A.I.D. EVALUATION SUMMARY - PART I

PD-ABA-387

04493

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS
2. USE LETTER QUALITY TYPE, NOT DOT MATRIX TYPE

IDENTIFICATION DATA

A. Reporting A.I.D. Unit:

Mission or AID/W Office AID/W S&T/H
(ES# _____)

B. Was Evaluation Scheduled In Current FY Annual Evaluation Plan?
Yes [XX] Slipped [ ] Ad Hoc [ ]
Evaluation Plan Submission Date: FY 88 Q 2

C. Evaluation Timing
Interim [XX] Final [ ]
Ex Post [ ] Other [ ]

D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated. If not applicable, list title and date of the evaluation report.)

Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
931-1018	HEALTHCOM	6-27-78	9-30-93	24,500	17,145,228

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director

Action(s) Required	Name of Officer Responsible for Action	Date Action to be Completed
1. Assessment of current project activities in four areas: community participation; use of face-to-face channels; private sector; and health communication training (formal or non-formal training of counterparts in elements of the HEALTHCOM methodology). This assessment will provide information toward the strengthening of these four program areas, critical to the project's long-term success.	CTO Robert Clay in coordination with contractor	7/89
2. Assessment of current methodology to determine whether it can be streamlined, including the research component.	"	12/89
3. Development of a long-term strategy for institutionalization.	"	12/89
4. Development of a distribution list for dissemination of reports with the goal of expanding distribution of HC documents in country.	"	7/89

(Attach extra sheet if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation: (Month) 2 (Day) 13 (Year) 89

G. Approvals of Evaluation Summary And Action Decisions:

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Name (Typed)	Robert Clay	Mark Rasmuson	Genease Pettigrew	Dr. Kenneth Bart
Signature	Robert Clay	M. Rasmuson	Genease Pettigrew	Kenneth Bart
Date	9/24/89	9-24-89	6-26-89	8/22/89

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

1. The Evaluation Team strongly recommends the continuation of the Project to a new phase, and hopes that the conclusions and suggestions in this Report will be considered when planning it. Because in developing countries there often is not an explicit national health communication policy, nor is there integration of a health education methodology in all primary health care programs, the need for the Project is urgent and vast.

2. The Team believes that the Mass Media and Health Practices (MMHP) and HEALTHCOM research experience to date provides a sufficient basis for beginning to streamline the Project's methodology for more immediate application to conditions in those developing countries where the Project operates at present, or will operate in the future. Therefore, it recommends a study to see if this is possible. Besides determining whether the methodology can be streamlined, the study should examine whether time for its application can be reduced, and the participation of host country professionals increased, so that they become self-reliant.

3. AED has faithfully executed the terms of the Contract. But Contract requirements seemingly have led HEALTHCOM to over-emphasize audience effects and to under-emphasize institutionalization. That is, due in part to the Contract's requirement of producing "significant changes in practices for a significant portion of the population" in too-brief time (two years), the Project has concentrated mostly on audiences, mass-media, and campaigns. However, after the initial demonstration effects, advisory services have been extended to 3-5 years in most countries, still too short a time. We recommend that it is now appropriate to move into a new phase which would stress simultaneous institutionalization efforts with audience-change activities over a more realistic 15-20 year period (in five-year contract segments).

COSTS

I. Evaluation Costs

1. Evaluation Team

Name	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. $)	Source of Funds
Dr. A. Horowitz	PAHO	38		AID/W
Dr. G. Hursh-César	Independent Consultant	36		
Dr. J. Pansini	Independent Consultant	38		
Dr. L. Wasserman	Independent Consultant	38	$85,000	

2. Mission/Office Professional Staff Person-Days (Estimate) _____

3. Borrower/Grantee Professional Staff Person-Days (Estimate) _____

b

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)
Address the following items:

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office:	Date This Summary Prepared:	Title And Date Of Full Evaluation Report:
AID/W S&T/H	3-5-89	2-89

PROJECT SUMMARY

The Contract between the U.S. Agency for International Development (A.I.D.) and the Academy for Educational Development (AED) for implementing the HEALTHCOM Project has been in operation since August 1985. AED manages the Project and has provided technical and financial assistance to 18 developing countries, including long-term assistance to 14 countries, using the specialized inputs of four subcontractors and various consultants.

HEALTHCOM is an initiative of the Office of Health and the Office of Education within AID's Bureau of Science and Technology. In most countries, it is jointly funded with USAID/Missions.

The main purpose of the approximately $19.5 million, five-year operational project (1985-90) is to complete the development and application of a health education methodology that has thus far evolved in two phases: Phase I (1978-1984), entitled the "Mass Media and Health Practices" (MM&HP) project, was largely the trial and development stage in two countries, The Gambia and Honduras: a research-and-action application of state-of-the art communication and social marketing methods to diarrheal disease programs. Phase II (1985-1990), the "Communication for Child Survival" (HEALTHCOM) Project has been the demonstration phase in up to 17 countries. A large percentage of its efforts has been spent in convincing MOHs, donors, NGOs and the private sector, through results-oriented programs, that communication is important in delivering child survival messages, and that it works to change awareness, knowledge and practices of mothers/caretakers. As such, it has emphasized mass media campaigns to reach large numbers of mothers quickly and has devoted proportionately fewer resources to the institutionalization process.

If the Project were extended, Phase III (1990-2000), "HEALTHCOM II" would reinforce and strengthen the sustainment of communication efforts as well as continue to build our technical understanding of communication. The project would try to improve the mix of mass and personal communication and improve the supply-demand balance of simultaneously institutionalizing at-home behavior and health provider capability.

In essence, HEALTHCOM intends to change behaviors resulting in more appropriate health practices to prolong life, prevent diseases, or treat them effectively and timely. Because the pace of formal education and cultural imitation as well as of economic development has been too slow to promote better health, the need for focusing directly on people and their behavior--particularly mothers, as agents of significant change--has become urgent.

EVALUATION METHODOLOGY

The evaluation was carried out in September-November 1988 by a team of four professionals with complementary experience in health, social and management sciences. The report addresses the priority questions posed to the Team it its Scope of Work by S&T/H and S&T/ED. The findings, conclusions and recommendations are organized around the following major headings:1. Methodology, Selection, and Evaluation 2. Sustainability and Institutionalization 3. Integration 4. Management and 5. Conclusions.

The method of evaluation is based on "observation and experience," meaning that what we heard in briefing sessions at AID S&T/H, S&T/ED, and at the Regional Bureaus, what we observed in the four countries visited--Honduras, Indonesia, Nigeria and the Philippines--and what we read in the very useful documentation of AED, was examined, organized and qualified by the Team on the basis of its collective professional experience. The Evaluation is retrospective and prospective; it looks at what has been accomplished in the last three years in terms of the Agreement, and to the immediate future, the remaining years of the current Contract, and beyond. But our collective mind is more often in the future, the direction in which activities should be moving apace to reach the stated goals.

RECOMMENDATIONS

With reference to Research and Development, the Team recommends more emphasis on the operational than on the research component of the Project and also suggests certain studies to shorten the time the Project needs to reach its goals. Furthermore, greater importance should be given to process indicators, stemming from effective monitoring of health education interventions, than to outcome indicators, i.e. morbidity and mortality rates. With regard to the latter, the Report contends that too many distinct variables may explain trends on infant and early childhood mortality, so that it becomes very difficult to identify the actual role of improved health practices resulting from the Project's activities. It suggests case fatality rates as a major criterion against which project success is measured.

On evaluation, the Report includes a series of recommendations to study low-cost and easily teachable alternative methods of data collection by community health workers.

With reference to Management, the Team believes that the present organizational structure in Washington and in the field is sound to carry out the Project's goals and objectives. However, if the Project methodology becomes streamlined and the institutionalization process strengthened, a different organizational arrangement should be examined.

In synthesis, the Team believes that the result of the Project would be--over a long period of time--to introduce and sustain a new communications "ethic" requiring innovative government and private sector commitments to improve health services that take greater account of the needs and circumstances of the public served. The contributions that HEALTHCOM has made to this process are highly significant. The clock cannot be turned back; the research-based use of mass and interpersonal communication media, combined with marketing principles, is a permanent, positive condition of the development process to improve health and prevent disease.

CONCLUSIONS

The audiences serviced first by the HEALTHCOM initiative are among the poorest and at greatest risk of death and disease. Changing behavior for better health practices is a complex, prolonged process--and all the more so in poverty-stricken communities lacking basic services and resources. The institutions the Project deals with are often poorly staffed, lack equipment, and have a low standing.

Audiences: The Project has developed a "home strategy" that tends to look past its client (the MOH) to concentrate mainly on its principal audience (mothers). As a result, simultaneous institutionalization efforts have been largely deferred.

Mass Media: The home strategy emphasis has resulted in a disproportionate use of, and allocation of funds to, mass media to reach large audiences, which has curtailed efforts to enhance face-to-face communication to translate media messages into daily uses of MOH staff and recipients.

Community Research: The home strategies have led to an undue emphasis on research and development. Still, operations research--i.e., looking for the most cost-effective alternatives to different components of the methodology has not yet been developed. We reiterate that the HEALTHCOM methodology is based on knowledge of health behavior which must be changed. However, we believe that this research should be developed to the extent that the knowledge is lacking and is necessary to design an effective communication strategy.

Outside Expertise: Although outside experts are necessary because the extensive use of the methodology is original and new in health education, its application has not given sufficient attention to upgrading national research and communication planning capabilities. From its earliest days in-country, HEALTHCOM should be working earnestly toward the time when technical assistance is no longer needed.

