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TRIP REPORT

NATIONAL LEVEL IEC ASSESSMENT IN MOZAMBIQUE

*BASICS is an USAID-funded project administered by
the Partnership for Child Health Care, Inc.*

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**NATIONAL LEVEL IEC ASSESSMENT
IN MOZAMBIQUE**

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ACRONYMS

ANC	African National Congress
BASICS	Basic Support for Institutionalizing Child Survival
DANIDA	Denmark Development Agency
HPN	Health, Population, and Nutrition
ICS	Instituto de Comunicacao Social
IEC	Information, Education, and Communication
IMR	Infant Mortality Rate
MISAU	Ministry of Health
MOH	Ministry of Health
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PSI	Population Services International
PVO	Private Voluntary Organization
RESP	Reparticao de Educacao para Saude Publica
UNFPA	United Nations Fund for Population Activities
URC	University Research Corporation
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

BACKGROUND

Due to years of civil war and drought, the health situation in Mozambique is worse now than it was in the early 1980s. Available health statistics show that Mozambique child health problems are among the most serious of any country in the world. With an infant mortality rate estimated at between 140 and 173 deaths per thousand births in 1993, Mozambique is well above the sub-Saharan average of 104 per thousand. The life expectancy of 47 years at birth is almost 30 years lower than in the United States.

USAID/Maputo is strongly committed to the improvement of child health, as outlined in the Mission's Strategic Objective 3: Increased Use of Essential Maternal and Child Health/Family Planning Services in Focus Areas. USAID has thus far concentrated its principal efforts in three provinces: Zambezia, Gaza, and Niassa. Due to continuing constraints within the institutional health sector, the most effective interventions must take place in the community and in home management of illness and through preventive behaviors. Focus interventions should target malnutrition, malaria, diarrhea, pneumonia, and measles.

Although Mozambique is committed to improving health care, infrastructure is weak to non-existent and the human resource base in the health sector is severely limited. It is only recently that the MOH has recognized the non-emergency role of the PVOs and the legitimate role of traditional providers. Strong bonds of collaboration and cooperation have yet to be forged. Currently health programs are inadequately focused on child survival needs, although the above-mentioned statistics clearly show the need for more resources to be devoted in this area.

PURPOSE OF TRIP

The USAID Mission in Maputo, after engaging in a process of reengineering and planning, produced an updated strategy for assistance to the health sector in Mozambique. Both the Mission and the MOH are very interested in IEC/behavior change interventions coordinated at a national level. To support its Strategic Objective 3: Increased Use of Essential Maternal and Child Health/Family Planning Services in Focus Areas, USAID asked BASICS to conduct a national-level IEC assessment, and to provide the Mission with recommendations regarding:

- Organizational models which might enhance more effective integrated IEC programming in the future.
- How to prioritize and integrate IEC initiatives by different primary health care program areas.

- Appropriate roles for national-level institutions in effective IEC programming.
- How to link national IEC efforts with district and community-based initiatives.

TRIP ACTIVITIES

The BASICS team met with members of the Mission's Strategic Objective 3 Team on 24 June 1996 to review the scope of work and receive further guidance. In the course of the first week, the team reviewed the relevant documents and met with additional USAID personnel, members of the Primary Health Care Support Project (PHCSP), Ministry of Health staff, UNICEF, the World Bank, DANIDA, and a number of national and international PVOs. The team also met with representatives of the FRELIMO party, the *Instituto de Comunicacao Social* (ICS), TV Mozambique and Radio Mozambique.

During the second week, the team traveled to the Gaza Province to meet with the PHCSP representative, the provincial director, PVO staff, ICS staff in Xai-Xai, health center staff, and community health activists. This was followed by travel to the Zambezia Province, where the team met with PHCSP staff, the provincial director and staff, ICS personnel, UNFPA, and World Vision staff in Quelimane, and traveled to Mocuba and Nicodala Districts to meet with MOH and PVO personnel, traditional providers, volunteers, and community members.

Returning to Maputo, the team met with the Mission HPN officer, Karen Nurick, to begin formulating various strategy options and reviewing them with key constituencies. The team's preferred options were endorsed by counterpart organizations, and form the body of this report.

FINDINGS/CONCLUSIONS

The team concluded that much of the analysis and many of the recommendations made in the BASICS trip report "Recommended USAID Health and Family Planning Sectoral Strategy for Mozambique 1995-2000" remain valid. The virtual state-of-siege in effect at that time limited the range of potential activities and partners. However, there has been dramatic change in Mozambique in the two years since that report was written, and many of the previous constraints have been replaced by new possibilities. Although fifteen years of destabilization, armed conflict, and drought are not that far in the past, and although the economic and health situation remains one of the worst in the world, things have improved and there is hope that this trend will continue.

The team observed a number of currents that appear to be converging, and that present both a significant challenge and a series of opportunities. The overall decentralization of the government is well underway, moving limited, but additional resources to the provincial and district levels. Physical plant and human resources are being upgraded, and much of the

population has moved from camps and urban concentrations back onto the land. PVOs that came to Mozambique to provide famine and refugee relief now deal with issues of community health and sustainable health care delivery.

Although health infrastructure is being rebuilt and health personnel are being trained, there is a national appreciation of the continuing constraints on the institutional health system, and a recognition that facilities and trained human resources will continue to be limited. Social mobilization infrastructure is being rebuilt and encouraged to play a significant role in both health and education. Families and communities will have to continue to assume much of their own care, and traditional providers have a legitimate role to play. Priority should be placed on educating caretakers and communities as to what care can appropriately be provided at the household and community levels, and what danger signs indicate the need to seek facility-based care. Information, education, and communication (IEC) will provide an important link.

The BASICS team was pleased to find a number of organizations with active IEC programs at the national and provincial levels. UNICEF and the UNFPA are both major actors in IEC through their investment in campaigns and the expansion of the *Instituto de Comunicacao Social* at the provincial and district levels. USAID is also supporting significant efforts with the MISAU and the PVOs. There seems to be a consensus that more formal coordination and collaboration would be mutually beneficial.

In meetings with the heads of the Directorate of Community Health and RESP there were strong expressions of support for the IEC technical assistance provided by URC and the expressed desire that future technical assistance build upon this experience. Training-of-trainers experience, applied operations research, and the need for production nuclei at the provincial level that can respond with appropriate messages for specific populations were all identified as potential areas of technical assistance.

Previous IEC efforts have shown that information alone does not empower care-givers to adopt health practices which improve child health. Analysis of current behavior, community determination of which improved behaviors can be adopted, and positive reinforcement of those adopted behaviors through face-to-face and media messages facilitate the adoption of successful behaviors. Evidence already exists in Mozambique that such an approach has produced positive change in the rehydration of children with diarrhea and in completing malaria medication.

There is a recognized need among PVOs, the MOH, and the international collaborating agencies to document systematically the current Mozambican experience in IEC and behavior change, as well as attempts to replicate success. Such experiences should serve as the core of an IEC training strategy designed to provide the tools and skills necessary for national dissemination, as well as a basis for dialogue among policy makers as to the appropriate role for IEC in the context of national, provincial, and district plans.

RECOMMENDATIONS

IEC Priorities

Given the constraints on the health system in Mozambique, an improvement in infant and child health can only be achieved through a strategy that gives priority to the empowerment of women, caretakers, and communities; and uses all of the available health resources, both in the formal and informal sectors, to promote appropriate health behaviors.

A principal focus of these efforts should be communication (IEC) programs targeted at caretakers, especially mothers. The fundamental goal of communication is to influence behavior. The underlying assumption of IEC is that positive changes in health-related practices will lead to reductions in morbidity and mortality. This behavioral imperative has led communicators to seek support from behavioral scientists, anthropologists, and sociologists to better understand the factors that shape the behavior of individuals and groups. Instead of beginning with information, health communicators now begin with behavior and its determinants.

Although the role of men must be incorporated, the primary audience for health communication in Mozambique is the mother, who serves as the first-line responder to the child's illness. Mothers are empowered by learning preventive and curative practices which they themselves can perform in the home. Since there are limited possibilities for substantially expanding health service coverage in the next five years, this strategy seems to be the only viable alternative for significantly reducing infant mortality in the short and medium terms.

