World Vision does not negate, denigrate, or confront traditional health beliefs That would simply impair further communication As long as the beliefs do not lead to behavior considered harmful by public health, it is respected In fact, in group discussion, competing viewpoints or theories are elicited and discussed as well, demonstrating to all that multiple theories of disease do exist (and implying fallibility?) In this atmosphere of epistemological pluralism and tolerance, the health educators explain what modern medicine believes and--importantly--what people should do to maintain health whatever theory of disease causation they hold

World Vision staff felt certain that straight lecturing about health does no good They attempt to create a dialogue with the people they are trying to influence, and to base their medium and message on existing beliefs (see body of report for detailed description of this method)

IEC and Health Education

World Vision staff showed us visual teaching aids and posters they had developed, based on knowledge gained about Zambesians in the districts where they work The teaching aids require explanation and carry more complex messages than the posters, which can stand alone without explanation Staff also described a process of providing guidelines for village volunteers who develop little dramas around a single, simple health message (Guidelines set time limits and define the message and suggest a general approach) Apparently these are well received I asked if these dramas and print media can be understood throughout Zambesia and not just in the districts where they were developed The staff felt they could be, only the local language might need to be changed to the extent that language is used

2/13/96

Family Planning in Zambesia

Before leaving the DDS (after field trip to Nicuadala District--see text of report, above), we had a bit of discussion about AIDS and STDs, also family planning The Community Health Chief commented that sexual fidelity is hard to promote but condoms are even harder (see body of report, above) Oral contraceptives are used for family planning--for child spacing so that mothers can rest and regain strength after giving birth World Vision promotes family planning as part of its integrated MCH program

Since village-based health education activities were not to take place until much later, we visited a village in order to interview a traditional healer We located an old man, and with a couple of younger men in his family serving as translators, we talked with him about his specialties "headaches" and "stomach aches" Headaches may refer to malaria (as World Vision staff and I felt) because the syndrome under discussion was also characterized by fever "hot body" and weakness The traditional healer said this illness is more common in the rainy season The cause was said to be fumes that linger where lightning has struck [18] People who happen to be in the area--but particularly children--breath in these fumes through the mouth and nose This traditional healer also treats the area where lightning struck in order to neutralize (the term purify was not used, even when prompted) the fumes, and the headache illness can thereby be prevented

Another way to describe the lightning process is that "God fell there", at the place where the headache fumes linger Bulugu seems to refer both to God and to the illness The reason this illness is prevalent in the rainy season is because "that is when we have lightning "[19]

Treatment involves boiling some medicines, placing a blanket over the patient's head, and then breathing in the medicinal steam

Note that when "God" is invoked in illness etiology in Africa, it often means that the cause is considered unavoidable and natural, rather than supernatural or personalistic [20]

We then discussed child diarrheas The healer distinguished between diarrhea-with-blood and "simple diarrhea " Bloody diarrhea is caused by a baby drinking milk pro'uced by a sick

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[18] There is a literature among some medical anthropologists on "environmental dangers" as a category of illness causation Honwana (1994) has described Mozambican Tsonga ideas of the "pollution" of environments by a number of contaminants "foreign essences", "traces" of foreign people, "discarded elements" of illness that have been removed, as well as medicines and poisons of sorcery found in the atmosphere against which Tsonga have no immunity Purification rituals are required to treat pollution of this sort Such ideas are also common among the Swazi (Green 1992, Reis 1994) and the Zulu (Ngubane 1977 24-29) "Ecological health" dangers of this sort tend to be viewed as naturally-caused illness, rather than something related to magic, sorcery, witchcraft, or spirits of any sort

[19] Unlike the nyoni or lightning bird concept of the Nguni-speakers to the south, there seems to be no bird involved with bulugu

[20] See discussion of "natural causes" in African medicine, in special issue of Social Science and Medicine Vol 15B , pp 429-437, 1981

mother Her milk becomes yellow, discolored Treatment involves the mother as well as the child Treatment for the child consists of "spoonfuls of a tea with root medicine (roots only are used, as is the pattern in southern & eastern Africa)

I asked if any particular foods are good or bad for a baby with bloody diarrhea It seems (if I understood correctly) that food and liquids are in fact withheld in such situations But it is not withheld for long because it does not take long to treat the mother and child

Simple diarrhea is different and has a different treatment than that of bloody diarrhea Adults and children also require different treatments for diarrhea

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2/15/96 <u>IEC Component Discussion with IEC Advisor</u>

Jose Romero, the PHCS IEC Advisor, and I went over the objectives and scope of my consultancy after which JR outlined the goals and accomplishments of the IEC component He sees the objectives are to (1) focus on the health areas of maternal and child health (MCH), AIDS/STDs and family planning, (2) train counterparts in AMOFEDA, RES, and those with IEC responsibilities at the provincial and district levels, conduct baseline studies, develop materials and messages in the three health areas, institutionalize methodologies appropriate to the MOH and to the tasks at hand, and base them on empirical studies, get messages out by all appropriate media, messages that make sense to the target audiences, using local languages, and do monitoring and (periodic) evaluation of all these efforts More recently, USAID has strongly been promoting a community based approach to all such efforts (Here we had a little discussion about whether "mobilization of the people" and "community participation" mean the same thing I said the former term was used by Frelimo in the past, therefore it might suggest the former, highly-centralized, top-down approach of Frelimo)