Campaigns: It is advisable to combine health education interventions in the established health infrastructure--including outreach to home--with campaigns that are highly visible, but that may have short-term effects on awareness and on behavioral changes.

On the basis of our experiences in four countries, we believe more caution should be taken by the Project to keep national and regional authorities duly informed about objectives, interventions and monitoring indicators in order to avoid the image of a foreign-financed and managed enterprise.

Integrating health education on the basis of the methodology into policies and plans of primary health care, reviewing the methodology to decide whether it can be streamlined, strengthening face-to-face communication, retraining health education staff, building MOH commitments, and other issues related to the Team's recommendations, should receive increased attention in the current as well as the future Project.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

EVALUATION DOCUMENT: HEALTHCOM Project Report of a Mid-Term Evaluation 2/89

COMMENTS

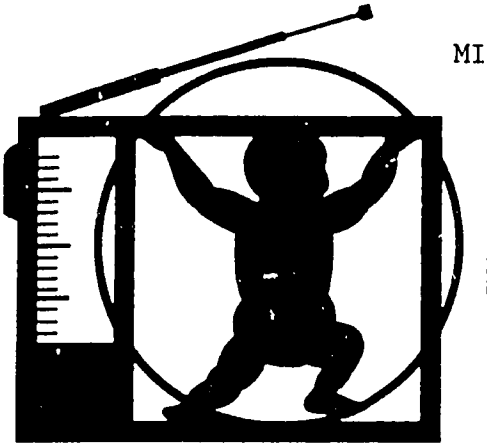
L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

1. Overall, the report is a very useful document to A.I.D. It is obvious that a great deal of careful thought has gone into the preparation of this report. The team asks some very provocative questions.

2. A.I.D. looks at this mid-term evaluation of the HEALTHCOM project as a catalyst for the strengthening of activities during the remaining contract period and for the maturation and refinement of the methodology in a new phase. It has helped us to formulate a framework for the design of communication activities in the next decade.

XD-ABA-387-A

64994



MID-TERM EVALUATION

OF

Communication for Child Survival

HEALTHCOM

Prepared for the
Agency for International Development
S&T/Office of Health

Office of International Health
Public Health Service
Department of Health and Human Services
Rockville, MD. 20857

MIDTERM EVALUATION

OF

HEALTHCOM

COMMUNICATION FOR CHILD SURVIVAL PROJECT

Cooperative Agreement No. DPE-1018-C-00-5063-00

Authors: Abraham Horwitz, M.D., Team Leader
Gerald Hursh-César, Ph.D.
J. Jude Pansini, Ph.D.
Lawrence Wasserman, Ph.D.

April 7, 1989

Evaluation conducted under Resources Support Services Agreement (RSSA) between the S&T/Office of Health and the PHS/Office of International Health. Report prepared by Devres, Inc., and submitted to the Office of International Health, under Contract No. 282-88-0009.

LIST OF ACRONYMS AND ABBREVIATIONS

A.E.D.	Academy for Educational Development
ACT	Applied Communication Technology
A.I.D.	Agency for International Development
ARI	Acute Respiratory Infections
CCCD	Combatting Communicable Childhood Diseases
CDD	Control of Diarrheal Disease
DES	Health Education Department (Spanish Acronym)
DHS	Demographic and Health Survey
EPI	Expanded Program of Immunization
ESF	Economic Support Fund
FHS	Family Health Services
ISTI	International Science and Technology Institute
IUC	International University Consortium
KAP	Knowledge, Attitudes and Practices
MMHP	Mass Media and Health Practices
MOH	Ministry of Health
MSH	Management Sciences for Health
NGOs	Non-Governmental Organizations
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PHC	Primary Health Care
PRITECH	Technology for Primary Health Care Project
PIHES	Public Information Health Education Services
PSC	Programme Support Communication
RA	Resident Advisor
REACH	Resources for Child Health Project
S&T	Bureau for Science and Technology
SOMARC	Social Marketing of Contraceptives
SOW	Scope of Work
SUPPORT	Supply, Production and Promotion of Oral Rehydration Salts Project
UNICEF	United Nations Children's Fund
WHO	World Health Organization

TABLE OF CONTENTS

	Page
LIST OF ACRONYMS AND ABBREVIATIONS	i
TABLE OF CONTENTS	iii
EXECUTIVE SUMMARY	1
A. Objectives	1
B. Methodology	2
C. Conclusions and Recommendations	3
INTRODUCTION: PURPOSE AND METHOD OF EVALUATION	9
A. Purpose	9
B. Organization	9
C. Method	9
D. Framework	10
E. Schedule	11
F. In-Country Contacts	12
I. METHODOLOGY, SELECTION, AND EVALUATION ISSUES	13
A. General	13
1. Contract Requirements	13
2. General Contract Performance	14
a. Development of Methodology	14
b. Appropriateness of Methodology	16
c. Use of Available Research	18
d. National Bases	19
e. Communication Methodology	20
3. Streamlining the HealthCom Methodology	23
4. Recommendations on the HealthCom Methodology	24

Page

B. Research and Development..... 25

1. Outcome Research..... 25

a. Data Context..... 25

b. Cause-Effect Attribution..... 26

2. Future Focus..... 26

a. Supply and Demand..... 26

b. Technology Transfer..... 28

c. Manuals on Research Methodology..... 28

d. Effect on Implementation of Health Behavioral Studies..... 29

3. Recommendations on Research and Development..... 31

C. Evaluation..... 32

II. SUSTAINABILITY..... 37

A. General..... 37

B. Financial Sustainability..... 37

C. Functional Sustainability..... 40

1. Developing a Systematic Planning Process..... 41

2. Integration of Program Elements..... 42

3. Regular Interaction and Coordination at MOH Level..... 42

4. Use of Ethnographic Research to Inform Plans and Strategies..... 42

5. Focused Instructional Goals Established around a Set of Specific Behavioral Objectives..... 42

6. Careful Testing of All Educational Materials..... 43

7. Regular Monitoring of Program Activities to Identify and Correct Problems..... 43

Page

D. Constraints 43

1. Prestige 43

2. Technical Assistance Availability 44

3. No Communication Slots or Budget Items 44

4. Paucity of Resources 44

5. Scarcity of Communication Expertise 44

E. Recommendations on Sustainability 44

F. The Private Sector 45

1. The Role of the Private Sector 46

2. Recommendations on the Private Sector 46

III. Integration 49

A. Working with Other Groups 49

B. Demand Creation/Supply and Training 54

C. Recommendations on Integration 57

IV. Management 59

A. Organizational Structure 59

B. Relationship to the Field 61

C. Financial matters 62

D. Recommendations on Management 63

V. Conclusions 65

ANNEX 1: SCOPE OF WORK 1-1

ANNEX 2: BIBLIOGRAPHY 2-1

ANNEX 3: LISTS OF PERSONS CONTACTED 3-1

EXECUTIVE SUMMARY

The Contract between the U.S. Agency for International Development (A.I.D.) and the Academy for Educational Development (AED) for implementing the HEALTHCOM Project has been in operation since August 1985. AED manages the Project and has provided technical and financial assistance to 18 developing countries, including long-term assistance to 14 countries, using the specialized inputs of four subcontractors and various consultants.

HEALTHCOM is an initiative of the Office of Health and the Office of Education within A.I.D.'s Bureau of Science and Technology. In most countries, it is jointly funded with AID/Missions.

A. Objectives

The main purpose of the approximately $19.5 million, five-year operational project (1985-90) is to complete the development and application of a health education methodology that has thus far evolved in two phases:

- Phase I (1978-1984), entitled the "Mass Media and Health Practices" (MMHP) project, was largely the trial and development stage in two countries, The Gambia and Honduras: a research-and-action application of state-of-the-art communication and social marketing methods to diarrheal disease programs; and

- Phase II (1985-1990), The "Communication for Child Survival" (HEALTHCOM) Project has been the demonstration phase in up to 17 countries. A large percentage of its efforts has been spent in convincing MOHs, donors, NGOs and the private sector, through results-oriented programs, that communication is important in delivering child survival messages, and that it works to change awareness, knowledge, and practices of mothers/caretakers. As such, it has emphasized mass media campaigns to reach large numbers of mothers quickly and has devoted proportionately fewer resources to the institutionalization process.

Phase III (1990-2000), if the Project were extended, "HEALTHCOM II" would reinforce and strengthen the sustainment of communication efforts as well as continue to build our technical understanding of communication. The project would try to improve the mix of mass and personal communication and improve the supply-demand balance of simultaneously institutionalizing at-home behavior and health provider capability.

In essence, HEALTHCOM intends to change behaviors resulting in more appropriate health practices to prolong life, prevent diseases, or treat them effectively and timely. Because the pace of formal

education and cultural imitation as well as of economic development has been too slow to promote better health, the need for focusing directly on people and their behavior--particularly mothers, as agents of significant change--has become urgent.

B. Methodology

By applying an original methodology that integrates anthropological, behavioral, and social marketing sciences and technologies, the Project aims at promoting and extending healthful practices mainly for CDD, EPI, and other primary health care problems.

The evaluation was carried out in September-November 1988 by a team of four professionals with complementary experience in health, social, and management sciences. The report addresses the priority questions posed to the team in its Scope of Work by S&T/H and S&T/ED (see Annex I). The findings, conclusions, and recommendations are organized around the following major headings:

I. Methodology, Selection, and Evaluation
II. Sustainability and Institutionalization
III. Integration
IV. Management
V. Conclusions

The method of evaluation is based on "observation and experience," meaning that what we heard in briefing sessions at A.I.D. S&T/H, S&T/ED, and at the Regional Bureaus, what we observed in the four countries visited--Honduras, Indonesia, Nigeria and the Philippines--and what we read in the very useful documentation of AED, was examined, organized, and qualified by the team on the basis of its collective professional experience.