IEC interventions should be low-cost, sustainable, and designed to produce the maximum impact in the shortest time possible. In addition, they should be consistent with the pattern of provincial and district level decentralization to allow them to better reach caretakers in the households. It is important to use existing health personnel, as well as other locally based organizations and structures. The IEC strategies adopted should include a list of key behaviors to be changed and/or supported at the caretaker level, and a similar list should be prepared for health workers' key behaviors.

IEC strategies should focus activities in three areas:

- Empowerment of mothers and caretakers in household and community health management
- National and provincial level policy formulation and regulation, including coordination and consensus building
- Strengthening and supporting an integrated health care services delivery model

National Level Policy Development and Coordination

The current and anticipated expenditures for health-related IEC and the significant bridging role implicit in that funding warrant the formation of a national IEC working group, perhaps as a subcommittee of the existing interagency coordinating group. This working group might begin by facilitating coordination at the national level in support of unified provincial IEC strategies. It should also consider establishing a high level IEC consultative group for policy review of such issues as public service air-time. Collaborative relationships with partners beyond MISAU who are involved in or who are supporting IEC should also be explored.

UNICEF has facilitated joint planning meetings on health at the provincial level, but without the specific inclusion of IEC. After donor coordination and consensus is reached at the national level, it is recommended that a strategic planner conduct an integrated IEC planning exercise to develop provincial IEC plans that are supportive of provincial objectives and consistent with donor strategies.

Data Collection and Analysis

For various reasons, data collection and analysis in Mozambique has been limited. Before proceeding with major IEC interventions, it is imperative that community-level data be collected and analyzed for the development of the interventions targeted at key behaviors. It is also important to collect outcome data that will provide information for USAID's strategic objective indicators. IEC data collection efforts should concentrate on the technical areas given priority by MISAU, UNICEF, and the community: malaria, diarrheal disease, and acute respiratory infections. It is important that the staff of the RESP and collaborating PVOs are trained in data collection and analysis methodologies.

Documentation and Dissemination

The limited visibility of successful IEC efforts impedes developing the constituency for an expanded IEC program. A systematic collection of applicable experience from neighboring states (Tanzania, Mali, Zambia, Zimbabwe, Swaziland, South Africa) and more importantly, from within Mozambique, is recommended. A careful analysis of the various means of dissemination should be conducted to ensure maximum diffusion. An analysis of the Mozambican experience on addressing the emphasis caretaker behaviors related to malaria, diarrheal disease and acute respiratory infection should be documented for training purposes, but also to motivate policy dialogue at the Ministerial level. A "lessons-learned" package of these positive experiences should be disseminated systematically to the various provinces and districts. It is essential to produce high-quality audiovisuals in-country, adapted to the local context, which accurately portray appropriate health messages for the various target populations.

Training

The limited access to Mozambican communities in the past has not permitted the development of appropriate local tools and skills for IEC work at that level. With the current decentralization of resources and responsibility to the provincial and ultimately the district level, there is a need to examine what local efforts have been successful and to what degree they can be replicated. PVOs are also being encouraged to apply their successful experience working with concentrated populations to new efforts with more dispersed populations, often in conjunction with district health officials. Focusing initial efforts in one geographic area could provide a learning laboratory for applied community-level training for a broad range of participants, while providing quality control for the documentation of such efforts. The current expansion of ICS infrastructure, as well as the concentration of training facilities and PVOs, would seem to make Zambezia a logical site. In keeping with the MOH's decentralization policy, central- and provincial-level MOH staff could be provided hands-on training and field experience in Zambezia.

PVOs and other donor representatives should also participate in training on social marketing and social mobilization. The *Tool Box for Building Health Communication Capacity* can be modified to meet the needs of districts and PVOs, and the application of selected tools could be documented and packaged for replication.

Appendix A describes a proposed short-term strategy for training in IEC/behavior change activities.

Personnel

To facilitate an IEC strategy at the national level, with implementation linkages in Zambezia, two full-time IEC advisors are recommended. A full-time, national-level IEC advisor is needed to assist the working group in Maputo on policy development, central-level advocacy, documentation and dissemination, and coordination and promotion of IEC activities with the MOH, USAID and its partners, and other donors. In addition, a second full-time IEC advisor based in Zambezia is needed to coordinate operations research and IEC training activities in conjunction with other donors and PVOs in the province. BASICS understands that USAID/Maputo is considering several options for providing this long-term IEC technical assistance.

BACKGROUND - COUNTRY CONTEXT

Mozambique, which stretches along the southeast coast of Africa, occupies a space roughly twice the size of California. The country consists of coastal marsh, plains, and interior highlands, and is divided by several large rivers flowing from the interior of Africa into the Indian Ocean. The area was originally populated through a series of migrations by tribal bands from several different linguistic groups, many belonging to the greater Bantu.

Initial Portuguese colonization early in the sixteenth century consisted largely of wresting control of key points in the gold and ivory routes from Islamic traders, and for the first four hundred years could be characterized as largely extractive. Trade in gold and ivory was followed by exploitation of other natural resources, and Mozambique played a significant role in the slave trade well into the nineteenth century.

The process of consolidation of the territory of Mozambique into a nation state did not begin in earnest until the European scramble for markets in Africa. British ambitions in Rhodesia forced the negotiation of the current borders under an Anglo-Portuguese agreement in 1891. The colonial administration was reorganized in 1907, introducing an administrative system that remained intact until independence. The Colonial Statute of 1930 tightened Lisbon's control of Mozambique through its incorporation into "Greater Portugal" and the stimulation of Portuguese immigration. By the 1960s the white population had grown to around 200,000, compared to an indigenous population of around 6.5 million.

As the independence movement swept Africa and the different colonial powers began to negotiate the terms of their withdrawal, the Portuguese moved against the current, sending in additional troops and cracking down on any incipient attempts to organize opposition. The independence movement FRELIMO was founded outside the country, and both its cells inside Mozambique and its limited military presence came under severe attack. In the end it was a Portuguese soldier's revolt and the resulting coup in Portugal that brought FRELIMO-negotiated independence to Mozambique.

Independence was followed by a mass exodus of the Portuguese and other elites, resulting in the almost complete depletion of the professional, managerial and entrepreneurial class. Mozambique opposition to apartheid in South Africa, support for the ANC, and participation in the boycott against white-ruled Rhodesia brought retaliation and additional economic hardships.

One of the first major endeavors of the FRELIMO government was the extension of the health system. With its focus on primary and preventive care, it was somewhat of a model for Africa. The identification of the health system with FRELIMO, however, turned health workers and facilities into principal targets for the Rhodesian- and South African-backed RENAMO forces, and much was destroyed during the 1980s.

Armed conflict during the 1980s and into the 1990s led to large numbers of dislocated and refugees. In 1992, drought displaced additional populations, resulting in widespread starvation. Peace accords, political changes in South Africa, and national elections have all helped to create a more positive climate. Decentralization, municipal elections, and economic recovery are now the principal concerns.

BACKGROUND - HEALTH CONTEXT

Due to the years of civil war, the health situation in Mozambique is worse now than it was in the early 1980s. The health statistics show that Mozambique is one of the worst countries in the world in terms of child health. With an infant mortality rate estimated at between 140 and 173 deaths per thousand births in 1993, Mozambique is well above the sub-Saharan average of 104 per thousand. The Center for Health Information health statistics report for 1996 estimates life expectancy at birth at 47 years, with an under five mortality rate of 249 per 1,000 live births. Principal causes of morbidity and mortality are malaria, diarrheal disease, and acute respiratory infection.

USAID/Maputo is strongly committed to the improvement of child health, as outlined in the Mission's Strategic Objective 3: Increased Use of Essential Maternal and Child Health/Family Planning Services in Focus Areas. USAID has concentrated its initial efforts in three provinces: Zambezia, Gaza, and Niassa. Due to continuing constraints within the health sector, the most effective interventions must take place in the community and in home management of illness and through preventive behaviors. Focus interventions should target malnutrition, malaria, diarrhea, pneumonia, and measles.