Project accomplishments in this area were described as follows There was a KAP survey related to AIDS/STDs in the three provinces of implementation (I feel strongly that the way to begin would have been to done qualitative or formative research first) JR discussed the sampling, the margin of error, etc (as if this somehow ensured validity of the findings), and the data analysis by EpiInfo In response to my question, JR commented that he felt there was no need to do focus groups before conducting the KAP because he reviewed a number of AIDS/STD studies done in Mozambique before the undertaking

The data is being analyzed and the summary of findings that I read should not be taken as much more than something to keep donors happy for the time being

(Note the lack of time lines of even this quantitative data--more than two years into the project Moreover it has only covered one

of three areas of health, in fact the one where there has already been quite a bit of prior research--AIDS There has been virtually no research related to child spacing, family planning, contraception)

JR mentioned that the original plan was that USAID would fund a Demographic and Health Survey (DHS) survey during the first project year For whatever reasons, this was postponed But this explains why the PHCS Project did not do a survey in this area (but what about qualitative research? This is what is needed before anyone including DHS should want to design and implement a sample survey in a country where there is almost no background information On the other hand, values, attitudes, perceptions, etc related to fertility do not vary greatly from region to region in Africa, and studies--both qualitative and quantitative--have been done in neighboring countries among groups who sometimes even speak the same languages as in Mozambique This information should be compiled, reviewed, synthesized, reflected upon, and used provisionally in Mozambique until family planning research can be conducted here This information can and should be the basis for developing good questions and approaches for in-depth interviews, focus group discussions, and surveys in Mozambique)

There have been some recent focus groups conducted in the three provinces, related to premature pregnancies JR described the methods the variables of age, gender, literacy, and age of children were used in recruitment, as a result, quite a large number of focus groups were conducted (dividing by four variables times three provinces = 48 groups minimum)

Some other studies are planned focus groups on AIDS and STDs, a central location intercept study related to message testing, family planning, AIDS, and a behavioral analysis of health workers This last will be an attempt to measure project impact on targeted health workers, e g , can they effectively use a flipchart in AIDS education as a result of something the PHCS project has taught? Jose mentioned the difficulty of not having a baseline of health workers' KAP and teaching methods prior to project intervention I said that we may lack formal, baseline measures but that should not prevent us from doing such a study We can reconstruct a starting point on the basis of what health workers tell us their earlier KAP was (e g , "We used to lecture without using teaching aids or without trying to make teaching a dialogue ") Moreover, earlier approaches to health education in the MISAU are quite well known and therefore can be characterized in a general way

<u>The Proposed Computer Graphics Consultancy</u>

We next discussed JR's ideas about computer graphics I clarified a point in Mary Ann Abeyta-Benkhe's memo of 2/14/96, namely that I did not volunteer the opinion that computer graphics developed by RES were "totally unacceptable" as a result of a pre-test we did in the Gabinete de Estudos de Medicina Tradicional (MOH) In response to a question about the priority and relevance of

computer graphics to current needs, I commented that a few months ago we had pre-tested some icons supplied by an IEC person from RES I don't know whether these icons came from JR or his computer or the PHCS project In any case, some were in fact unacceptable, but some others were usable

JR explained his ideas about what he thinks is a need to the Mozambique MOH to be able to produce "final art", that is, graphics for use in health education that does not need to be produced outside of Mozambique Basically, one can take a locally-done drawing, or a photo from a book or magazine, and introduce it into a computer by scanner Using Omni-Page, Pagemaker, and CorralDraw--all of which the PHCS Project has--the artwork can be modified to suit local needs Regional needs, in fact For example, a round roof on a hut suitable for areas of the south can become a square roof for use further to the north A baby slung over the side can become a baby carried on the back JR mentioned--and I fully agreed--the importance of attention to details in artwork that depict the surroundings and cultural content of the target group Otherwise the audience can "identify out" with the message and assume it is meant for Tanzanians or someone else other than themselves

Explained this way, training IEC staff in MOH headquarters in computer graphics seems to be use of "high-technology" in a way that is appropriate, cost-cutting, responsive to local culture, capacity-building, and institution-strengthening Still, one might question whether it wouldn't be better to recruit a technical expert in this area who already speaks Portuguese and is familiar with Mozambique or at least southern Africa If no one can be found who has both the technical and language/culture skills, then the consultant already selected should spend some time working with Mozambican artists and health educators before beginning formal training sessions

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JR tells me that USAID, for various reasons, will be pulling out of Niassa and moving into Nampula and Manica, and possibly Tete 1996 will be a year of transition to new provinces and to a stronger commitment to community based approaches and impact indicators JR says he has developed a plan for training health personnel at the provincial and district levels in various areas, such as research (qualitative and quantitative), IEC methodology, community based approach, etc There will be an initial 2-week theoretical training, requiring interruption of normal work schedules, followed by several weeks of practical, on-the-job training