The evaluation is retrospective and prospective; it looks at what has been accomplished in the last three years in terms of the Agreement, and to the immediate future, the remaining years of the current Contract, and beyond. But our collective mind is more often in the future, the direction in which activities should be moving apace to reach the stated goals.

HEALTHCOM is designed to help developing countries and AID/Missions increase the impact of their child survival programs through improved communication. It is part of A.I.D.'s overall strategy to reduce infant mortality, and it works with other A.I.D. Programs, such as PRITECH, SOMARC, CCCD, REACH, and the Agency's Child Survival Action Program. HEALTHCOM coordinates its efforts with international agencies, such as WHO and UNICEF, to improve consumer education and to promote the correct use of oral rehydration therapy (ORT), and expand immunizations and other child survival technologies.

C. Summary of Conclusions and Recommendations

Overall, in terms of contract requirements the Project is essentially on track toward its field-level objectives.

One conclusion and three recommendations stand out in the Report. A.I.D. should be commended for building into its Child Survival Policy an organized, long-term, cross-cultural approach to health communication and education. No other international agency has taken the initiative, nor invested the necessary funds, for such an important, bold undertaking.

The Evaluation team strongly recommends the continuation of the Project to a new phase, and hopes that the conclusions and suggestions in this Report will be considered when planning it. Because in developing countries there often is not an explicit national health communication policy, nor is there integration of a health education methodology in all primary health care programs, the need for the Project is urgent and vast. The team's conclusions and recommendations are summarized below:

1. Study of Streamlined Methodology

The team believes that the MMHP and HEALTHCOM research experience to date provides a sufficient basis for beginning to streamline the Project's methodology for more immediate application to conditions in those developing countries where the Project operates at present, or will operate in the future. Therefore, it recommends a study to see if this is possible. Besides determining whether the methodology can be streamlined, the study should examine whether time for its application can be reduced, and the participation of host country professionals increased, so that they become self-reliant.

2. Institutionalization

AED has faithfully executed the terms of the Contract. But Contract requirements seemingly have led HEALTHCOM to over-emphasize audience effects and to under-emphasize institutionalization. That is, due in part to the Contract's requirement of producing "significant changes in practices for a significant portion of the population" in too-brief time (two years), the Project has concentrated mostly on audiences, mass-media, and campaign. However, after the initial demonstration effects, advisory services have been extended to 3-5 years in most countries, still too short a time. We recommend that it is now appropriate to move into a new phase which would stress simultaneous institutionalization efforts with audience-change activities over a more realistic 15-20 year period (in five-year contract segments).

3. Methodology Questions

The Report includes a series of comments and poses various questions related to each stage of the methodology to be considered by A.I.D./AED. In the same order of ideas, other issues related to the team's recommendations do not have to wait for the potential next phase of the Project. Among them: integrating health education on the basis of the streamlined methodology into policies and plans of primary health care; strengthening face-to-face communications; retraining all health education staff; introducing the HEALTHCOM concept and approach to the teaching-learning process of graduates and undergraduates at schools of health sciences in universities and other centers of professional education; and building Government commitments, particularly those of the Ministries of Health, Education, and Finance.

4. Emphasis on Operational Component and Short-term Goals

With reference to Research and Development, the team recommends more emphasis on the operational than on the research component of the Project and also suggests certain studies to shorten the time the Project needs to reach its goals. Furthermore, greater importance should be given to process indicators, stemming from effective monitoring of health education interventions, than to outcome indicators, e.g., morbidity and mortality rates. With regard to the latter, the Report contends that too many distinct variables may explain trends on infant and early childhood mortality, so that it becomes very difficult to identify the actual role of improved health practices resulting from the Project's activities. It suggests case fatality rates as a major criterion against which project success is measured.

5. Low-cost, Teachable Data Collection

On Evaluation, besides the relationship between process and impact indicators already referred to, the Report includes a series of recommendations to study low-cost and easily teachable alternative methods of data collection by community health workers.

6. Documenting Process Indicators

The Project may be better able to register the degree to which the institutionalization of the communication methodology is taking hold by investing in documenting process indicators at the university and MOH-level of the type used by WHO for CDD programs.

7. Simple Terms

The team also recommends a simplification of terminology related to different components of the methodology because, at present, it impairs communication with health professionals in the countries.

8. Institutionalization

The Report refers to the most important aspects of the methodology to be institutionalized and the constraints for implementing this process. The team believes that the concepts underlying the HEALTHCOM strategy are well established and universally applicable. As such, more time and resources can and must be given to **institutionalization**.

9. Sustainability

The Report differentiates **financial** from **functional sustainability**--or continued investments and continued recipient benefits after the Project ends.

10. Incorporation in the Educational System

Furthermore, functional sustainability requires health professionals imbued in, and able to, teach the methodology, and requires that the latter is incorporated in the curricula of Schools of Health Sciences. In the long run, sustainability will be strengthened when the formal system of education for Grade- and High-School students incorporates health issues and methods to deal with them, such as healthful behavior and practices.

Ideally, both financial and functional sustainability must be planned with the Government and the private sector from the beginning of each program to ensure its progressive application. On the other hand, both are essential for the institutionalization of modern, planned and monitored health education.

11. Reconciliation with Policy

While HEALTHCOM is innovation and demonstration and, thus, may sometimes be ahead of policy, its processes and effects eventually must reconcile with policy and be assimilated into host institutions. It cannot remain ahead of the curve if it cannot adjust the shape of the curve. Except as there is value in disseminating instructive case studies, what good is an effective five-year Project if it cannot ensure that goals reached are to remain? The need for planning sustainability and institutionalization early in each project is very important.

The private sector, both for profit and not for profit, is singled out by the team because of its importance in social marketing in the supply and in the demand side of the equation, and because of its role in the sustainability and institutionalization of modern health education. The team strongly believes that in the countries visited--and perhaps in all of the countries included in the Project--the private sector has not been explored in all its potential contribution for implementing the methodology in CDD/ORT, EPI, ARI, and

eventually in other health problems included in the Contract. To this end, the Report includes several recommendations.

12. Relations with International Organizations

In the chapter on Integration and, specifically, Working with other Groups, the Report states that relations with international organizations, multilateral and bilateral, private and public, have not sufficiently been developed, particularly at the country-level. And they should, because even the present order of investments will become more productive and benefit more people in need of healthful practices. This requires a deliberate effort on the part of the Project's staff in Washington and in the field. Recommendations to this effect are included in the Report.

13. Flexible Networks

The Evaluation team recommends improved networking among A.I.D. Projects having common goals and being interested in interchanging information, examining issues of relevance, designing effective solutions, and joining efforts with Governments to implement them. Networks are made by genuine peers ready to examine problems of importance to all members and share responsibilities. No rigid pyramidal structures with a complex administration, are needed. Some networking has taken place but it should continue and be strengthened.

14. On-going review

For the remaining life of the Project--and a future one if so decided--it is advisable to review in-depth the need, roles, and responsibilities of subcontractors and consultants, taking into account lessons learned until now.

15. Planning

In order to harmonize the relations between supply and demand for each health problem selected by the government, the team recommends that the MOH, with assistance from HEALTHCOM, and other projects as appropriate, develop a more systematic planning process, including detailed logistics, to ensure that products, either free or at an affordable price, are available at announced places to respond to educational promotion.

Systematic planning will also improve monitoring and evaluation of the Project's interventions and the quality of information between AED/Washington and the field. It will also lead to programming by objectives commensurate with resources and budgeting by programs, thus making the best use of the Project's financial investments. Systematic plans should serve as the basis for evaluating financial accountability as well as the Resident Advisors' management skills for implementing projects. The HEALTHCOM implementation plans and their budgets do not facilitate this exercise.

16. Management

With reference to Management, the team believes that the present organizational structure in Washington and in the field is sound to carry out the Project's goals and objectives. However, if the Project methodology becomes streamlined and the institutionalization process strengthened, a different organizational arrangement should be examined.

17. Regional Workshops and Project Visits

In order to strengthen the relationships between HEALTHCOM/Washington and the field, the team recommends that there be more regional workshops for the interchange of experiences, analysis of common problems and their potential solutions. Visits of national counterparts and Resident Advisors to different projects are highly advisable.

In synthesis, the team believes that the result of the Project would be--over a long period of time--to introduce and sustain a new communications "ethic" requiring innovative government and private sector commitments to improve health services that take greater account of the needs and circumstances of the public served. The contributions that HEALTHCOM has made to this process are highly significant. The clock cannot be turned back; the research-based use of mass and interpersonal communication media, combined with marketing principles, is a permanent, positive condition of the development process to improve health and prevent disease.

The team reiterates that the findings and recommendations in this Report do not alter the basic intent of the Project, while suggesting: (1) a new framework for reviewing the terms and conditions of the Contract that have driven the Project for (2) the purpose of timely development of a more simplified operational version as (3) a surer basis for a third, expanded phase of application.

INTRODUCTION: PURPOSE AND METHOD OF EVALUATION

A. Purpose of This Report

This is the report of a mid-term evaluation of the U.S. Agency for International Development's (A.I.D.) health communication project, HEALTHCOM; hereinafter, Project. The Project, presently active in 13 countries, is managed by the Office of Health with assistance from the Office of Education, Bureau for Science and Technology (S&T).

The Project is conducted by the Academy for Educational Development (AED) and a team of four subcontractors: University of Pennsylvania, Applied Communication Technology, Porter Novelli, and PATH, as well as various consultants.