Although Mozambique is committed to improving health care, infrastructure is weak to non-existent and the human resource base in the health sector is severely limited. It is only recently that the MOH has recognized a non-emergency role for PVOs and the legitimate role of traditional providers. Strong bonds of collaboration and cooperation have yet to be forged. Current health programs do not adequately focus on child survival, although the above mentioned statistics clearly show the need for more resources to be devoted in this area. A comprehensive IEC/behavior change strategy is needed to target key behaviors within the community and to promote appropriate home management of childhood illness.

PURPOSE OF TRIP

The USAID Mission in Maputo, after engaging in a process of reengineering and planning, produced an updated strategy for assistance to the health sector in Mozambique. Both the Mission and the MOH are very interested in IEC/behavior change interventions coordinated at a national level. Under the auspices of Strategic Objective 3: Increased Use of Essential Maternal

and Child Health/Family Planning Services in Focus Areas, USAID asked BASICS to conduct a national level IEC assessment, and to provide the Mission with recommendations regarding:

- Organizational models which might enhance more effective integrated IEC programing in the future
- How to prioritize and integrate IEC initiatives by different primary health care program areas
- Appropriate roles for national-level institutions in effective IEC programing
- How to link national IEC efforts with district- and community-based initiatives

TRIP ACTIVITIES

The BASICS team met with members of the Mission's Strategic Objective 3 Team on 24 June 1996 to review the scope of work and receive further guidance. In the course of the first week, the team reviewed the relevant documents and met with additional USAID personnel, members of the Primary Health Care Support Project (PHCSP), Ministry of Health staff, UNICEF, the World Bank, DANIDA, and a number of national and international PVOs. The team also met with representatives of the FRELIMO party, the *Instituto de Comunicacao Social* (ICS), TV Mozambique and Radio Mozambique.

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Returning to Maputo, the team met with Mission HPN Officer Karen Nurick to begin formulating various strategy options and vetting the generalized concepts with key constituencies. The team's preferred options were endorsed by counterpart organizations, and form the body of this report.

FINDINGS/CONCLUSIONS

Ministry of Health

The Mozambique MOH, as in many countries, is going through a process of decentralization. In the past, almost all of the work in health was done from Maputo. As a result of decentralization and a more stable political climate, the emphasis is now moving out of Maputo and into the field, where the programs are implemented. The move towards the provinces is a significant structural

change for the MOH's operations and for personnel whose activities have largely been confined to Maputo.

Reparticao de Educacao para Saude Publica

Within the MOH, prime responsibility for IEC in health resides with the "Reparticao de Educacao para Saude Publica" (RESP), which is part of the Division of Community Health. The RESP currently has a central-level staff of eleven, and is assisted by an IEC advisor from URC. UNICEF traditionally provided both technical assistance and resources to RESP, but in 1994, unhappy with the degree of skills transfer and limited capacity for budget management, they withdrew their support. The appointment of a new program head, recently returned from specialized training in Zimbabwe and Brazil, may reverse this situation.

Although RESP is the repository of specialized IEC skills within the MOH, most vertical/normative programs have a limited appreciation of these skills. When given discretionary power over budgets, programs do not necessarily seek out RESP. UNICEF has been the source of significant funds for IEC health efforts, some channeled through the MOH and some through ICS. The ICS has, in the past, relied on RESP or normative divisions for the technical content of health messages.

Cooperantes

In the immediate post-independence period and continuing up to the present, a significant role in the health system has been played by expatriate cooperantes. These volunteers, motivated by both political and humanitarian concerns, have served at every level, from policy to service delivery—not as advisors, but as ministry or other institutional staff. The cooperantes served in positions vacated by professionals who had left the country, or staffed infrastructure that had not existed under the colonial regime. Many of these individuals now have worked for 10, 15 or 20 years in Mozambique, and continue to have a significant role in the health field. They see themselves, and are viewed by Mozambicans, as very different from many of the personnel that later came to staff the relief and refugee organizations. As the emphasis has shifted to decentralization, many cooperantes have sought provincial postings.

Postos de Saude

Postos de Saude, or health posts, are the manifestation of the institutional health system closest to the community. Access is defined by the MOH as being within 20 km. of such a post, and under that definition approximately 30 percent of the population has access. Given the lack of transportation infrastructure however, access, practically speaking, means within walking distance. The postos are largely staffed with auxiliary nurses, although some have professional nurses, and some are staffed with lower-level, empirically-trained staff. They are supplied with UNICEF standard package drug kits and little else, and serve as ambulatory care centers. As

mentioned earlier, these posts were often targets of attack during the armed conflict, and are the primary focus of the current World Bank infrastructure rebuilding project.

Maternidad and Centros de Saude

The next level of complexity in the health system is the *Maternidad*, a center for prenatal care and occasional delivery, which may be staffed by a trained midwife, and the *Centro de Saude*, or health center, which may be staffed with a professional nurse or, rarely, a physician. Hospitals are generally located in the provincial capital, although some exist in other major cities. There are few physicians even at this level.

USAID

As noted above, USAID/Maputo modified their health strategy after a process of reengineering and planning. Strategic Objective 3—Increased Use of Essential Maternal and Child Health/Family Planning Services in Focus Areas—provides the framework for USAID's strategy in child health. USAID has chosen to concentrate its initial efforts in three provinces: Zambezia, Niassa, and Gaza.

URC Institutional Strengthening Project

USAID's bilateral health project, the Primary Health Care Support Project (PHCSP), focused originally on strengthening planning and management systems in the Ministry of Health. USAID's strategy has shifted however, and the project is now oriented toward three major program outcomes:

- Increased use of essential, maternal and child health services in focused areas
- Increased demand for community-based services
- Strengthened management of decentralized, essential services

At the central level, the project continues to provide technical advisors to the Ministry Planning and Health Education Units; most of its activity, however, is based in the provinces of Gaza, Niassa and Zambezia, where URC has resident advisors. A training advisor is located full-time in Zambezia, while the other provinces are served by a second trainer working out of the capital. As previously mentioned, URC has a full-time IEC advisor working with RESP at the central level. USAID also appears to be looking to URC to play a facilitating/coordinating role with the PVOs under the PVO II project.

Private Voluntary Organizations

The displacement of a significant part of the population due to armed conflict from the mid-1980s until the peace accords were signed, and a drought in 1992, resulted in a massive

relief effort in Mozambique. Although the UN High Commission for Refugees and the Red Cross were the major actors, much of the work was done by national aid agencies from Europe and North America, as well as international PVOs. Through its PVO I and the proposed PVO II project, USAID is providing significant support to a number of different PVOs, many of which began their work in Mozambique as either refugee or famine relief agencies. With the changing country situation and the refocusing of USAID's strategy, these PVOs are being encouraged to develop local partner collaborating organizations and redirect their efforts away from relief and towards community development. One area within this new focus is the improvement of family health through the promotion of behavior change, as well as the expansion and improvement of services. Given the scarcity of health resources, much of the responsibility for action to improve health will have to be assumed by the families and communities themselves. Health IEC is seen as receiving almost no attention within the government health system, and PVO-assisted facilities at the district level are viewed as potential entry points for these skills.

The magnitude of the change being requested of the PVO community is enormous. Original missions often involved providing goods and services to a concentrated population with agency administrative and logistic support, and limited or no local intermediaries. The current strategy anticipates systematic institutionalization of PVO activities through the development of local frameworks incorporating dispersed communities and local organizations whose mandates extend far beyond their resources. Although the PVOs continue to play a significant role in the nation's health, the government's view of their non-emergency role has sometimes been ambiguous.

Population Services International/Social Marketing

Population Services International (PSI) has a Southern African AIDS Prevention Initiative in Tanzania, Malawi, Zambia, Botswana, South Africa, Lesotho, and Mozambique. Their work in Mozambique began with a pilot project focused on the Maputo, Sofala, Manica, and Tete Provinces. PSI opened an office in Maputo in December 1994 with an expatriate IEC advisor who subsequently hired three local communication specialists to work on the JeitO condom campaign. In-house staff was trained in focus group and social marketing methodologies, and operational skills. Staff worked on research protocol development as part of their training, selecting study populations, developing an analysis plan, moderators guide, samples, etc. At the provincial level, the project is represented by a sales agent and a motivation agent, both fluent in the local language. The motivation agent is responsible for implementation of all IEC and demand creation activities; local community groups are trained with peer educator volunteers.