NGO staff working in relevant programs in relevant provinces will also be trained I took this opportunity to ask JR what he thought of the work NGOs such as World Vision and Save the Children are doing Our discussion centered on Zambesia, both because I had just been there and because JR seems to feel that little relevant work has been done in Niassa or Gaza (I of course feel that NGO/PVO projects such as those in Zambesia are

completely relevant to the design if not the implementation of IEC efforts at district and provincial levels) JR said he was aware of the work World Vision and SCF have done and thinks it is good Was he aware of the IEC activities they have done in MCH, FP and AIDS/STDs? The research and pre-testing they have done? The print materials? He said he was But in research, for example, he felt they need more training I gave the opinion that even though staff might lack adequate--or any--formal training in many of the areas in which they must function, they nevertheless do what they can and the results speak for themselves--they are good JR agreed and said that his training is only intended to "oil the machinery" so that it can work even better Informal discussion groups with community leaders, for example, can serve the purpose of pre-testing a poster but upgrading this approach to focus group discussions can make the process of information-gathering more systematic

At another point, we had a discussion about ORT I was interested in learning if JR agreed with the cereal-based ORT (home mixing, as it were) approach of World Vision and its counterparts in the DDS where they are working That is, should we build upon something already in use (porridges for children including sick children) or only promote ORS packets, as has been MOH policy up to now? JR agreed that CB-ORT makes sense He also thought that MOH policy is in flux and maybe ambiguous Since there has apparently been no radio promotion of CB-ORT, doesn't this imply need for a clear policy? JR said that his chief of party had told him he should not become involved in policy (the COP later said this is not true) Yet there seems to be a need and even a desire for this on the part of the MOH The mid-term evaluation pointed this out as well

JR describes his basic approach to IEC as Studies--> Training, capacity-building-->development of materials-->diffusion of messages-->monitoring-->evaluation

Regarding materials, USAID has supplied quite a bit of audiovisual materials not only to the project but to (or for distribution to?) central, provincial and district MOH, churches, NGOs, etc , including televisions, video players/recorders, and videotaped programs from elsewhere in Africa JR spoke about how use of materials from elsewhere is much cheaper than producing things locally Translations into Portuguese can be voiced-over films and video programs What about cultural relevance and identification? JR thought these materials could at least be used with health personnel and maybe at the community level in some places He also said that the PHCS project could develop low-cost, locally produced videos using lecture/demonstrations with a series of photographs taken locally, used as flip charts Puppet shows can also be videotaped and people with local credibility such as traditional healers could be used in these to promote, e g , ORT (check here and throughout what has already been done and what is being planned or discussed?)

(See body of report for description and criticim of IEC radio spots)

There has been no research or IEC so far in family planning because the project has been waiting for the Demographic and Health Survey (DHS) that was originally scheduled for the first year of the project (Is the delay of the DHS a reason to have done nothing to date in this important area, an area emphasized in the design of the DHS project?) What about formative, qualitative research? I asked JR if he saw value in conducting some focus groups or other qualitative research prior to the DHS, to improve the design of the DHS if for no other reason (such as being able to design family planning related IEC) He said that focus groups might better be done after the DHS to aid in its interpretation

Meeting with Mozambique Health Committee (MCH), Chimoio (2/19/96)

My general impression from reading the Oct 1994 project evaluation of the Mozambique Health Committee (MHC, an American NGO baced in Seattle, Wa) is that the project is trying to make the old Frelimo Health delivery system of clinics, health posts, APEs, and activists work now that the war is over In fact MHC grew out of one US doctor/epidemiologist who worked under the old system But there may be an assumption that the only reason the old system didn't work is because of the Renamo attacks and maybe lack of money and other resources A lot of effort prior to the 1994 evaluation went into trying to motivate people to use services, including preventive services such as screening blood (and having a physical examination of genitalia) for syphilis in the hope of avoiding future infant morbidity and mortality Not surprisingly, it proved hard to persuade mothers to go through this Coverage actually went down in the year before the evaluation (current MHC staff said that maybe the survey or statistics were wrong)

Many possible reasons were cited by the evaluation team for disappointing particpation in blood screening, many of which pertain to clinic use or "demand for health services" in general transportation costs ("bush taxis" have gone up, there was and is a nominal fee for clinic services, there was and is an under-the-table charge (illegal) by health care providers whose government salaries were irregular or delayed for months, clinic/hospital service is strange and impersonal, etc (See Main Reasons for Dissatisfaction with Health Services, a summary of research findings in Manica, cited in body of report above)

In the case of syphilis screening, blood specimens were sometimes lost through carelessness or power outages The evaluation team estimated that even with mothers successfully screened, less than half were given the correct follow up treatment with penicillin (antimicrobial resistance was not mentioned, this is no doubt another factor) If the outcome of all the efforts to screen pregnant mothers is poor, and if positive outcomes are additionally delayed by many months--and on top of this the mother may not be sure her baby wouldn't have been healthy anyway--it is not surprising that it has been difficult to recruit women to participate in this preventive program It may

help to try to have councils of community leaders and "community activists" motivate and exhort mothers to use M/CH services, but it still appears to be an uphill battle

(The MHC Director has proposed to USAID that this activity be funded on a larger, three-province scale)

Mothers urged to avail themselves of pre-natal care services were said to "fear being referred to the provincial hospital" Reasons for this fear were not gone into adequately--and could only, I suppose, be speculated on One possible reason is that mothers would often encounter young, inexperienced and foreign doctors at the hospital

Once again, more needs to be learned about the ongoing, indigenous system of traditional healers and midwives to better understand how and why clinic and hospital services often come up short when they compete with these It doesn't help to simply pretend that "traditional" services do not exist, as the government did for a great many years

Talking to Jorine Muiser, MHC Project Coordinator, and Silvia Gurrola, Health Educator, and asking about ORS and AIDS strategies, among others, my impression that MHC emphasizes improving clinic services was confirmed The approach to ORT seems to be to promote ORS packages in health posts (see discussion above) Even after hearing about how some NGOs are successfully promoting cereal-based ORT through porridges, the MHC staff seemed sceptical They thought ORS was best, and that people would mix S/S solution incorrectly and as for CB-ORT, they seemed to think that people did not have any cereals locally (?)