The main purpose of the approximately $19.5 million, five-year operational project (1985-90) is to complete the development and application of a health education methodology that was the product of an earlier five-year research phase, known as the Mass Media and Health Practices (MMHP) project. The earlier phase was undertaken to apply state-of-the-art communication and social marketing principles and practices to selected child survival programs.

The overarching, long-term goal of the HEALTHCOM Project is to change the health behaviors of a critical mass of persons in communities of the developing world, so that more children survive infancy and childhood. This is, of course, a most difficult and complex undertaking.

The retrospective and prospective purposes of this mid-term evaluation of the second phase of the Project are to: (1) assess its achievements; (2) recommend actions to strengthen it; and as possible, (3) recommend future priorities and activities for health communication assistance.

B. Organization of The Evaluation

The evaluation's findings, conclusions, and recommendations are organized below around the categories of:

I. Methodology, Selection, and Evaluation
II. Sustainability and Institutionalization
III. Integration
IV. Management
V. Conclusions

C. Method of Evaluation

The HEALTHCOM evaluation was carried out in September-November 1988 by a team of four professionals. The evaluation was undertaken to address 19 priority questions posed to the team in its Scope of Work by S&T/H and S&T/ED (See Annex I, Scope of Work.) The findings and

Previous Page Blank

recommendations for the 19 questions posed are presented in Sections I-IV. Conclusions are included in Section V. Our method of evaluation was "observation and experience"--meaning that the team reached its conclusions mostly by relating limited, first-hand information to its collective professional experience.

D. Framework of the Evaluation

For years, there has been discussion among health professionals as to whether health education can be planned as any other specific health activity. The team is convinced that the HEALTHCOM methodology has brought the distinct possibility of planning health communication in a systematic way. Accordingly, the Project was evaluated at mid-term using an experiential framework to address A.I.D.'s 20 questions with principles and criteria of development-assistance planning and management. As such, the framework emphasized the need (1) to coordinate the communication approach with national policy; and (2) to plan communication in relation to other program components at all stages of programming. Some of the principles used by the team in its analysis include the following:

1. Consistent with National Policy: Project communication is consistent with Government policy. If policy cannot be modified, communication activities either support it or Project objectives and activities are redirected.

2. Maximizing Technology Transfer: Project activities are planned and carried out in a way that maximizes Ministry of Health (MOH) and private sector participation and, thus, promotes more rapid, comprehensive transfer of skills--e.g., in research, material design, communication planning, service provider training.

3. Partnership: The Project is structured and staffed in a way that promotes active, timely, continuing engagement of MOH partners in project-related planning, field preparation, training, communication delivery, and analysis.

4. Resources: Resources are managed in a way that (a) defines objectives commensurate with resources; and (b) stimulates partners' contributions and facilitates phased absorption by public and private institutions.

5. Coordination: Communication activities do not stand alone, but are driven by the same objectives of the overall national health intervention strategy and are carried out as an integral part of it.

6. Motivating Service Providers: Professional and non-professional health service providers are both the client and among the target audiences for Project communication. Thus, changes in the motivation and skills of service providers at all levels are an important communication objective.

7. Tailored to Audience and Client Needs: As consistent with Government policy, Project communication is tailored to client and target audience needs, preferences, and circumstances.

8. Communication Balance: The "mix" of mass and interpersonal communication media has real potential to be sustained in the wake of the Project's phase-out.

9. Research: Communication approach, design, and materials are based on systematic research before (during and after) the intervention, and are planned with indicators of changes in awareness, beliefs, and behavior that can be readily monitored and evaluated.

10. Management: The Project must be efficiently managed, utilizing available resources and applying a systematic planning approach.

Because our primary concern is for replication and continuation of the communication methodology, the above principles give importance to Government policy and programming coordination, involvement and training of health professionals and para-professionals, and technology transfer across-the board, because the supply-demand equation in social marketing is difficult to implement. The principles emphasize the dynamics of institutionalization to ensure the sustainability of the Project. However, the purpose of these principles is not to promote that which is staid and conventional over that which is creative and new. Rather, they emphasize a (sometimes protracted) process of negotiation between the creative communicator and the policies of the clients for whom we undertake communication.

E. Schedule of Evaluation Activities:

Activities and time were allocated as follows:

Week 1: Washington Area: Two days in a team-building exercise; three days in a series of meetings with representatives of A.I.D. Central S&T Bureau, Regional Bureaus, AED, subcontractors, and other A.I.D.-funded projects.

Week 2-4: Site Visits: The team divided: Week 2-3: two members to the Project in Honduras and two to the Philippines; Week 3-4: two members to the Project in Nigeria and two to Indonesia.

Week 5-7: Washington: Team reassembled: Week 5 devoted to team reporting, discussion, analysis, and consensus; Week 5-6 devoted to report writing. Week 7 devoted to report revision and production.

Week 10-12: Team reassembled to discuss A.I.D.'s comments on its Draft Report, and to revise the document as appropriate.

F. In-Country Contacts

In-country respondents included national, regional, and/or state-level representatives of the Project, Ministry of Health and other Government offices (e.g. National Television Authority, Ministry of Education, State Controller), A.I.D., UNICEF, WHO, PAHO, various non-governmental organizations (NGOs) (e.g., Helen Keller Foundation, Philippines Pediatrics Society, University of Ibadan), commercial advertising agencies (e.g., Philippines Advertising Corporation), private research companies, (e.g., Consumer Pulse, Inc.) as well as other U.S. and A.I.D. development projects, such as Combatting Communicable Childhood Diseases (CCCD), PRITECH, Family Health Services (FHS), and others.

Findings and recommendations are mostly the products of the collective program, research, and communication field experience of four senior professionals. We believe that the results of this evaluation are most useful for suggesting activities during the remaining period of the Project and for future directions of a third phase of the Project, should A.I.D. take that decision.

The next five sections give the findings, recommendations, and conclusions for A.I.D.'s priority questions across the five categories described on page 1.

In examining the Scope of Work in depth, (Annex 1) and each of the questions therein, we focused on improvements for the remainder of the Project period and, should A.I.D. decide to undertake a new venture, a future phase of the Project. In doing so, many impressive features of HEALTHCOM conceptualization and implementation have been observed.

The research and communication components of the HEALTHCOM methodology were the most heavily emphasized subjects of the series of orientation meetings prior to our field visits. Therefore, these activities are stressed in this report.

I. METHODOLOGY, SELECTION, AND EVALUATION ISSUES

A. General

Q #1. **Given the primary purpose of the HEALTHCOM Project, is the Project meeting its stated goals and objectives?**

This section presents a general review of the Project activities and progress. In reaching their conclusions, the team wishes to commend AED Project managers for the open, frank candor with which they gave their views of HEALTHCOM strengths and weaknesses. Overall, in terms of contract requirements the Project is essentially on track toward its field-level objectives.

1. Contract Requirements

The HEALTHCOM goal is to improve the health practices of a critical mass of mothers in all communities in a way (a) that enables them to continue these practices after the intervention period, and (b) that leads to the reduction of child mortality.

The methodology relies on the development, testing, and monitoring of products, messages, strategies, and materials in relationship to the analysis of community-level behavior.

The objectives of the Contract are that the Project's methodology be further developed, adapted to new conditions, institutionally supported at existing project sites, and diffused to other countries during the life of the Project.

- Complete development and application: Apply the methodology to a broad range of child survival programs.
- Complete Integration: Incorporate product promotion and consumer education, aimed at changing behavior, into the methodology.
- Expand Applicability: Use at approximately 10 new sites representing different institutional and technological conditions.
- Institutionalize: To support institutionalization of the methodology at all project sites insofar as possible.
- Diffusion: Spread knowledge and use of the methodology to other A.I.D. projects, U.S. academics and practitioners, and the donor community.

To meet the objectives, the Project is divided into three components: health practice studies, institutional studies, and diffusion activities.

2. General contract performance

a. Development of Methodology

Intended to span a broad range of child survival problems, the bulk of Project interventions in its first operational stage are confined to immunization programming (hereinafter, EPI) and diarrhea control (CDD)/oral rehydration therapy (ORT), with related aspects of nutrition and breastfeeding as part of CDD. A few projects have begun, or plan, to address acute respiratory infections (ARI), child spacing, personal hygiene, vitamin A, water and sanitation, and vector-borne diseases.

The methodology developed by AED is in place. It consists of the following components executed roughly in the following order:

- Formative research
- Instructional and operational designs
- Testing of strategies and materials
- Social marketing plan:
  - mass media
  - printed materials
  - face-to-face instruction and communication
- Implementation
- Monitoring
- Evaluation

Among research activities, the contract requires AED to complete 10 health practice/behavioral studies in the course of adapting the HEALTHCOM model at existing and new sites. To date, three have been done; others are being planned.

In Honduras, Indonesia, Nigeria, and the Philippines, the methodology has not yet been applied to many of the possible range of interventions outlined in the contract. This is understandable, especially for Nigeria and the Philippines, where the program was implemented less than two years ago. Given the 10-year pioneer role of Honduras in developing the methodology for health interventions, its limited use of specific interventions is also understandable. However, formative research and pilot studies have been carried out for ARI and current plans call for nutrition as the next area for application of the HEALTHCOM methodology. In Yemen, Jordan, and Papua New Guinea the Project is only beginning.

- Complete Integration

  Overall, the Project is succeeding in incorporating product promotion and consumer education into the HEALTHCOM methodology, but it is less successful in integrating health education interventions, based on the methodology, into

primary health care programs. The Philippines offers a good example of the Project's reach to the private sector in using local advertising/marketing and research firms, and in trying to involve pharmaceutical manufacturers in oral rehydration salts (ORS) production and distribution.