PSI has 34 Mozambican staff employed full time, and has developed close partnerships with musicians, drama groups, and the advertising agency *Coop Imagen*. In addition to condom sales, PSI has added an initiative with the Ministry of Health and UNICEF for the promotion of iodized salt. PSI is interested in converting its local organization into a social marketing PVO that would assume project implementation responsibility. The PVO is seen as potentially being sustained through work in the following intervention areas:

- Control of diarrheal disease through promotion of ORS/ORT
- Control of malaria through the promotion of impregnated mosquito bednets
- Micronutrient supplementation through the promotion of vitamin A, iodine, and iron

Demographic Health Survey

Internal conflict and the concurrent displacement of a large part of the population has not permitted the systematic collection of census or other demographic data. An initial Demographic Health Survey will be carried out by MACRO in late 1996 and is expected to be repeated in four years.

Other Donors

Swiss Coordination

The Swiss have traditionally made the largest financial contribution to health, and have often served as "donor-of-last-resort" for the Ministry of Health. They have been recognized by the MOH as serving a coordinating function among the different international agencies working in health.

World Bank

The World Bank is in the process of entering the health sector with a significant infrastructure rebuilding effort totaling over \$100 million.

UNICEF

UNICEF has been very much involved in IEC as part of their \$30 million Health and Nutrition Programme. The UNICEF project focuses include maternal and child health essential drugs, education, human resource development, decentralization, and nutrition.

For a more detailed summary of donors involved in health in Mozambique, refer to USAID/Maputo's Health Sector Strategy.

Private Sector

FRELIMO, as previously mentioned, actively supported health, and TV Mozambique, Radio Mozambique, and the "Instituto de Comunicacion Social" as organs of the state, played a significant role in mobilizing the population around health issues. The first two institutions have now been privatized, while the ICS is once again in an expansion phase after having had much of its material infrastructure destroyed during the war.

Other parts of the private sector in communications (i.e., advertising, printing), previously weak to non-existent, have increased their productive capacity both through privatization and their role in the national elections. Although much work continues to be contracted in South Africa and Zimbabwe, the upcoming municipal elections, increased economic growth, and the policy of decentralization may generate increased materials production capacity at the provincial level.

Community Resources

The population targeted for USAID assistance lives largely from subsistence agricultural efforts. The country has little transportation infrastructure for the marketing of surplus food, and the countryside is home to dispersed family units. Women are the principal agriculturalists and often work various plots called *mashamba*, which are many times far from home. In these cases, older siblings or other family members serve as the primary care givers for the younger children.

The next unit of population is the *aldea*, which consists of a grouping of families. The principal health provider in the community might well be a *curandero* (a traditional healer) or a *partera tradicional* (a traditional midwife). The administrative structures set up by the Portuguese are still in place in many aldeas, as well as FRELIMO party cell structures or the alternative RENAMO structures. An organized "Comite de Saude" may exist at this level to encourage well construction or provide organized support for a related health endeavor.

Activistas, facilitadores, soccoristas and *voluntarios* are those individuals within any given community whom the PVOs identify as their collaborating community counterparts. Selection criteria may vary, and although their relationship with the PVOs may be clear, it is often not clear what role they play in the community, since volunteerism is not necessarily traditional behavior.

Vehicles for IEC

Among the various institutions discussed above, there are many existing structures, communications materials, personnel, and social gatherings that could be used as vehicles for IEC activities. They include:

- Television and radio
- Journals and other printed material
- Posters and flyers
- Health personnel
- Educational personnel
- Community volunteers
- Traditional providers
- Churches
- Theater and choirs

Television and radio were used extensively in the post-independence period for social mobilization. Radio is being reestablished at the provincial and district levels and broadcasts in a number of local languages. As the economy improves, radios are among the first things people are buying, and batteries are readily available at the community level. What is less clear is who has access to a radio and during what hours. Existing health messages are more informative than action oriented. Since it is not clear what the feasible health behaviors are, it is difficult to say whether radio can encourage the adoption of such behaviors.

Journals and other printed material reach an important but very limited audience in Mozambique. Literacy is low, especially among women. Although Portuguese is the unifying language, it is not most people's first language. Printed material will, however, continue to be an important channel for reaching decision makers.

Posters and flyers often suffer from the same weaknesses as written material as they are often unintelligible or open to diverse interpretation if not generated locally. Although this is widely recognized within the MOH, alternative solutions have not yet been proposed—a not unusual situation for a centralized bureaucracy which, for long periods of time, was cut off from the field. The audience for much of the material currently produced seems to be the bureaucracy itself rather than the community.

Health personnel should be an important source of health information, but it is not clear that they serve that function. Many health workers received limited initial training and claim to have had no follow-on training for the past ten years. Counseling and communication skills for health workers are not priorities, and PVOs report reluctance on the part of Ministry colleagues to provide these skills.

Educational personnel are significant allies for the promotion of health messages in many countries, but this linkage does not seem to be made systematically in Mozambique.

Community volunteers have played an important role in the success of PVO efforts and there is a great deal of interest in stimulating the participation of volunteers in other communities. Little is known either about the motivation of these individuals or how they are perceived by their communities. It would be extremely useful to collect such data prior to any significant expansion of the existing cadres.

Traditional providers play an important role in communities, whether or not their role is endorsed by the Ministry of Health. Whether that role can be expanded upon to further specific public health goals is another question. Many efforts to encourage traditional midwives to adopt clean birth practices seem to have been successful, while efforts to have these same providers serve as messengers for the advantages of family planning or oral rehydration have been less so. Traditional healers have been identified as potential partners in improving community health and they may well prove to be, but some see ORS as an inappropriate treatment for diarrhea and provide prescriptions for malaria and tuberculosis that few practitioners of Western medicine

would be comfortable with. However, as there are more than 80,000 traditional healers, including herbalists, diviners, spiritualists, and faith healers in Mozambique, their roles and increased participation in promoting child health need to be explored.

Churches provide the most consistent opportunity for social gatherings in Mozambican society and should provide unlimited opportunities for the promotion of health messages. Although some churches do provide this service, it is not a widespread tradition. Three of the strongest groups are the Moslems, the *Conselho Cristiano* (composed of 19 denominations), and the Catholics.

Local theater and choirs can potentially play an important role in disseminating health behavior messages. PSI may have the most extensive recent experience, but other entities have used such groups in the past or propose to use them in current projects. Although they have a high entertainment value, it is not clear that evaluations have been carried out to gauge how effective theater groups have been in the transfer of messages. What has been apparent is a degree of artistic license which is difficult to control and which has led to message modification. Theater groups are also expensive to transport and maintain.

Current Efforts and Limitations in IEC

Current national-level IEC efforts appear to be focused on campaigns which are either national or regional in scope. Campaigns often involve printed material such as posters and fliers, as well as radio spots. At the time of this consultancy a major effort was underway in support of the national polio eradication campaign.

Provincial IEC activities appear to be smaller versions of national campaigns. At the provincial level, the staff responsible for IEC are often responsible for a variety of other tasks and do not have their own budgets. Although resources may exist in other institutions, this may not be known, or the individual responsible for IEC may not be in a position to negotiate with other institutions on behalf of the MOH.

At the district level, there appears to be little in the way of skills or resources. If logistics permit, the district may receive some centrally-produced printed IEC material, or it may be within transmission range of health messages broadcast from the provincial capital. There does not appear to be a tradition of involving the local educational institutions or church organizations in health campaigns.

At the health post level, most IEC work consists of advice given to caretakers, or if there is a PVO with local activists, there may be talks given sporadically on the need to vaccinate children, dig latrines, or use ORS.

At the national level in the MOH, there appears to be limited understanding of, or prestige for, IEC. Given the scarcity of resources, it is not surprising that interest and resources are focused

more on service delivery and drug management. Without providing some concrete examples of successful IEC efforts, this trend will most likely continue. On the other hand, IEC does have the support of the head of the MOH Community Health Department and others who have supported the recent growth of the RESP and would like to see them coordinating such activities within the MOH.

RESP has attempted to promote its coordinating role by increasing productive capability and thus, its ability to respond to the MOH's vertical programs which do have IEC funds. Unfortunately, this strategy appears to have had the contrary effect by putting RESP in a re-active stance, responding to external demands, rather than carrying out a coherent, pro-active strategy of its own. Since no one is currently measuring impact, IEC efforts are more likely to be measured on commercial criteria, and it is doubtful that the RESP will be able to successfully compete with the private sector on this playing field. Dr. Mondlane and Mr. Chalufu of the Directorate of Community Health have expressed that the RESP will continue to produce IEC materials for the Ministry.