MHC says it has changed aspects of its approach in 1995 and into 1996 But the emphasis still seems to be to improve health posts and their utilization MHC does have a program component of mobilizing local village leaders This may look like a community-based approach, but it is aimed primarily at getting people out of the villages and into the health post or center (After writing this sentence I was given a project hand-out, "Community Leaders Program 1995", which actually states that the improvement of health services is its goal) There is not much about engendering self-help, things people can do for themselves in the their own communities This can be seen in microcosm in the promotion of ORS in health posts rather than cereal-based porridges that mothers can make themselves

The 1994 evaluation of the MHC noted that the putative community leaders were chosen by the government health workers, and the evaluation team therefore wondered if these were really genuine leaders The MHC staff told me that nowadays leader identification is more a process of discovery rather than outsiders choosing them Leaders were described as chiefs, traditional healers and functionaries in the old Frelimo system, plus any other locally important people So it may be that the Community Leaders Program is improving its recuitment process Note that in their role in a community leader council,

traditional healers may be expected to promote clinic health services that are in competition with their own paid services This might go against their financial and prestige interests (In this same province, UNICEF has developed a collaborative program whereby traditional healers themseleves promote and administer ORS)

The emphasis of the MHC since 1994 was described as threefold health post improvement, maternal and child health and health education There is no "parallel structure" or "sideshow", everything is done with and through the DPS (The big donor working intensively with the Manica DPS is Finida It has 6 fulltime advisors in the planning area It does a lot of facility reconstruction) This approach no doubt limits effectiveness of any NGO, but in the case of MHC the staff seems uncritical of the MOH/DPS business as usual approach

One program component with more of a community based approach orientation seems to be the TBA training being done (one of the few community based initiatives to have originated in MCH headquarters) But because of various problems, it has pretty much came to a halt in 1995 in Manica, I was told James Pfeiffer, former Project Coordinator, put special emphasis on infant nutrition This has been discontinued apparently because James himself deemed MHC efforts to reach the neediest children had failed It was suggested that I ask him for details

Health Education/IEC in Manica

There is a mobile drama group called the Programa de Activists Culturais (PAC) that has become a provincial NGO in Manica With donor money, this group will put on dancing, singing, miming, plays, etc to support health education, latrine construction, mine awareness, or anything else They are fun to watch, amusing, and draw crowds (I saw a performance) The trouble is, they are totally unsustainable without donor money Transportation including petrol costs limit their productions largely to towns Costs amount to about US$100 per performance The value of travelling dance or other performance groups should be explored by the PHCS Project, but it seems that it is far more cost-effective and sustainable to have a volunteer activista conduct "inductive", participatory learning with groups who come to a central location, such as a health center Perhaps some of the entertainment value of the former could be incorporated into the latter

PAC also has equipment available to them to project videotapes on a large screen for group viewing Again, due to transportation and generator costs, this is effectively limited to towns

After three hours of discussion, one of the MHC staff ventured to say something critical about government services IEC print materials are sent down the system from Maputo They are not pre-tested and they are not understood locally Many egregious mistakes are made the cartoon convention of voice and thought balloons are not understood, even apart from the Portuguese, a

health education T-shirt has two unrelated messages on the front and back, a picture in a circle shows a dismembered-appearing breast being suckled, a poster shows a naked baby being handed over to a nurse by a mother ("But we don't do that! We always wrap our babies in a capolana!") There is much room for improvement, she noted

MHC showed me a flip chart they use Unsurprisingly, it promotes use of clinic services MHC plans to develop a cloth flannelgram for better durability for use in rural areas (the other ones are used in health posts, it seems)

The MHC also puts out a health newsletter for DPS and DDS staff This attractive publication disseminates useful information and no doubt boosts morale of underpaid staff working under difficult circumstances

(MHC staff were most eager to cooperate and provide any and all information I expressed interest in I hope my candid comments are not taken as anything but a sincere attempt to direct MHC activities more toward true community based activities It is no doubt unfair for an outsider to make a short trip and then make criticism of an organization working under difficult circumstances, doing what DPS and DDS counterparts want them to do I might have a bias in favor of community based approaches and therefore be unfairly critical of what I call the business-as-usual health service approach However, USAID itself now wants health education and related efforts to become far more participatory, community based, and sustainable And UNICEF in Manica is demonstrating that this approach can work in that province Finally, MCH staff seemed open to many ideas along these lines after we had discussed them for some time)

(I have also seen that a number of recent USAID-sponsored evaluations have been unusually <u>un</u>critical I think USAID needs to know what is going on with the projects it sponsors, and that NGOs and contractors have a need and indeed a right to critical feedback so that they can improve)

<u>UNICEF/Manica's Community Based Approach</u> 2/20/96

Adi Patel and Jorge Lamiao (and Dr Stefano F)

UNICEF/Manica seems to be implementing district-level programs showing features of a genuine, culturally-sensitive, community based approach About top-down approaches, Adi commented, "I think the arrogance shown by people in development may be greater than that of people in any other type of work Don't development people know that they have to <u>learn</u> from the people they are supposed to be working with?")