- Expand Applicability

The Project is intended to work at approximately 10 new sites representing different institutional and/or technological conditions, such as in the poorest countries without a significant health services infrastructure; in countries where the ownership/use of TV is relatively widespread; and in countries where the private sector is significantly involved in health care. The Project is presently working in 13 countries.

- Institutionalization

The contract stresses the importance of institutionalizing the HEALTHCOM methodology within collaborating institutions through in-service training programs, improved operational and management procedures, staffing, budget allocations and long-range planning.

The team sees this as an area where the Project needs greater attention in terms of the optimum balance of activities and resources. (See Chapter II.) However, the contract's emphasis on demonstrating audience effects derives from the need to convince MOHs, donors, NGOs and the private sector, through results-oriented programs, that communication is important in delivering child survival messages. The team recommends that for the remainder of the contract and for a potential follow-on project, more time and resources be given to the institutionalization process. Plans and efforts should be directed not only toward the government collaborating institutions, but also toward NGOs, educational institutions, and the private sector.

The contract also calls for close coordination between other A.I.D. funded health projects--e.g., the A.I.D./CDC African Regional Bureau's Combatting Childhood Communicable Diseases (CCCD), S&T's Technology for Primary Care (PRITECH), and S&T's Social Marketing of Contraceptives (SOMARC).

Coordination is also called for with WHO and UNICEF--for a time, the latter was funded by an A.I.D. grant to assist HEALTHCOM related activities in Nigeria. As will be seen in the section in "Integration," close cooperation with donors and with other projects is sometimes lacking--in different degrees, in different countries--although cooperation among A.I.D.-funded projects is generally better than between HEALTHCOM and other major donors at the field level. (See Chapter III.)

o Diffusion/Dissemination

The Project has produced approximately 100,000 pages of text and three videotapes for dissemination purposes. Its bibliography is impressive, although most products are AED papers and only a few are professional journal articles.

Given its stage of development in different countries, it is close to the mark in meeting A.I.D. reporting requirements for, e.g., Semi-Annual and Annual Reports, Implementation Plans, Evaluation Plans, Special Reports, and Field Notes. Special reports on the Technical Advisory Group meetings and on "Institutionalizing a Methodology for Public Health Communication" are especially thoughtful.

However, in-country diffusion activities are underemphasized in the Contract (which targets U.S. and donor audiences) and have no budget support in country programming. Consequently, we found little knowledge of HEALTHCOM activities or products among other A.I.D. projects or in government ministries, universities, or commercial and non-profit and private voluntary organization. In particular, the failure of research study reports to reach the desks of MOH health education counterparts and service offices was a disappointing finding. Moreover, the team did not find in-country key audience lists or dissemination plans. The team is concerned that reports do not reach all national institutions in some of the countries visited.

Diffusion can be an expensive operation, but it is essential that HEALTHCOM outputs be disseminated, since health communication is a relatively new strategy in child survival. The team recommends that AED consider expanding its distribution lists for publication and reports to national and international institutions, and that a budget for such dissemination be considered by A.I.D.

b. Appropriateness of Methodology to Goals and Objectives of the Project

Q #2. **Is the communication methodology developed by the Project appropriate for the goals and objectives of the Project?**

As it has been implemented, the Project's methodology is generally appropriate for meeting community-level objectives, and less so for meeting institutional objectives (see Chapter II).

The team believes that AED has faithfully executed the terms of the Contract, taking into account the long-term iterative process of trying to bring changes in government institutions as well as in the health practices of the poorer segments of developing nations. However, the Contract requirements and AED's

strong commitment to health-practice improvement have seemingly led to over-emphasis on rapid and wide-scale audience effects and under-emphasis on institution- and skill-building. Specifically, the Contract states:

- Integration

  Section C.3.2.(d) stipulates that Project performance will, following start-up, promote the adoption of various health practices "over an approximately two-year period at each site. Significant changes in practices for a significant portion of the population as judged by public health standards is expected from these interventions."

- Expand Applicability

  Section C.3.2.(b) and (c) require plans for institutionalizing HEALTHCOM methodology, and accepts a definition of institutionalization as referring "only to the ability of a host country institution or set of institutions to apply the project methodology in an on-going way, as part of the normal routine of how it (or they) conduct public health education."

- Institutionalization

  Acceptable institutionalization criteria include evidence of personnel training, changes in job descriptions and routine procedures, and indefinite modification of management expectations (policy, plans, etc.). The contract provides for other criteria as well as for a case study evaluation of institutionalization efforts.

- Diffusion/Dissemination

  Despite these intentions--which have concerned the Technical Advisory Group and have been the subject of AED papers (see Bibliography, Annex 2) --our findings suggest that the probable effect of the two-year time limit for producing significant behavioral changes among significant populations (e.g., 60%-90% effects) has driven the Project to develop communication strategies ahead of the capability of governments to carry them out.

  Of course, the opposite may also occur: when Project demonstration areas are being expanded by the Government (as in Indonesia) to larger regions in advance of its own technical capacity to absorb the HEALTHCOM methodology.

  The large-scale use of mass media supplemented by interpersonal health communication is a significant milestone in health development assistance. There have been many successful educational/behavior modification media (mostly radio) programs for limited area audiences, but no program

has ever attempted to develop the use of mass media for health behavior modifications on such massive (national) proportions.

- Qualifications of the Resident Advisors

To add to the uniqueness of the Project and the competence of its implementation, the professional calibre of Resident Advisors (RA) is unusually good. In the four countries visited, the RA's are notably well-trained, knowledgeable of the culture, and work conscientiously and productively. This is an essential ingredient to the potential success of the Project. AED's selection and training of RAs has been an important contribution to HEALTHCOM's general quality. However, the team believes that greater use could be made of national professionals for other Project activities (see Chapter II).

c. Use of Available Research

HEALTHCOM documents and reports largely omit reference to the rich literature on the effective use of mass and interpersonal communication both in education and development activities in industrialized and non-industrialized settings. The omission seems to give a "newness" to the methodology, at least in the field of health education. As such, the emphasis on research may be slowing its application to different socio-cultural regions within countries as well as from one country to the next.

HEALTHCOM staff might find the perceived cross-cultural barriers to a more quickly paced Project application to be somewhat less formidable, by developing project guidance based on the histories of the following:

- The work in the 1940s-60s of the Canadian Broadcasting Corporation (CBC) in developing the prototype for radio education supplemented by print and interpersonal communication.

- The work in the 1950s-60s of All-India Radio (AIR) in applying CBC principles to Radio Farm Forum development programming and to television and classroom instruction. And then, AIR's development of the Satellite Instructional Television Experiment (SITE).

- The work of the Escuelas Radiofonicas in Guatemala during the 1960's-1980's.

- A.I.D.'s own cross-cultural "Diffusion of Innovations" project (Brazil, India, and Nigeria) during the 1960s-70s, which abstracted principles of, especially, radio education (e.g., the Radio Development Forum) supplemented by animators and by group discussion among village leaders, farmers, women, clergy, etc.

- More contemporary data on cross-cultural field research and programming experience can be supplied now, for example, by UNICEF's Programme Support Communication (PSC) activities in numerous radio broadcast zones of India. This particular activity makes extensive and rapid, effective use of local residents and research to develop broadcasting and village discussion-group materials.

- Further, many of the principles of mass-mediated (particularly television) Distance Learning have been provided, tested, and applied over many years in Britain by the Open University program and in the United States by the International University Consortium (IUC) at the University of Maryland. Altogether, there are some 600 distance-learning programs around the globe, many in developing countries.

In sum, the team thinks that mining the rich vein of relevant, useful data on complementary mass/interpersonal media-use and publishing a practical lessons-learned guide would assist in-country managers in focusing and streamlining HEALTHCOM's planning and application.

d. National Bases

In its earliest stages, the Project needs expatriate expertise. The length of their stay will vary by country and intervention. What is too much reliance in one situation may not be in another. However, it is important to emphasize that over-reliance may hinder institutionalization which depends, primarily, on national professionals.

One common problem that can occur in the use of expatriate consultants in any project is that misperceptions may arise among national MOH officers, project staff, and others regarding the actual need for these outside experts. In the Philippines and Nigeria, for example, the team was informed about misunderstandings and some resentment on the use of HEALTHCOM subcontractors, Porter-Novelli and Annenberg in the Philippines, and Annenberg in Nigeria. In the first case, staff of the local advertising and research companies felt that the subcontractors had nothing new to offer the Filipino firms, and that the subcontractors were confused about their own assignments. In the second case, Nigeria MOH and Project staff felt that the subcontractors had been brought in unnecessarily to conduct training that the local staff was capable of conducting. We were informed by HEALTHCOM/Washington that the two consultants did not present the methodology but behavioral health education methods in the Training of Trainers Workshop.

In neither case is there a question of right or wrong, but a matter of incomplete communication about the nature of the assignments and, thus, different perceptions about whom should do what, and why. In both countries, HEALTHCOM had assessed local capabilities and

determined that their subcontractors were needed. The general lesson for all is to take great care to fully communicate to MOH contacts and Project staff the nature of the problem to be addressed and expatriates' roles.

Moreover, experience shows that the advertising, marketing, and consumer research industries are highly developed in most Latin American countries. When such experts are needed, it might be better to find more of them regionally, with the understanding that short-term technical assistance may still be required at times to ensure a full understanding of the Project's methodology and objectives.