The RESP could better compete with the private sector and legitimize its coordinating function within the MOH in the area of operations research and evaluation. The limited national experience in analysis of health behavior, selection of behaviors to be targeted, and evaluation of effectiveness of strategies selected would make RESP a significant player and asset to the MOH.

At the provincial level, the responsibility for IEC currently falls on a limited staff with multiple tasks which are largely administrative. Materials dropped from above with limited guidance don't necessarily respond to perceived needs, and there is limited logistical support for their distribution. There is almost no local adaptation. If MOH input into radio programming is sought, it may well be from the political level rather than from an IEC specialist. The ability to respond to the increased demand for assistance from the districts and the PVOs is limited and dependent on external support and guidance.

At the district level the current situation is bleaker. The burden of IEC efforts, if any, fall on existing staff and resources ill-prepared to assume it. The concept of counseling skills is generally unfamiliar, and there is limited experience with collaborative efforts with schools and churches. PVOs which have some of these skills are not necessarily seen as allies, but rather as more successful competitors for scarce resources.

CONCLUSIONS

The team concluded that much of the analysis and many of the recommendations made in the BASICS trip report "Recommended USAID Health and Family Planning Sectoral Strategy for Mozambique 1995-2000" remain valid. The virtual state-of-siege in effect at that time limited the range of potential activities and partners. However, there has been dramatic change in Mozambique in the two years since that report was written, and many of the previous constraints

have been replaced by new possibilities. Although fifteen years of destabilization, armed conflict, and drought are not that far in the past, and although the economic and health situation remains one of the worst in the world, things have improved and there is hope that this trend will continue.

The team observed a number of currents that appear to be converging and that present both a significant challenge and a series of opportunities. The overall decentralization of the government is well underway, moving limited, but additional resources to the provincial and district levels. Physical plant and human resources are being upgraded, and much of the population has moved from camps and urban concentrations back onto the land. PVOs that came to Mozambique to provide famine and refugee relief now deal with issues of community health and sustainable health care delivery.

Although health infrastructure is being rebuilt and health personnel are being trained, there is a national appreciation of the continuing constraints on the institutional health system, and a recognition that facilities and trained human resources will continue to be limited. Social mobilization infrastructure is being rebuilt and encouraged to play a significant role in both health and education. Families and communities will have to continue to assume much of their own care, and traditional providers have a legitimate role to play. Priority should be placed on educating caretakers and communities as to what care can appropriately be provided at the household and community levels, and what danger signs indicate the need to seek facility-based care. Information, education, and communication (IEC) will provide an important link here.

The BASICS team was pleased to find a number of organizations with active IEC programs at the national and provincial levels. UNICEF and the UNFPA are both major actors in IEC through their investment in campaigns and the expansion of the *Instituto de Comunicacao Social* at the provincial and district levels. USAID has institutional capability in targeting health communication and is supporting significant efforts with the MISAU and the PVOs. There seems to be a consensus that more formal coordination and collaboration would be mutually beneficial.

Previous IEC efforts have shown that information alone does not empower caregivers to adopt health practices which improve child health. Analysis of current behavior, community determination of which improved behaviors can be adopted, and positive reinforcement of those adopted behaviors through face-to-face and media messages facilitate the adoption of successful behaviors. Anecdotal evidence exists in Mozambique showing a positive change in the rehydration of children with diarrhea and in completing malaria medication.

There is a recognized need among PVOs, the MOH, and the international collaborating agencies to document systematically the current Mozambican experience in IEC and behavior change, as well as attempts to replicate success. Such experiences should serve as the core of an IEC training strategy designed to provide the tools and skills necessary for national dissemination, as

well as a basis for dialogue among policy makers as to the appropriate role for IEC in the context of national, provincial, and district plans.

RECOMMENDATIONS

IEC Priorities

Given the constraints on the health system in Mozambique, an improvement in infant and child health can only be achieved through a strategy that gives priority to the empowerment of women, caretakers, and communities; and uses all of the available health resources, both in the formal and informal sectors, to promote appropriate health behaviors.

A principal focus of these efforts should be communication (IEC) programs targeted at caretakers, especially mothers. The fundamental goal of communication is to influence behavior. The underlying assumption of IEC is that positive changes in health-related practices will lead to reductions in morbidity and mortality. This behavioral imperative has led communicators to seek support from behavioral scientists, anthropologists, and sociologists to better understand the factors that shape the behavior of individuals and groups. Instead of beginning with information, health communicators now begin with behavior and its determinants.

Although the role of men must be incorporated, the primary audience for health communication in Mozambique is the mother, who serves as the first-line responder to the child's illness. Mothers are empowered by learning preventive and curative practices which they themselves can perform in the home. Since there are limited possibilities for substantially expanding health service coverage in the next five years, this strategy seems to be the only viable alternative for significantly reducing infant mortality in the short and medium terms.

IEC interventions should be low-cost, sustainable, and designed to produce the maximum impact in the shortest time possible. In addition, they should be consistent with the pattern of provincial- and district-level decentralization to allow them to better reach caretakers in the households. It is important to use existing health personnel, as well as other locally-based organizations and structures. The IEC strategies adopted should include a list of key behaviors to be changed and/or supported at the caretaker level, and a similar list should be prepared for health workers' key behaviors.

IEC strategies should focus activities in three areas:

- Empowerment of mothers and caretakers in household and community health management
- National- and provincial-level policy formulation and regulation, including coordination and consensus building
- Strengthening and supporting an integrated health care services delivery model

National Level Policy Development and Coordination

The current and anticipated expenditures for health-related IEC and the significant bridging role implicit in that funding warrant the formation of a national IEC working group, perhaps as a subcommittee of the existing interagency coordinating group. This working group might begin by facilitating coordination at the national level in support of unified provincial IEC strategies. It should also consider establishing a high-level IEC consultative group for policy review of such issues as public service air-time. Collaborative relationships with partners other than the MISAU who are involved in or who are supporting IEC should be explored.

UNICEF has facilitated joint planning meetings on health at the provincial level, but without the inclusion of IEC. After donor coordination and consensus is reached at the national level, it is recommended that a strategic planner conduct an integrated IEC planning exercise at the national and provincial levels to foster consensus among the policy makers concerning the important role of IEC, and to develop provincial IEC plans that are supportive of provincial objectives and consistent with donor strategies.

Data Collection and Analysis

For various reasons, data collection and analysis in Mozambique has been limited. Before proceeding with major IEC interventions, it is imperative that community-level data be collected and analyzed for the development of the interventions targeted at key behaviors. It is also important to collect outcome data that will provide information for USAID's strategic objective indicators. IEC data collection efforts should concentrate on the technical areas given priority by MISAU, UNICEF, and the community: malaria, diarrheal disease, and acute respiratory infections. It is important that the staff of the RESP and PVOs are trained in data collection and analysis methodologies.

Documentation and Dissemination

The limited visibility of successful IEC efforts impedes developing a constituency for an expanded IEC program. A systematic collection of applicable experience from neighboring states (Tanzania, Mali, Zambia, Zimbabwe, Swaziland, South Africa) and more importantly, from within Mozambique, is recommended. A careful analysis of the various means of dissemination should be made to ensure maximum diffusion. An analysis of the Mozambican experience on addressing the emphasis caretaker behaviors related to malaria, diarrheal disease, and acute respiratory infection should be documented for training purposes, but also to motivate policy dialogue at the Ministerial level. A "lessons-learned" package of these positive experiences should be disseminated systematically to the various provinces and districts. It is essential to produce high-quality audiovisuals in-country, adapted to the local context, which accurately portray appropriate health messages for the various target populations.