Part of what UNICEF does in Manica is to work with the Provincial Action Program, which covers things like EPI and rehabilitation of health posts--in other words business as usual Adi and his Mozambican counterpart Jorge seem to have little patience for these activities They are interested in having an impact on

health and so they try to find better ways to emphasize preventive health behavior and community based approaches This has brought them inexorably into work with traditional healers, and so they are working collaboratively with healers in the two districts Part of these programs is to enlist healers in promotion of ORS

[I tested the nyoka concept with Jorge, a Shona, and he agreed that it was a positive force He volunteered that one tries to keep the nyoka calm and happy in order to be healthy He said the comment, "I have nyoka is equivalent to "I have head" or "I have stomach" Everyone obviously has these three things, saying you have one means that there is something wrong with that part of your body (Is this a reason why outsiders think nyoka is something bad? I have a snake = I have a stomach ache = the snake is the cause of the problem?) (Adi tells me that Jorge, who has no formal training in health, is very effective in community based activities He suggested that in addition to personality traits such as a genuine interest in what people think and do, it may be precisely because he has no health training that he is unburdened with a health position, which means he is free of the arrogance that often accompanies the position He notes that Jorge also has a way with people--he treats them all with respect, from Provincial Directors to illiterates)

In discussing the importance of cultural sensitivity, Adi mentioned that UNICEF has a program for children in difficult circumstances He spoke disparagingly of people in UNICEF who want to import western-trained psychotherapists to somehow treat war-traumatized kids He told me there are purification ceremonies in this area where traditional healers handle war and other trauma successfully [This led to a discussion about this general topic Jorge affirmed that the goal of purification is to remove death pollution Neither had heard of the Children and War program in Mozambique I must send them a copy I left a copy of my evaluation report from Angola and the NCIH traditional healer/AIDS article]

We discussed ORT The UNICEF community based program in two districts is using traditional healers to promote ORS sachets, feeling this is the best way to get ORS out to the communities What about cereal-based ORT? They hadn't done it, and MOH policy --or policy vagueness, or UNICEF vagueness--might be standing in the way Adi agreed on the biological and therapeutic advantages of cereal biologically and recognized that it is a practice already in use and familiar Millet is the primary grain around this part of Mozambique

I asked if "rice water" would be understood if mentioned in a radio spot Jorge said maybe, but they don't have rice nor do they have coconuts Would it make better sense to promote thin, "liquidy" millet porridges, with a pinch of salt? Yes

I asked what they thought of the health education materials that they get from eithe UNICEF or the MOH They were very critical In their view, tne MOH gets IEC material from outside Mozambique

and then thinks it can use the material in Mozambique without modification Or it devises something in Maputo and never pre-tests it Or they might pre-test it after a fashion in Maputo, but not in the provinces or districts IEC as a rule makes no impression on local people

Another element in good community based work Jorge, in discussing their community based approach, mentioned that what the DPS is pushing and what local people want out of the health system are not the same thing One of the highest priorities locally is treatment for bilharzia (Shonas understand the Nguni term umthundungazi, blood-in-urine, for S haematobium and use it as an alternative, J, said) The DPS pushes ORS and condoms, and the people want help with bilharzia which traditional healers admit they are not good at treating [21] Jorge tries to help them with pills for bilharzia, which in turn creates good will and confidence and respect, after which it becomes much easier to promote ORS and condoms or whatever the MOH & DPS want

This is another sign of a good approach program staff are flexible and willing to move into areas beyond what was planned in order to meet the felt needs of the people they are trying to influence and serve This of course implies that the program will take the time to find out what the hell it is the local people want Accordingly, the UNICEF community based program has moved into income generation, wells and sanitation, etc We see exactly the same thing with World Vision and Save the Children in Zambesia All three programs are stimulating sound, community based, integrated development aimed at health but perforce becoming broader than the organizations had in mind at the outset It seems that this need not necessarily get out of hand as far as demand on technical assistance and other resources as long as technology is kept very simple and locally-available/ sustainable, and the community is doing the great part of the work and the assisting organization is providing encouragement, "low tech" help, and pointing people to appropriate outside resources

More on Health Education Materials/IEC

In addition to the above comments, we discussed electronic and print media further J and Adi thought radios can be found in less than 20% of households in Manica as a whole What people can pick up is Zimbabwe radio, not Mozambique broadcasts Health education through this medium is probably a waste of time

What about PAC? (see above) My informant wasn't sure about PAC's motivation If its money only, then its not OK If its money and an interest in helping people, then its OK They do sometimes get out to small villages But they just push the priorities of the MOH/DPS and current donors They are insensitive to the needs and