It is likely that such national professionals are also available in other HEALTHCOM countries. For example, the Annenberg team in particular could probably find local counterparts to assist in carrying out their KAP survey operation and analysis. It seems safe to assume that many national professionals are familiar with the multiple cultural settings of their countries and are, therefore, able to guide program designs, and/or are capable of obtaining additional information as needed at a fraction of the cost and effort of most expatriates.

Each subcontractor/consultant's Scope of Work should require identification of local counterparts with a schedule of skill-building objectives, as necessary. It is imperative for the longer-term success of the Project that nationals be identified and used, not just for cost considerations, but because (1) skill-transfer activities should begin in the earliest phase of any project; and (2) they stand at a shorter social distance from the beneficiary. Other factors being comparable, the shorter the perceptual distance between planner, service provider, and beneficiary, the better the chance for institutionalization and field-level success.

e. Communication Methodology

Q #3. **Is the Project methodology utilizing the best communication mix for reaching its target audiences? In other words, is there an appropriate balance between radio/TV, print, and face-to-face communication?**

i. Limited Face-to-face Communication

The question above needs to be asked for each country. In the few countries visited, the mixes vary as noted below:

- In Honduras, the best-known example, emphasis is given to radio (TV to a lesser extent). The Project has developed good supplemental print materials. However, its face-to-face approach needs more emphasis.

- In the Philippines, the first media campaign for EPI in the Manila metropolitan area allocated its media budget: 65% television, 30% radio, and 5% print. Television has near-universal coverage in the metro zone, and a highly

attentive viewing audience. Radio is a better selection than print, according to Project staff and advertising officials, because Filipinos are not a "reading public."

Future print materials are intended to make most use of comic books, which are popular. Little is planned for newspapers or general magazines, but more is planned for village outdoor posters and for clinic and retail display material. While some training occurs, face-to-face communication is generally weak.

- In Nigeria, radio is being planned for extensive use. It has about three times the reach of television nationally, and UNICEF is doing considerable television work. The project is creating Child Survival Units in national and state-level broadcast facilities to integrate messages on ORT, EPI, ARI, hygiene, etc. into dramatic and documentary programming. Print materials consist to-date of an EPI flipchart and supporting posters. The flipchart has been used in training workshops and has been distributed to some 800 service providers. A training manual has been developed, but the face-to-face component is still under-emphasized.

- In Indonesia, Vitamin A and ORT Programs, radio messages, banners, printed materials and face-to-face encounters through training of health educators (Kaders) and mothers' visits to health posts are in operation.

- In Lesotho, there is no television service. To guide selection among alternative media, a study of radio listenership and newspaper readership is presently being conducted by an outside source. The project plans fairly broad use of social mobilization techniques and health provider training, which presumably implies strong face-to-face emphasis.

- In Jordan, 70% of the population is urban and television's reach is everywhere. TV will be supplemented by radio and by personal sermons and speeches by religious leaders. Newspapers will be used little, and most print materials are leaflets and posters.

HEALTHCOM has done very well in selecting mass media in accord with local facilities and tastes. Probably research has been done in some HEALTHCOM countries on the varying credibility of media sources and/or authoritativeness of prominent persons, there was no evidence in the four countries visited. In them, each communication strategy appeared to have stronger mass media components than face-to-face communication in staff training and in village-level delivery. However, the team observed two instances in which face-to-face activities were an integral part of the communication strategy:

- In Indonesia, the face-to-face component was strongest--with over 15,000 kaders trained and 20,000 sets of counseling

cards have been developed for village volunteers to use with mothers.

- In Nigeria, the Niger State pilot project has radio broadcasting as its centerpiece, and a face-to-face health education component built around some 600 flipcharts on immunization benefits. In the single village situation observed, the flipcharts were effectively used by the health educators in a session with about 50 mothers.

In all four countries visited, nevertheless, none of the face-to-face strategies provided for re-training visits, monitoring of field delivery, or remedial in-service guidance. Although it can be argued that such follow-up activities are the responsibility of the MOH, the team believes (1) that any interpersonal communication/training component is incomplete without follow-up assurance of field effectiveness; and (2) that any communication activity should be planned for devolution to the MOHs concerned--if the MOH is not going to commit to the continuation of a given activity, then more feasible alternatives should be considered.

Further, the team believes that HEALTHCOM and any other communication strategy must look beyond outputs (e.g. number of Kaders trained, number of counseling cards produced) to the outcomes of communication components: to the effectiveness of training, etc. on staff performance and on mothers' behavior in home-health management. For example, print materials (e.g. flipcharts, counseling cards) have long been used in development assistance to effect behavioral change; and AED has set many of the standards of excellence. For use primarily among semi- and non- literate people, the potential for success of print materials depends almost totally on the person who uses them--from physician to village volunteer. Regardless of how much research has gone into their preparation, print media alone are not likely to be successful in helping to modify behavior in any permanent way. For example, studies of radio-only versus radio with supplementary interpersonal communication routinely show the latter to be much more effective than the former in changing audience behavior.

Even in the case of ORT, when national policies have a great influence on the design of marketing and advertising strategies, the media messages are important to help mothers take the first step toward healthful practices, including going to the clinic. Interpersonal reinforcements are essential to the second step of mastering and continuing good practices. Whether in packet or SSW forms, proper mixing and use of ORS is not likely to be learned by a critical audience mass from the media alone.

ii. Campaigns

While the HEALTHCOM strategy is programmatic and long-term, we nonetheless observed "one-time" immunization campaigns in the Philippines (90 days), and Honduras. From Project materials and conversations with HEALTHCOM staff, it is known that short-lived educational campaigns are not their preferred strategy.

Apparently, conditions in different countries became such that different Project teams found it necessary to try to convince MOH and other skeptics of the potential significance of communication in effecting changes in health practices. This was, indeed, the case in the Philippines. Of course, such demonstration may be persuasive, and thus momentarily useful, but brief campaigns generally do not advance the institutionalization of the methodology, thus the sustainability of benefits. Changes in awareness do occur and temporary behavioral changes often occur as well. But behavioral change rates--if there is no systemic improvement in health delivery capabilities--are likely to regress to previous levels in the quiescent post-campaign period, as happened in the Philippines as the mass media activities subsided.

3. Streamlining the HEALTHCOM Methodology

The methodology itself is not necessarily linked to any particular intervention. This is in its favor. It is adaptable to any health, or other development intervention. The team believes that the principles underlined in the methodology are well established. Accordingly, the team recommends a study to determine whether the methodology can be streamlined for reaching large numbers in a culturally sound manner. In any event, the use of mass media communication, joined with printed materials and face-to-face teaching/learning situations, is a sine qua non for modern development. Its discontinuance cannot be imagined.

The team believes that a more simplified version of the Project methodology could be applied at a quicker pace and with relative ease across health and other development efforts without sacrificing the research base for planning, the relatively large numbers of mothers to be reached, or the quality of the interventions.

However, in order to facilitate and accelerate the application by developing countries of the HEALTHCOM methodology, the Evaluation Team strongly recommends a study to streamline it--a high-priority research exercise. To begin the process, the following are questions to be considered by A.I.D. and AED:

- Are KAP surveys needed everywhere, or can they be developed in a demonstration area and results extrapolated to regions with the same general cultural patterns? How often do they need to be repeated?

- Are there norms and procedures for qualitative formative research that can be applied across culturally homogeneous or culturally similar areas?

- Is there a system for building into the communication strategy, specific messages to motivate mothers to change their health practices, that can be easily transferred to local health educators?

- Can the field testing of materials/messages on the basis of behavioral studies be also systematized for local use?

- Is the implementation of the communication strategy country- or region-specific?

- Can monitoring of health education interventions be improved?

- Are case fatality rates a more useful method to evaluate outcomes of health education methodology in specific health problems, i.e., ARI, EPI, CDD, etc?

- Can the feedback process be systematized on the basis of the monitoring and evaluation results?

4. Recommendations on the HEALTHCOM Methodology

- Review the terms and conditions of the contract. The emphasis on mass media for reaching large numbers of people (especially mothers) to change their behaviors over a three-to-five-year period, has led de facto to a de-emphasis of the need to focus on the institutionalizing process for the principal client, i.e., the respective MOHs. This emphasis appears also to have been responsible for de-emphasizing the face-to-face component of the marketing methodology.

- Review the methodology. It appears to be too complex, too time- consuming, and too dependent on expatriate (U.S.) expertise to enable host country nationals to reach the goal of changing health practices of a critical mass of persons. The team believes that the MMHP and HEALTHCOM research experience to date provides a sufficient basis for examining and beginning to streamline the Project's methodology for more immediate application to conditions in those developing countries where the project operates.

- Do not wait for HEALTHCOM II to begin streamlining the methodology. Begin the review and implement findings now. Use accumulating evidence at hand and, as soon as possible, continue up-dating it in order to give A.I.D. specific bases for justifying proposals for the extension of the Project.

- Devote more time, resources, and energies to those activities that improve its "hold" on and place in government health institutions, including means of inducing more active, shared government commitments to adoption of the new health education methodology. Time and resources should also be devoted to institutionalizing the methodology within NGOs,

educational institutions and the for profit private sector.

- Re-evaluate Project activities to ensure maximum consistency with national policy and coordination with national health programming. Granted the differences of political and social situations, the Project should influence the shape of health education policy in order to justify its continuation. A.I.D. should be willing to tolerate some "false starts" and redirection--even relocation--of Project activities.

- Build day-to-day, on-the-job MOH staff involvement that runs deeper than merely a counterpart administrator.