Training

The limited access to communities in the past did not permit the development of appropriate local tools and skills for IEC work at that level. With the current decentralization of resources and responsibility to the provincial and ultimately the district levels, there is a need to examine what local efforts have been successful and to what degree they can be replicated. PVOs are also being encouraged to apply their successful experience working with concentrated populations to new efforts with more dispersed populations, in close conjunction with district health officials. Focusing initial efforts in one geographic area could provide a learning laboratory for applied community-level training for a broad range of participants, while providing quality control for the documentation of such efforts. The current expansion of ICS infrastructure, as well as the concentration of training facilities and PVOs, would seem to make Zambezia a logical site. In keeping with the MOH's decentralization policy, central- and provincial-level MOH staff could be provided hands-on training and field experience in Zambezia.

PVOs and other donor representatives should participate in training on social marketing and social mobilization. The *Tool Box for Building Health Communication Capacity* can be modified to meet the needs of PVOs and districts, and the application of selected tools could be documented and packaged for replication.

Appendix A describes a proposed short-term strategy for IEC/behavior change activities.

Personnel

To facilitate an IEC strategy at the national level, with implementation linkages in Zambezia, two full-time IEC advisors are recommended. A full-time national-level IEC advisor is needed to assist the working group in Maputo on policy development, central-level advocacy, documentation, and dissemination, and coordination and promotion of IEC activities with the MOH, USAID and its partners, and other donors. In addition, a second full-time IEC advisor based in Zambezia (or another appropriate province) is needed to coordinate operations research and IEC training activities in conjunction with other donors and PVOs in the province. BASICS understands that USAID/Maputo is considering several options for providing this long-term IEC technical assistance.

APPENDICES

APPENDIX A: Technical Assistance Option 1

**Strengthening IEC Implementation and Coordination at the National Level
and in Zambezia District**

**Technical Assistance Option 1:
Strengthening IEC Implementation and Coordination at the National Level and in
Zambezia District**

(The following is one of three options being proposed by BASICS to USAID/Maputo. It is a short-term option, relatively modest in terms of funding requirements, which responds directly to the Mission's interest in strengthening implementation and coordination of national and provincial IEC efforts. Other longer-term options will include attention to other program elements in which BASICS also has special expertise.)

To help implement the recommendations made by the BASICS IEC assessment team at the conclusion of its June/July 1996 consultancy, BASICS proposes the following short-term technical assistance and training program, to be carried out over an approximately one-year period of time.

In close cooperation with the national and provincial IEC advisors, BASICS can implement a three-phase training program in communications and behavior change in Zambezia province. The participants in the program will be MOH district-level personnel from Zambezia province, as well as those from Niassa and Gaza, and equivalent staff from the major PVOs working in the province. National level Ministry of Health staff from the health education division (RESP), and staff from the *Instituto de Comunicacao Social* (ICS) will participate as co-trainers and resource persons where appropriate and as participants in areas where they have limited expertise. This would be contemplated as part of a training of trainers experience to allow them to replicate this experience in other provinces. The objectives of the training are the following:

- Acquisition of skills in planning and implementing appropriate behavior change interventions at the community level;
- Completion of appropriate local formative research and behavior analysis to form community IEC plans;
- Development of practical, actionable IEC plans for achieving positive changes in high-priority health behaviors;
- Development of partnerships among district MOH managers, PVO managers, and relevant community organizations; and
- Strengthening the role of RESP in providing technical support to provincial and district-level communication initiatives.

Phase I - Overview and Analysis: A one-week seminar/workshop is held to give an overview of the health communication process, health problem analysis, selection of emphasis behaviors, planning of formative research, and community resource assessment.

Phase II - Field Work: Following the first phase of the training program, operational staff participants will return to their jobs and communities and actually implement the research/data collection/community assessments which have been planned (3-4 week period depending on human resources available for monitoring and the number of districts). They will then bring the data from this exercise to Phase III of the program.

Phase III - Developing Intervention Plans: Using the data collected during the field work phase, the training team will work with participants to develop practical work plans to achieve (and evaluate) positive change in the emphasis behaviors selected. Emphasis will be given to identifying concrete roles that local community groups (including churches, schools, community leaders as well as local radio stations and other media groups) can play to help achieve the behavior change objectives.

Sharing Results / Making Mid-Course Corrections: Following an approximately 4-6 month implementation period, the training group will be reconvened to share their experiences to date; report interim results, implementation problems, and issues; and make any needed adjustments.

As recommended by the BASICS IEC assessment team, the tools and training materials used to support the program above will be drawn from the *Tool Box for Building Health Communication Capacity* and *Guide to Emphasis Caretaker Behaviors*. Other BASICS tools will also be adapted and utilized, including guidelines being developed in the Zambia and Ethiopia programs for assisting district level managers to engage community partners in mobilization and behavior change efforts, and Mozambique appropriate versions of communication training materials used by BASICS in Bolivia and Ecuador.

The TA/training program will be conducted by a team of 2 experienced IEC trainers, fluent in Portuguese, who will make 3 trips each to Mozambique coinciding with the three phases of the program. An initial planning trip by one of the trainers is also recommended, during which time an optional seminar for senior national-level decision makers could be held to gain their understanding and support of the training effort. The trainers would, of course, be working very closely with the national and provincial IEC advisors. Both, particularly the provincial advisor, would be expected to be very much involved in supporting the implementation of the IEC plans developed.

To document the process and results of this program, BASICS will seek to involve RESP, ICS or another appropriate local organization in producing a documentary video about the program, in conjunction with the national IEC advisor. This product and, more importantly, the interim results of the community behavior change programs implemented in Zambezia, could be presented at the end of the year-long program in a national-level meeting designed to both disseminate results to other provinces and develop a clear national policy in support of health communication. Such meetings and policies have proven valuable supports to child survival and other health communication programs in a number of countries.

APPENDIX B: Technical Assistance Option 2

**Expanded Assistance to IEC and Community Development
in Three Provinces**

Technical Assistance Option 2: Expanded Assistance to IEC and Community Development in Three Provinces

The following option is an expansion of option 1. The same three phases of IEC training and technical assistance outlined in option 1 would be conducted, but with two significant additions: participants from all three USAID focus provinces (Zambezia, Niassa, and Gaza) would be invited to participate and the program would then continue on to Phases IV-VI outlined below. The program would require a higher level of on-the-ground support--at least a half-time MCH advisor in addition to the two IEC advisors--and would require approximately two years to complete.

Phase IV: Household/Community Assessments

Because of the extremely limited access to quality services, BASICS' initial activities should focus on improving family preventive practices and home management of childhood illness. In order to do this, BASICS would capitalize on the information gained from the proposed Option 1 activities—specifically in terms of data collected on “emphasis behaviors” derived from the participatory, qualitative exercises in target communities. Depending upon the extent of information obtained, BASICS would then design additional participatory and quantitative exercises to fill in the gaps—especially pertaining to current home practices and health seeking behaviors.

For example, BASICS might undertake adaptation and use of one or more of the following methods:

- Mortality Survey (Bolivia),
- Integrated 100 household survey instrument (Nigeria and Ethiopia),
- Verbal Case Review (Indonesia, India).

These exercises should both develop local capacity (to implement and use information in local planning), as well as highlight important intervention areas. These would be performed in each province, to identify regional differences, as well as congruences.

If the Option 1 plan is successful in developing partnerships between district level managers and PVOs, members of such partnerships could jointly participate in the household surveys. Involvement of the nascent private sector PVOs in such endeavors would strengthen their planning skills, and facilitate planning with both public and private sector representation.

Possible activities: Mortality Survey and Surveillance, Integrated 100 household survey instrument, Verbal Case Review.

Phase V: *Community Partnerships for Health*

Depending on the success and level of development of the partnerships proposed in Option 1, Phase V would focus on either establishing or strengthening community level partnerships between health facilities (public, private PVO, traditional healers, TBAs and community organizations, including religious groups). The methodology used in Nigeria and the associated materials may be helpful, as would emerging experience from Zambia.

The methodology being developed in these countries follows eight steps:

1. Inventory and map health facilities and community-based organizations.
2. Develop criteria for optimal partnerships.
3. Invite potential partners to community-based forums.
4. Form partnerships.
5. Conduct action planning exercises.
6. Conduct capacity building exercises.
7. Develop interventions.
8. Implement interventions.

In some provinces, it might be necessary to perform full inventories of current health facilities and community based organizations, and to map their location, thereby facilitating the identification of potential partnerships. In others, it might be only necessary to supplement existing information, for example, add the traditional healers or community organizations. The number, size, and location of different organizations, along with their impact vis-a-vis utilization patterns or potential outreach would influence the selection of initial "model" partnerships.