[21] Several times these men commented on how healers are more open to collaboration than biomedically trained health workers, and more humble about their limitations

health beliefs/practices of the people My informant seems to see PAC as kind of a charade of participatory development it looks popular, it uses the name popular, but its really the old top-down, government and donors-know-best, business as usual approach He commented that there needs to be some sort of sensitivity training for all those who work with local people, whether in health, agriculture, water and sanitation--"you name it"

Jorge said that during the war, it was perhaps OK for the government to implement services the way it did, "We were under emergency conditions " But now Mozambique needs an integrated, community based approach

Water and Sanitation in Manica

Jorge said that one of the justifications for Frelimo's communal village program was that it was not cost-effective to build wells for people living in scattered homesteads People around here were particularly resistant to being forced out of their ancestral lands and homes and into communal villages Since the war and the abandonment of many aspects of scientific socialism, people around here have quit the villages and gone back home So how to see that they can have access to potable water? Appropriate technology and self-help is the only answer UNICEF has promoted a "family wells" program in which people are shown how to use a little concrete and zinc covering (provided by UNICEF) to reinforce and protect water sources already in use Families provide labor and materials other than zinc sheets and concrete

Adi noted that in this mountainous area, aquifers are shallow and it doesn't take too much to tap into a water table (CARE apparently works in the lower areas of Manica, sinking deep boreholes where water tables are deep and drop much during dry seasons)

The UNICEF self-help, low tech water scheme seems to be producing a lot of wells (USAID should look at this) One recent problem is that German AID has started an ambitious wells program that has set high numerical targets It seems that in its rush to meet these targets, it has sacrificed self-help and community involvement and has simply provided everything This makes it more difficult to promote participatory development--which in this case means wells that will be used and maintained by the local folk

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Dr Stefano, an Italian doctor with UNICEF, told me about his involvement in promoting health education in the schools This program is still in the planning stage His feeling about RES (the national health education unit of the MOH) is that it is weak One reason cited is that staff is poorly trained in health education methods found in recent years to be effective Its approach is still very heavy-handed, top-down, and insensitive to local beliefs and felt needs

He also commented on the Centro Regional de Desenvolvimento Sanitario (CRDS), whose regional scope encompasses Portuguese-speaking African countries Quite a bit of money went into CRDS development of video materials of health education to "reach the majority population" Apparently nothing ever come out of this expenditure

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Indigenous Knowledge

On the South African radio news this morning (2/21/96), a conference on agriculture was closing and the person giving the concluding speech said that poor people everywhere have a great fund of valuable knowledge that guides their actions It is up to those attempting to do development to involve the intended beneficiaries or participants in every step of the planning process, before or during which the local knowledge systems must be learned by the outsiders What is needed and workable is not something that can be planned in distant capital cities, it must be learned and developed together with the people being "developed" This may take more time at the beginning, but the extra effort is more than justified since without it, efforts are doomed to failure Amen

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Health Education/IEC FINIDA's Perspective

(2/21/96 Meeting with FINIDA) (Finnish aid) (Jaakko Yrjo-Koskinen)

Jaakko seems to be someone sensitive to issues surrounding participatory, community based development It is not always easy to get his counterparts to think this way

FINIDA has 6 fulltime advisors to the DPS (!), working with counterparts in areas like management, public health, training, and health education We started by looking at some posters and flipcharts in use in Manica These are a bit problematic too much writing and too writing-dependent, pictures too small relative to writing, ORS packet not identifiable, (in an earlier version) mother breastfeeding with no shirt on--"We don't do that here!", people looking like they are from somewhere else and other details (I later discussed the wisdom of having all messages directed solely at bringing the child to the clinic--Jaakko agreed that there needs to be some effort directed toward self-help, local responsibility, not undermining people's ability to take care of themselves) (See also comments from the MHC, whose IEC specialist agreed with these criticisms)

There seems to be no prior experience with pre-testing print materials, and so Jaakko tried to get his counterparts to do some of this After much effort they finally managed to carry out a very quick, informal and not very systematic pre-test of some of the materials I saw Jaakko said he realized that pre-testing could have been done better, in any case he would like to see this procedure institutionalized in the Manica DPS

He mentioned the school health education effort being planned Students are a captive audience and they are in school to learn Jaakko would like to find a good training manual for PHC, MCH, AIDS/STDs, family planning, etc , and then try to have teachers use a more engaging, participatory, experiential, learn-by-doing approach Maybe this could influence their general approach to teaching (I later showed J the World Vision health training manual from Zambesia He too thought this could be adapted slightly for use with Manica teachers The drawings could be modified a bit, and the scientific language (especially in the AIDS section) could be simplified He will contact World Vision in Maputo about doing this)

This led to a discussion about AIDS, because Jaakko would like to see the school program begin with this topic The hope is to start with secondary schools but later move to primary schools as well As might be expected, teachers initially were opposed to this idea, citing the opposition from parents against discussing sex in school Biology teachers seem more open to the idea, so this might be the entré

I asked which behaviors, if any, were being targeted in the school-based AIDS education effort Condoms will be soft-peddled

in order to not provoke controversy among parents, teachers, churches, etc (condom promotion presumes that kids are having sex, theoretically they are not) But it also seems that not having sex, or fidelity to one partner, is not being (or planned to be) explicitly promoted either--it is just implicit in the discussion/education