- Give preference to those country situations in which governments are willing to share responsibilities and resources for institutionalizing the HEALTHCOM methodology. Be prepared to withdraw from countries after a reasonable period of time when governments do not respond effectively.

B. Research and Development

Q #4. Are HEALTHCOM's current research and development efforts appropriate and on target? Where should HEALTHCOM focus its research efforts in the future?

1. Outcome Research

a. Data context

The team believes that the research and development (R&D) approach although appropriate, must be reviewed in order to streamline it. It is difficult for the team to make an assessment of whether current R&D efforts are on target because of the very nature of applied research in the field, which must be flexible and responsive to field conditions. The team suggests, however, that R&D efforts (i.e. data collection and analysis) be strengthened within a framework of systematic planning with measurable and time-framed objectives.

HEALTHCOM is a process/performance project. Where it looks at mortality impacts, its advisable focus is on case-fatality rates among the treated children's population, small samples in sentinel areas, and not changes in mass mortality rates.

As such, project data may not coincide with established MOH or WHO data. Since MOH data are national and AED's regional, both deriving from different sets and measurement contexts, Project data differ at times from MOH or WHO data. Such a case was found in Honduras. The Project Amendment reports that the Project has achieved over 60% ORT use in Honduras; and the Baume paper (Preliminary Report on the Results from the 1987 Resurvey in Honduras, February 1988, page 14) indicates

ORS knowledge figures of 99.3 and 97.8 percent, and usage of 85.4 and 83.9 percent. These are extraordinary achievements. At the same time, these data differ markedly, regarding use of ORS, from those obtained in a National Survey on Epidemiology and Family Health developed in 1987. Knowledge-usage figures are 87% and 23%, respectively.

b. Cause-Effect Attribution

A.I.D. and other development agencies have a long, frustrating history record of sponsoring high-cost, time-consuming, large- scale control-field experiments and quasi-experiments in variable sociocultural conditions that did not provide useful cost-effect data for program decision making.

It is the opinion of A.I.D. and other bilateral and international donors, that field research is largely unable to make cost and effect attributions and must be viewed in the context of all other host governments, NGO/PVO, and donor activities. Trying to separate out the impacts directly attributable to a single agency or its program is mostly unfeasible, especially since the number and complexity of unknown intervening variables confounds our causality models. There are a bewildering number of variables involved in lowering infant mortality rates in Honduras, for example, as anywhere. Except in unusual (likely to be artificial) circumstances, results cannot be attributed to any single intervention nor even to a combined series of health interventions, as there are frequently other types of development programs (e.g., education, income generation, food availability) which impact on infant mortality and morbidity.

2. Future Focus

The following are suggestions for future directions for R&D efforts. Whether they can be implemented will be based upon the major objectives of a new project, and the available funding and staffing.

a. Supply and Demand

Given appropriate advertising about a product, including service products, some type of demand is likely to be created. Whether the demand created matches the supply manufactured or the level of services provided is another issue (described in Section VII, below). In marketing human services, alternatives are found when demand cannot be met (return to village healers, reliance on doctors' prescriptions); which impedes diffusion of improved health practices. But "supply and demand" has other dimensions that offer research challenges to the Project:

- Institutions: HEALTHCOM might consider the need for more formal, but unintrusive research data-gathering on the MOH as an immediate step of the Institutionalization Plan. To overcome human obstacles to health innovation, to reduce the perceptual distance of an "outside" project, and to keep an even balance between institutionalization and field activities, HEALTHCOM might consider a more systematic

"entry" approach. Such an approach would view the MOH as a consumer for whom "demand" must be created for "supply" of the Project's methodology. The literature is rich on research for the purpose of improved communication in large-scale organizations. Likewise, a study of the obstacles to private-sector cooperation with government in product/service provision might be a necessary requirement for the Project's institutionalization in some countries.

- Service Providers: Service providers are another "supply-demand" research problem requiring attention. AED has done some valuable research in support of worker training and face-to-face communication techniques. This is an area that deserves, we think, as much attention as research on mothers' knowledge, attitudes, and practices. The consumer is the end-point of a complex, human communication chain; each link of which needs understanding and invariably requires corrective actions.

The team feels that HEALTHCOM should strengthen the development of systematic follow-up schemes for retraining, remotivating, monitoring, and otherwise supporting fieldworkers after initial training. Training should, of course, develop a "demand" among the participants. But back home in their state or local offices or clinics they usually find that little has changed in their absence: the "supply" (even of morale) equation has not changed. In such situations, unlearning new training principles is very common. Informal research of how to improve back-home institutional and collegial supports is needed. Similarly, future HEALTHCOM research on PHC clinic staff and village-level workers is well advised. Research on "value formation" to fashion a strategy to improve staff (and volunteer) motivation and performance, is important to support research used to induce mothers to come to the clinic.

- Consumers: Finally, what is usually meant by service supply and consumer demand offers an area of research often neglected: research on family members and others in the mother's personal health network who impede or facilitate her visit to the clinic. For example, there is increasing evidence of husbands and fathers assuming new responsibilities for child health decisions. The team found some encouraging examples in the Project of research on, say, physicians and pharmacists, who, for a variety of motives continue prescribing useless medicines. Research on how to convert uncooperative medical practitioners into supporters is greatly needed.

Other likely research areas are: (a) determine the level of remembrance cues needed to sustain knowledge/attitude/behavior gains between campaign periods--how to strengthen the mother's resolve to return to the clinic; (b) how to overcome suspicions of government facilities, services, and staff--how to rectify previously bad experiences; or (c) the characteristics of parents who are early adopters of innovative health practices. The latter subject

(innovators' characteristics) could be extended to MOH staff, primary health care (PHC) staff, paraprofessionals, physicians, etc. The team believes that some of HEALTHCOM's research should focus on individual behavior and activities that strengthen the supply side of service delivery (e.g., research to support training of village workers) and on other processes (e.g., comparative studies of different intervention designs) rather than attempting to show outcomes.

b. Technology Transfer

A future "focus" should be on the value of research/evaluation methodology as a training tool for bringing MOH offices into the HEALTHCOM methodology. Earlier, the team recommended pairing consultants with national researchers. One result could be the development of a culturally-relevant training module. Strong criticism was heard in the Philippines (Annenberg; Porter/ Novelli) and Nigeria (Annenberg) of subcontractors who come in, collect data, and take them back to the U.S., leaving no residuals of their methodologies or findings. The Nigeria MOH counterpart complained about never having seen a Project research report, and about never being briefed by the subcontractor; nor about how many studies had been done. Here again is the problem of insider-outsider perceptions: the Annenberg team refutes the complaints in the Phillipines and Nigeria, stating that a full data set(s) was left with the contractors in the Philippines and that the MOH Director of Health Education was briefed by their consultants in Nigeria. In Nigeria, the CCCD computer facilities have more than adequate staff and capabilities for any of the analyses and graphics done in HEALTHCOM reports. Future research efforts might investigate local capabilities as an alternative to taking the data out of country.

c. Manuals on Research Methodology

Similarly, research skill-building can lead to the production of lay-language, how-to manuals for various qualitative and quantitative methods. The MOH health education staff are the intended students to benefit from training in qualitative research methods. Such training efforts should be continued and strengthened. The Porter/Novelli manual, Handbook for Excellence in Focus Group Research, is a good step in that direction, but it is written in overly sophisticated language. A series of practical VCR "courses" could retain the human quality and would be very useful. The more simplified the methodology, the easier to standardize print, video, or personal transfer.

There is consensus that qualitative formative research is to be designed and implemented by the resident advisors and their counterparts, as well as other health educators in each country. It is a fundamental educational process for transferring methodology that should be extended to all other phases of the project so as to have an effective implementation of the communication strategy. Formative research needs also refining and simplifying to become more easily transferable without sacrificing quality standards. This is perhaps the most important aspect of the methodology to be institutionalized.

d. Effect on Implementation of Health Behavioral Studies

Q #5. **Have the health behavioral studies been an effective tool for improving the implementation of field activities? Have they played a role in the development and refinement of the Project methodology? What has been learned by the Project from these studies?**

HEALTHCOM research, strictly speaking, is applied research rather than basic and theoretical. As such, its fundamental purpose, as described in the Contract, is to facilitate health behavior modifications for large numbers of people.

The team is in agreement with the HEALTHCOM methodology and its sequence as presented. However, there is concern about the excessive use of the several kinds of ethnographic research already mentioned. The team believes that the amount of research should be in proportion to the cultural diversity of each country, as well as the experience of the professionals involved in the investigation of any phase of the methodology, e.g. the design of messages, materials, or training. Nigeria and Guatemala may need more extensive and in-depth studies than culturally more homogeneous countries such as Honduras. The Nigerian material designers, assisted by a top notch consulting medical anthropologist, need less research assistance than HEALTHCOM countries without such a resource.

Health behavioral studies have played an important role in the developing and refining of the Project's methodology through revision and adaptation of printed and radio materials. In Honduras and Nigeria it became apparent that health behavior studies are, in fact, field testing of radio messages and printed materials which were themselves designed either on the basis of the ethnographic studies or of the cultural knowledge which the national staff had with relatively little research--they were not necessarily trained social scientists.

In both countries, the Resident Advisor assisted effectively in the development of the health behavioral studies. Although messages and materials are culture-specific, this does not mean that for each cultural setting new ones should be prepared. In Nigeria, an identical flipchart is used by village health workers taking into account language and other cultural characteristics. They were instructed in workshops conducted by health educators trained by the Project, who participated in the field testing and analysis of the resulting data.

The most immediate learning benefit from this process is increased skills for making the appropriate adaptations and refinements, as well as better quality of them. There is no question on the value of a sound, culturally relevant study as a basis for program design.