The partnerships would vary in composition and interventions from community to community; hence, different partnership models could be examined and evaluated over time.

Such community partnerships could form the infrastructure for training, and outreach activities, as well as automatically linking facilities and communities in local area planning. Their input and relationship with the local health committees would need to be examined.

Phase VI: *Home Management of Childhood Illness: Training*

BASICS is developing materials for improving knowledge and skills in home management of childhood illness in Nigeria, Niger, Zambia and Ethiopia. These materials could be adapted for Mozambique, using findings from the community exercises regarding knowledge and practices. Each partnership would determine the best way to reach its members or clients with this information. BASICS would be responsible for developing the materials and curriculum, and providing TOT level training (to partners or to PVOs). Clearly, this training must be consistent with the IEC messages developed and disseminated through mass media. (The materials would also be used in health facilities to perform counseling and health education). Thus, the home management of illness messages/materials would be purveyed through at least 3 channels:

community partnerships, health providers in facilities, and selected mass media. One or more of the PVOs might assume the ongoing responsibility for TOTs in the future.

Specific possible activities during this phase include materials development, training of trainers, training of partners, and monitoring and evaluation of training.

In addition to the phases IV-VI outlined above, Option 2 would also include two additional activities:

Advocacy

The findings from the community exercises will be "packaged" for rapid assimilation and used to develop advocacy messages for local leaders. BASICS may work with the leaders to develop their skills to use such information for planning as well as advocating. (Bangladesh/Bolivia models)

BASICS might also provide URC with this information for use in their provincial and district planning/capacity building.

Workshops for Dissemination of Methods, Tools, Materials to Other Provinces/Donors

The methods and materials will be packaged for use by other provinces; BASICS might sponsor a workshop for other provinces and donors to share materials and experiences.

APPENDIX C: Technical Assistance Option 3-
Long-Term Strengthening of MCH/FP Services

Technical Assistance Option 3: Long-Term Strengthening of MCH / FP Services

This option builds on but looks beyond the assistance to IEC capacity development and fostering of community partnerships outlined in options 1 and 2. The activities proposed are seen as long-term, both in the sense of being longer-term priorities for the Mozambique health system and capacity, and of requiring a longer and more substantial level of effort to support. This option is seen as appropriate during approximately years 3-7 of BASICS' potential involvement in Mozambique (i.e. under BASICS 2), and is seen as requiring the in-country technical assistance of two full-time MCH experts.

Initially the focus of this strategy would be to increase outreach and quality of care in existing facilities through the community-facility partnerships noted under Option 2 above, coupled with targeted training and service improvements identified by provider/facility assessments (and 100 household survey). BASICS would assist the MOH and other donors in the identification of optimal sites for initial facility improvement, based on mapping and partnership activities. In other words, improved facilities (and new facilities) would be targeted for areas with active home based management outreach programs. Only when effective, accessible services are available, should the home management training begin to focus on signs requiring outside interventions, and where to go for that care. Effective referral can then be developed.

Facility-based assessments will be performed to direct training topics and interventions to improve quality of care. BASICS can provide IMCI training for the provider staff, and assist in the development of ongoing monitoring of care by introducing the facility quality review. The training might include both private and public sector providers. BASICS might work with other donors to develop a cadre of facilitators and trainers to continue such training, and expand to other provinces. Its district managers guidelines for IMCI could be adapted for Mozambique.

Health Facility Assessments

BASICS can adapt the current integrated facility assessment (Madagascar, Eritrea- public; Nigeria - private) for use in Mozambique. The assessment will also develop staff capability in the area of monitoring, and direct the development of quality interventions as well as focus training topics. It may be useful to expand the tool to include maternal health (as BASICS has done in Pakistan), given the Mission's emphasis on integration.

IMCI Training for Health Workers

Given the fact that most existing providers have limited formal education, the current IMCI curriculum may not be the most appropriate. However, Mozambique might benefit from a locally adapted version of the less reading dependant Complementary IMCI Course which BASICS is developing (World Ed).

BASICS might partner with other CAs such as URC and Pathfinder for this endeavor—providing these programs with the technical support to prepare for and perform such training. There would

need to be substantial planning and preparation with both the national and provincial government prior to embarking on such a course. Findings from the community exercises and surveys would provide valuable information for this decision.

Additional special sessions may be useful in IPC as well as health teams/outreach concepts to increase the ability of providers to work effectively as members of the partnerships.

Mid-Level MCH Centers

BASICS might pilot the development of a mid-level MCH Center, as a new component in the delivery system - between the rural hospitals and the current health centers. These centers would be the focus of reproductive and child health . . . and might become referral sites for TBAs. BASICS might collaborate with Pathfinder in the development of the training and working with TBAs.

These centers might also become the hub for IGP/skills development and maternal literacy programs (in which case BASICS would facilitate connections with other appropriate CAs).

EPI for Health Providers and Partnerships

The partnerships can be mobilized for EPI promotion, referral and assistance during NIDS. Immunizations can be included as another topic for the TOTs responsible for partnership home management training. These materials could be readily developed, and might be more appropriate to start with them, while the childhood illness materials are being developed.

Facility assessments would include cold chain and immunization practices - and training for health facility staff would be performed based on the findings.

This intervention could easily cross both child health and FP PVOs - so BASICS might work with other CAs to develop the training materials, and the methods for integrating immunizations into child survival and FP services now provided.

Immunizations would be a main component of the MCH Center activities.

REFERENCE NOTES

Meeting with Dr. Mondlane 6/27/96

In the meeting held with Dr. Mondlane he expressed his feeling that significant strides had been made in RESP under the leadership of Mr. Chalufu and with support from Dr. Romero. He stated that he hoped the BASICS teams recommendations would be an annex onto the gains already realized, rather than cutting off and starting from zero.

Dr. Mondlane suggested that there was a need to avoid verticality, that as services were increasingly integrated there was a need for an integrated approach in IEC. He further stated that this needed to focus on the people who don't have access to services, which he identified as the rural and peri-urban population.

He suggested that much of the rural population was more concentrated during the war and had acquired the habit of receiving health services, which they were now demanding be delivered to the rural areas. He stated that the MOH had attempted to respond with mobile brigades, which were recognized as not being able to provide the quality of service necessary, but was at least an attempt to respond to that demand.

Dr. Mondlane suggested that some of the IEC approaches taken by the MOH had been less than successful. He demonstrated a t-shirt designed to promote the use of bednets, which he felt did not deliver a clear message. He demonstrated a poster warning against the dangers of smoking and suggested that such posters have no effect. He suggested that whatever is done needs to be done locally and needs to reflect local reality. Songs, stories and comic strips, he stated, might be much more appropriate and capable of carrying a strong message. He said that traditionally songs were made up about people who were practicing socially unacceptable behavior, such as drunkenness, and sung without naming the person, but with the intent of changing their behavior. Musicians that were attempting to conserve the local musical traditions were another potential resource identified.

He suggested that a significant part of the population has radios and that this was another important IEC channel. He said that health education has to be done in the local language, and that this means more than just translation. He stated the need for production nuclei at the provincial level with people who know what are appropriate messages for a given population.

Dr. Mondlane said that he felt that RESP needed training-of-trainers experience to help them orient the people who are in service delivery. He also stated the need for additional operations research experience. He stated that in the past some people carried out KAP surveys, but their focus was on getting the results published, whereas the current focus is on application within the community.

Dr. Mondlane also stated that he felt that there had been a change in the working environment among the donors, and that they were working together and appeared less territorial.

Note to the file: ref. Trip to Mozambique by BASICS STTA David McCarthy 8/19-22/96

On Tuesday August 20, 1996 I met with Karen Nurick, Madupe Broderick, Armand Utshudi Lumba and Dr. Mussa Calu to provide them with copies of the draft report, discuss briefly its content, and discuss the concerns that had been expressed to them in their meeting with the MOH on August 1, 1996.