Regarding maternal and child health, the head of MCH at the DPS until recently was a poor manager and an overall ineffective -- perhaps uninterested--person It has taken three years to replace this person, meanwhile all programs of MCH have suffered

There has been little or no family planning in the area FINIDA and the DPS are in early stages of planning some sort of approach They would like to bring in a UNFPA specialist from Maputo as a consultant to help develop a plan Jaakko would like to do a family planning-related KAP survey, involving his DPH colleagues, to hopefully demonstrate that there already exists some unmet demand for ways to avoid unwanted pregnancy (see comments on user intercept study, above) I suggested a complementary qualitative study that would solicit views from two groups who might well have special knowledge about this interview traditional birth attendants and traditional healers and ask them the same question This would also give the DPS perspective about a possible, existing alternative service in the "traditional sector"

Already FINIDA wants to see child spacing become part of TBA training

Jaakko was unaware of any NGOs working in family planning in Manica He thought maybe the Mozambique Health Committee was (I think not)

We next discussed the value of community based approaches Jaakko seems to think the main thrust in this area has been the formation of "community health councils" When I pressed him, he admitted that when he looked closely at this process in northern Manica in 1994, the councils were appointed by the DPS and then more or less told them what their responsibilities were There was no process of discovering who the real leaders are, let alone finding out what the needs and priorities of the village might be (albeit described only by local leaders) There was some discussion about whether the MHC has improved on this one-sided approach J commented that the whole process is difficult, that "The idea of working with a community is quite foreign to the DPS " Health workers do not respect the ideas of the villagers-- they don't see these as constituting wisdom There are very elitist attitudes in the MOH, and these, Jaakko observed, are very slow to change He tends to see the MHC as experts in this area

We also discussed whether health councils that <u>only</u> promote going to the clinic deserve to be described as a "community based development" approach, any more than IEC aimed only at clinic attendance deserves to be called part of this effort, however

much pre-testing is done

Jaakko said that he wished there were clear guidelines from the MOH in Maputo about how to--or if to--promote community based approaches in health And if this is to be the MOH's policy, there ought to be guidelines about how best to mobilize villagers in health matters Again we see a clear area where the PHCS Project can and should help It is in a good position to influence such a policy The lead donor organization for the MOH, the Swiss Development Cooperation, would be glad to help in this effort, I am sure, since I know their views The IEC component of the PHCS Project could develop how-to-do-it guidelines, using the experience of NGOs such as World Vision, UNICEF/Manica, and Save the Children (doubtless there are others as well) who are successfully implementing this approach The PHCS Project/IEC and a group of these NGOs could come together for a few days and draft such guidelines without much trouble That should be phrased differently NGOs doing this right at the local level are the best ones to develop guidelines intended for community based work in Mozambique

Finally, the question of demand for health services was discussed Jaakko agreed that demand cannot be met currently (See discussion of the FINIDA-funded study of "client satisfaction", above)

I did not hear much about training/upgrading of traditional birth attendants (TBAs) in Manica, at least from the limited interviews I had, but this has gone on since 1988 as part of a national program whose impetus, unusually, came from MOH headquarters in Maputo, the Maternal and Child Health Program (The same is true with Manica's program of developing collaboration with traditional healers the impetus first came from the Gabinete de Estudos de Medicina Tradicional, MISAU, in 1991) There was an evaluation of TBA training to date in Manica in 1994 Results were basically positive knowledge changed measurably and significantly for the better, and trained TBAs became more active (assisted in more births) once people recognized that they had new skills

One problem mentioned by someone I spoke with in Zambesia is that there may be an impression in the TBA's village that after training, she begins to receive a cash stipend from the government This might mean that the TBA no longer gets the meal or chicken or other traditional token for her services It needs to be clearly and publicly explained that TBAs are not on the government payroll

2/26/96 Aspects of Save the Children's Program, Gaza

Village Health Worker Volunteers

Save the Children (SCF)/USA in Gaza has, among other accomplishments, trained some 400 village health workers (VHWs),

known locally known as activistas, in Gaza It has also trained 125 traditional birth attendants (TBAs) These cadres are fundamental to SCF's community based primary health care program

VHWs receive two weeks of initial training in promotive and preventive primary health care (as well as some environmental sanitation and water) under the sponsorship of Save the Children/Gaza Even though this village is one of the last communal villages in Mozambique, and one might expect that it would be difficult to recruit general volunteers in such an environment nowadays, these activistas seem to be the real thing they consisted of traditional birth attendants, the odd traditional healer, and other somewhat older women and men (about 90% were women), reflecting in part the demographic imbalance of the village and region)

They work without pay or other direct compensation other than rewards of prestige and recognition Some have been working this way since 1992 One thing they requested of Save the Children in our presence was an ID card so that people would know that they are really health activistas, including when they venture away from their immediate community This demonstrates the value and power of what we might call prestige rewards It should also be mentioned at this point that supervision, resupply (in the case of using curative kits), and regular if not frequent contact with health workers and/or NGOs or outside organizations seems to be an important factor in accounting for why village health workers may actually operate under these circumstances when the government APE program has largely failed