At 4:00 that afternoon I met again with the same USAID personnel Mr. Chalufu, head of RESP and Ms. Malanzela of his staff. After a brief introduction by Ms. Nurick, I gave a summary of the BASICS recommendations to Mr. Chalufu and suggested that we discuss any concerns either he or Dr. Mondlane might have regarding them. Unfortunately, though there was some discussion of the recommendations, much of what was said was shaped by the information that Ms. Nurick had shared earlier in the meeting, that URC had informed her Dr. Jose Romero would be undergoing eye surgery and be incapacitated for as long as two months. Much of the discussion was thus focused on how this might effect the RESP workplan, which led to a discussion of Mr. Chalufu's desire for a clearer understanding of what funds USAID was providing in support of RESP activities and the problems he had experienced accessing these funds. At Ms. Nurick's suggestion a second meeting was scheduled with Mr. Chalufu for the following day in his office at RESP.

On Wednesday August 21, 1996 I met with Mr. Chalufu in his office. Upon entering the RESP offices I encountered Dr. Romero, who informed me that his operation would be done on an outpatient basis and that he had been informed by his physician that it should not inhibit him from returning rapidly to work. After discussing briefly with Mr Chalufu the meeting of the previous day, and the agenda for the current meeting, it was agreed that Dr. Romero should join the meeting. We were later joined by Ms. Malanzela.

In the course of the meeting Mr. Chalufu emphasized that there were three principal RESP positions that he and Dr. Mondlane wanted to see reflected both in our report and our recommendations. These were:

The need for continuity with current efforts.

That they were not interested in pilot projects, that any effort undertaken needed to be both sustainable and replicable.

That any assistance provided needed to contain a strong component of counterpart training and skills transfer.

Under item one, it was expressed that the current RESP plan is consistent with long term MOH goals, and that any continuation of assistance or expansion upon that assistance should be within the existing context. This was a reiteration of the concern that had been expressed by Dr. Mondlane during the earlier BASICS visit that we had been sent to "amputate". There followed a discussion of concerns BASICS had expressed about the focus on building central level production capability as opposed to developing provincial or district level capacity. It was

recognized that the central level had a national responsibility and thus the need for a certain productive capacity, and that the experience of depending on collaboration from other public entities had not been positive. It was also recognized that some of the equipment currently being requested would be required to adequately support the proposed training and documentation efforts. It was further agreed however that the desire on the part of USAID to focus more on the province and district level was consistent with both the MOH policy of decentralization, and RESPs recognition that IEC needs to be able to respond to specific circumstances in the different districts and that this is not done well from a central perspective.

Under item two there was a more detailed discussion of what BASICS had in mind in recommending a concentrated effort in Zambezia, during which an attempt was made to try to distinguish this as more of a learning laboratory than a pilot project. Mr. Chalufu expressed the continuing concern that Zambezia was not representative due to the resources available which, he felt, would encourage focusing of training on the use of resources trainees would not encounter upon returning to their sites. It was recognized that this was a valid concern which needed to be addressed both in the design and execution of the training, but that this should not preclude Zambezia as a site since it was agreed that there were strong arguments that could be made in terms of infrastructure and a critical mass of possible participants from districts, PVOs, and cooperating institutions.

Under item three there was considerable discussion on two points. One, the need to go forward with a training package designed within the context provided by the Tool Box for Building Health Communication Capacity and secondly, Mr. Chalufu's expressed need that advisors assigned to work with him be available to accompany him on his work throughout the country, rather than being limited to visiting only those provinces where USAID is concentrating current efforts.

In discussions with the Ministry training has repeatedly been identified as a priority, though they recognize that their original proposal needs to be both scaled back, and modified to take full advantage of appropriate, locally available resources. BASICS sees this training as presenting several important opportunities. Though the RESP interest is primarily on capacity building within the unit, the training, if properly designed, can serve other equally important objectives. The process of training RESP staff in community level behavior analysis and message development can provide the basis for shifting the RESP focus away from providing posters to vertical program campaigns, and move it toward collaborative development of community based strategies. In the meeting with Mr. Chalufu it was agreed that PVOs and other cooperating agencies should be invited to participate both in the theoretical training and in the community level application. This should produce a variety of possibilities for joint efforts with those agents who should logically be RESPs future partners in such activities. The selection of participants might usefully be based on previous experience, giving priority to those PVOs, for example, that can bring relevant experience to the process. This should also be designed to move RESP staff quickly into the facilitator roles that will be necessary for continued replication of the process, using Mozambican human resources and drawing on Mozambican experiences.

The documentation of this process in a variety of ways, from case studies to video, could serve RESP well in the continued training of its own provincial staff, with district level personnel, and eventually in the formative institutions training future health workers. The same documentation of this process could also provide the building blocks required for the construction of a national IEC strategy. IEC has limited credibility (and thus clout) within the MOH precisely because it can't clearly demonstrate what it contributes to the Ministries efforts beyond graphic arts. The documentation of the training/ implementation experience should provide tangible products which can be demonstrated at the highest level within the MOH to justify political support for expanded IEC efforts.

Mr. Chalufu's second point under this topic, the need for advisors not to be limited to only a few specific provinces, seems not only reasonable, but also particularly advantageous at this point in time. Mr. Chalufu expressed the need largely in terms of skills transfer, having to respond to a nation-wide demand for his attention while his only technical assistance is, in his view, being limited to only dealing within three provinces. Given the appropriate advisor, responding to this request could prove quite advantageous. What is particularly important at this stage, is to be able to identify and document what are the most relevant IEC experiences in the country. Further on in the process, it is going to be important to be able to take advantage of targets of opportunity that present themselves to leverage other resources and replicate the positive experiences that emerge from the training . Given the above, and the fact that USAID does not yet appear to have finished defining where eventually it is going to want to work, the flexibility Mr. Chalufu is requesting seems eminently reasonable.

An important issue that has yet to be resolved is the relationship with the Instituto de Comunicacao Social (ICS). Each time this was mentioned during the current or the previous visit, the discussion seemed to get bogged down in negative history. The opportunities that Dr. Braun and I saw were dismissed, to some degree it appeared, because of Dr. Braun's involvement in the initial creation of ICS, and the supposed agreement of ICS support for health and education in exchange for UNICEF providing production capability. RESP has not found ICS particularly responsive to attempts to enlist their support in furthering specific efforts, and fears being put in the position where they are at the mercy of ICS's good graces to deliver a product. Under these conditions they obviously prefer building up their own in-house capability.

The inability to reach a shared vision thus far seems due to RESP seeing itself in terms of providing the MOH's institutional capability for materials production, where BASICS view, to the degree that it is articulated, sees RESP natural role as providing technical experience that leverages others productive capability. The lack of linkage arises because RESP doesn't see itself as having the technical expertise necessary to assume that role.

There are two cases with ICS that serve as excellent illustrations. As part of the recent negotiations under which ICS is again being provided with increased physical plant and production capability in Zambezia, they have incurred an obligation to dedicate a certain percentage of their efforts and air time to supporting initiatives related to health and education. This would seem to provide RESP with an excellent opportunity to assist ICS in meeting its obligation , and at the same time assure that its technical content and focus are incorporated into

ICS messages. Another example exists in Gaza, where ICS has the capability to broadcast in the local language, but has a lot more air time than content. At the time of the BASICS visit to Gaza in July, the radio station operated by ICS in Xai-Xai claimed to have had no contact with MOH staff, much less RESP, though their offices are on the other side of the same small town. Granted, a change assumes a different approach to what RESP is use to, but given the extent of the problems, and the resources that are likely to be available to the MOH, USAID should be doing everything possible to encourage this shift in approach.

I talked with Ms. Nurick by phone after the above mentioned meeting with Mr. Chalufu and Dr. Romero. She suggested again, as she had in the initial USAID meeting, that I identify what items in the existing RESP workplan seemed consistent for Dr. Romero to be working on in the remaining six months. I discussed this with Dr. Romero, who provided me with a copy of the current workplan, which unfortunately was not prepared in a form which readily identified the relative weight of the various activities, and did not contain much information directly related to the proposed training. Dr. Romero stated that he had other documents which provided a more complete description of the proposed training which, in our estimation is key to the strategy to be pursued in the next six months. Unfortunately, Dr. Romero was unable to provide these documents prior to my leaving the country. Given that the training that is planed is consistent with the Tool Box, I suggest that a tentative plan be drawn up taking the Mozambique context into consideration and forwarded to USAID and URC for discussion purposes.