Each activista is responsible for about 50 families, which happens to be the unit known as a zone within communal villages From talking to a fairly large group of them, and allowing them to each speak for a short time about whatever it is that they do or do best, we heard that they promote immunization, ORT (including cereal based home-made ORT porridges), infant nutrition, prenatal care, latrine construction, child spacing and other PHC type preventive health care At least one of the more articulate activistas said that there was some confusion over their role perception in the village "They come to us at night for malaria pills " This preventive/curative role confusion and paradox, which expressed the difference between felt needs in the community and the priorities of public health programs, is a common problem that bedevils VHW programs Two recent evaluations of the government APE program discuss this

Activistas are selected in open meetings by some sort of quasi-consensus process Save the Children/Gaza has trained about 400 activistas and 125 TBAs This is not to say that they have done the hands-on training themselves, rather that they have paid for and guided such training Everything is done in conjunction with the provincial and district health departments of the government The TBAs, for example, are considered part of the national TBA training program Trained TBAs in the districts of Gaza where Save the Children is working attend about 9 5 births per month (Karen Waltensperger of SCF thought this is a higher number than

births attended before training, but baseline data is not available See comment from Manica about this)

One of the problems of activistas in this area is that those who happen to live near health posts end up being recruited by government health staff to assist in their regular clinic work The activistas in effect become unpaid assistants to paid health workers Not surprisingly, this leads to some resentment on the part of the activista who begins to wonder why she isn't being paid anything A survey of Save the Children showed that activistas who live in areas without a health post make many more home visits and generally spend more time doing what they were trained to do They also spent more time in health promotion with men than activistas who work around health posts (where, as is usually the pattern in Africa, most patients are young mothers and their babies) On the other hand, there is some value is having at least some collaboration between activistas and trained health staff

Save the Children/Gaza has apparently not developed its own print materials for health education Instead it has used whatever is available from the Ministry of Health It is recognized that these need to be improved in the ways recognized by USAID several years ago there need to be stand-alone posters for a non-literate audience, materials in local languages, etc

Village-Based Committees

Save the Children has helped develop water committees and "agricultural committees" (general village committees) Water committees consist of people nominated by fellow villagers to take responsibility for maintenance of pumps and for raising and holding funds to be used for pump repairs requiring parts or outside expertise As noted in the above section on water and sanitation in Zambesia and Niassa, it is difficult to achieve widespread participation in maintenance of water systems The presence of functioning water committees that can actually come up with cash when it is needed is probably be best single measure of success in this area It happens that there are some broken pumps requiring spare parts that cannot be obtained either locally or regionally However this is outside of the control of Save the Children or the water committees, both of whom have done all they can and should be commended

Agricultural committees seem to be somewhat less successful, based on the relatively small numbers of participants in this organization There seem to be links between this and the old farmers' cooperatives that many Mozambicans were coerced into when they were coerced into communal villages In many parts of Mozambique people shy away from anything that sounds anything like cooperative farming, based on experiences they have had or heard about in communal villages Nevertheless, one of the useful things that the agricultural committee does in Julius Nyrere communal village is to maintain a store with farm supplies and other needed items that are usually not available locally (They

also offered Jeito condoms from PSI's social marketing program)

(See section of family planning, in body of report, above, for more on SCF in Gaza, and more on VHWs)

ANNEX B LIST OF PERSONS AND ORGANIZATIONS CONTACTED

USAID
Jay Smith, Deputy Director
Laura Sloby, GDO
Karen Nurick, HPNO
Armand Utshudi-Lumba, HPN
Dr Calu, HPN
Modupe Broderick, Anthropologist

University Research Corp
Mary Anne Abeyta-Behnke, COP
Jose Romaro, IEC Adviser
Frederico ?, Gaza Provincial Adviser
Dr Fernando ?, Zambesia Provincial Adviser
Dr Thelma ?, Training Adviser
Lindanor ?,
Dr Harry Owens, consultant
K C Soares, Consultant
Ed Connerly, former consultant to PHCS

Save the Children/UK, Zambesia
Jane Gibreel, Program Manager

World Vision, Zambesia
Veronique Kollhof, (title?)
Jaime Morais, program assistant
Ed Vosotros, Water & Sanitation

IBIS (Norwegian NGO), Zambesia
Ragnar Hansen, Project Coordinator
(Mozambican counterpart in Minitry of Works)

MCD/I, Niassa
Peter Macie, Project Director
Emmanuel ?, Project Assistant

UNICEF, Manica
Adi Patel, Field Officer
Jorge Lamiao (title?)
Dr Stefano F (title?)

Mozambique Health Committee, Manica
Jorine Muiser, Proj Coordinator,
Sylvia Gurrola, Health Educator

FINIDA, Manica
Jaakko Yrjo-Koskinen

Africare, Sofala
John Swed, water and sanitation

Save the Children, Gaza
Justin Opoku, Field Office Director
Karen Waltensperger, Program Manager/Coordinator
Bonifacio ?

Sabastian ?
Sashi ?

Population Services International

Clayton Davis, COP
Andrew Carlin, consultant

Pronar

Sra Nicole B

Provincial Direction of Health, Gaza
Sr E Naiene, Provincial Director of Health
Dr Ligia Masia, Provincial Medical Director
(Chief of Community Health, Nicuadala District)

Additional
(a number of Mozambicians at the local level such as activistas, animators, traditional birth attendants and healers, nurses, etc)