The team found many examples of well conceived and executed field studies. The exceptions are important, however, because of their potential for sidetracking research foci and resources.

The most important lessons learned about behavioral studies have to do with the following:

- That for different cultures and languages (including particular words), field testing will vary and final messages and field practices will be culture-specific;

- That health behavioral studies and field testing methodologies should be transferable to national health educators at all levels;

- That the results of such studies be compared with those of the ethnographic studies, including KAPs, in order to look for consistency;

- That lessons learned from the behavioral studies should facilitate the streamlining of the methodology recommended by the team as an area of research.

Other important lessons have to do with simplicity. The use of behavioral studies terminology may be impeding the transfer of research skills to host nationals. The cause and effect model for human behavioral change (antecedents, behavior, consequence--ABC) is for HEALTHCOM the raison d'etre of all social sciences. To change human conditions in the direction of preferred ones is A.I.D.'s mission. Giving value to the discrepancies between "what is" (observed) and "what should be" (expected) following a program intervention is usually considered evaluation--the measurements of changes in cognitive, affective, behavioral, and physical states--regardless of the social science discipline in which the evaluation is conducted. If the subcontractors were to simplify their terminology, Resident Advisors and counterparts' skill-building roles would be aided.

Similarly, "qualitative formative research" is informal study before a project. It might be more useful to describe the process to host counterparts as formal and/or informal study before, during, and after the HEALTHCOM intervention. This may reduce communication "noise" (formative, summative) and improve understanding.

The team regrets that lack of time prevented an in-depth analysis of country research activities and a review of the results within the framework of the resulting communication strategy. It is suggested that this be considered by A.I.D. for future evaluation.

3. Recommendations on Research and Development

- Emphasize the operational. HEALTHCOM is an operational project, with a research component. Simplify the methodology accordingly. The team recommends a careful review of the methodology aiming at streamlining it. At the pace of the present phase, the goal of changing the health behavior of a critical mass of mothers in all communities will not be reached.

- Emphasize process. Time remaining is insufficient to achieve significant changes in health practices of large numbers. Findings need to be reinterpreted in terms of process conditions rather than outcomes.

- Focus on case fatality studies. Instead of a general population base, the rate of mortality for children treated within specified health interventions (such as EPI, CDD, etc.) should be the major criterion against which project success is measured.

- Make greater use of host country researchers. Subcontractors do not appear to be making appropriate efforts to strengthen in-country research capabilities.

- Simplify terminology. Terms describing formal/quantitative and informal/qualitative research methods used before, during and after the Project intervention obstructs communications.

- Reduce, simplify, and speed up research activities. Use research skill-building as an opening wedge to enhancing the competence of government officials.

- Focus some of its research on articulating the links between mass media messages and their face-to-face translation in clinics, communities, and homes.

- Refocus research to develop training programs for connecting the complementary interpersonal activities of national, state, and local professional and non-professional health workers.

- Develop a cohesive, multi-stage training curriculum that emphasizes practicum experience and builds on monitoring and retraining (and more retraining) as necessary.

- Develop more low-cost methods of documenting Project achievements; and give the same priority to documenting successful strategies and lessons learned from engaging public- and private-sector institutions as for documenting village-level communication effects.

C. Evaluation

Q #6. **What should be the evaluation criteria used by the Project to measure its effectiveness, i.e. are demonstrations of changes in knowledge and attitudes enough, or should HEALTHCOM be expected to demonstrate impact on health practices? In countries where priorities or constraints make quantifiable changes in health practices an unlikely outcome, what is an appropriate evaluation approach and level of effort for assessing accomplishment of other program objectives? What kind of changes over time should be expected? How much time should be allowed to demonstrate these changes? How much impact should be expected?**

The purpose of the summative evaluation is usually understood in terms of project success or failure. This should not be the case for HEALTHCOM. What the team felt should be stressed is a process evaluation which sets out to observe and measure the extent to which the project methodology is taking hold and being institutionalized by the government in community health centers, hospitals and universities; and the extent to which the private sector is becoming involved, and other major donors are cooperating. The success and/or failure of such communication efforts cannot be seen in short periods of time as five years. To make decisions and measure the contribution of health education to real, durable changes in client and audience behaviors, longer periods are needed. Even if significant village-level behavioral changes are observed, they mean little (for very long) if the methodology is not institutionalized to give some assurance to the sustained delivery of improved services and education.

If A.I.D. considers extending the Project concept to another phase of application, the end-of-project evaluation should be seen as another monitoring point along the continuum of embedding the methodology into the health infrastructure and private profit/non-profit networks. For example, the development of a time-framed strategy, with MOH concurrence, for phasing out technical assistance and phasing in an MOH-only managed methodology would be a most significant criterion for evaluating project success.

Given the fundamental goal of child survival, it is quite understandable why major government-to-government donors want to know whether fewer children are dying as a direct result of their program support, and why evaluations give so much importance to it. But it is self-evident to the vast majority of grass-root human service development workers, that there are many health interventions--as well as non-health interventions--which contribute to lower child mortality rates. To attempt to determine to what extent particular interventions are responsible is, after all is said and done. a very difficult task. In such research situations it may be sufficient to know that the combined effort to reduce child mortality and morbidity is working, i.e., fewer children are dying of major diseases--something which all data sets to measure mortality will indicate.

As regards the HEALTHCOM Project, it is known by mass media advertisers that given repeated advertising, product sales will usually increase. In the case of HEALTHCOM interventions, project managers need to be satisfied to know that health behaviors are being changed; that processes are managerially sound; that management and process objectives are being met. The team felt that given the great difficulty of measuring outcomes, the most reasonable, reliable and cost- effective evaluation criteria appear to us to be both quantitative and qualitative aspects of project processes from beginning to end of the methodology.

The team reviewed the HEALTHCOM evaluation plans, as prepared by Annenberg School of Communications, for West and Central Java and the Philippines, as part of its contract to carry out summative evaluations in up to 15 HEALTHCOM sites. These plans would be improved by adding study goals or objectives; a time-table showing the activities for the evaluation with milestone events; and resources needed by activity, and their origin. In addition, an account of the monitoring process to oversee the implementation of the evaluation should be included, as well as a description of the data management and analysis methodologies. The team recommends that a detailed evaluation strategy be incorporated in the Implementation Plans.

Q #7. What portion of Project funds should be devoted to documenting impact?

The problem with this question is that fixing, say, a percentage-of-budget ceiling on documenting impact assumes that we can anticipate the full range of variables and their significance at all times during the project. That is extremely difficult to envision. But realizing that budget line items have to be established, the team makes the following suggestions.

The monitoring and evaluation of communication strategies and the assessment of the methodology calls for a system of information on Project activities. Development of data bases for the storage and retrieval of information from country programs, and indexing of data tapes needs to be established. This system facilitates the sharing of information between Resident Advisors, AED Washington, A.I.D. S&T/H and S&T/ED, A.I.D. Missions as well as MOH and Research Institutions.

In the selection of indicators to measure outputs and outcomes of health education programs, the team suggests that consideration be given to international as well as country measurements.

Costs are a measure of resources used in any activity, be they human, material, or financial. This applies to health education programs sponsored by the Government and the Project. The team found the cost analysis to determine cost-effectiveness was not considered in the evaluation of the communication strategy and recommends that it be incorporated in the remaining years of the Project.

When enough experience becomes available related to the same program in different countries, say CDD/ORT, comparative analysis as part of the evaluation process to identify similar and dissimilar factors related to field project results should be performed.

Recommendations on Evaluation

- Redirect the focus of evaluation research to an emphasis on process indicators for formative purposes rather than on outcome indicators for summative purposes.

- Examine now how much money is being spent on KAPs and other measures of "impact." Recalculate the sum for comparable activities under the model of the streamlined methodology (described earlier) when achieved.

- Look for low-cost and easily teachable alternative methods of data collection by community health workers, such as:

  -- Develop clinic reporting systems of number and types of clients by health need.

  -- Devise a short-form questionnaire for clinic administration in client-intake and service contacts on -- e.g., reasons for coming, what mothers know accurately about EPI/CDD, (unsubstantiated) self-reports of recent behavioral changes and clinic record report of previous visit, where they got their information, etc.

  -- Sample no more than a reasonably diversified number of clinics (by location, cultural region) to get a notion of clinic-based changes in mothers' behavior;

  -- Institute a doctor/pharmacy/retailer sentinel system in the same sentinel clinic service areas. This will cost (payment will need to be made on an in-kind or cash basis for the cooperation), but it will link changes from private practitioner to clinic changes. If well negotiated, it could be an important step in involving the private sector.

  -- In sentinel villages within the same service areas, institute a reporting system for volunteers to the same sentinel clinics, where staff may be induced to monitor validity of village workers' reports.

  -- Before/during/after media campaigns, personally visit a number of health stations, checking records, interviewing staff casually, observing staff and patient behavior.

  -- Establish an information system for the storage and retrieval of information collected in-country regarding Project's activities. Include an indexing of data tapes accessible to Governments and A.I.D.

-- Add cost-analysis as a component of evaluation criteria in assessing Project's effectiveness.

The Project may be better served spending money and in-kind contributions for documenting MOH and universities indicators on institutionalization, as well as for systematically improving the competence of the health service delivery system, urban and rural. But this requires a restatement of some contract objectives. Still, carefully defined KAP studies regarding scope, place, frequency, data analysis, may be needed for some projects.

If A.I.D. were to ask AED now to begin developing, and updating, a forward-looking SOW, it would benefit both organizations, since (a) AED would have a solid basis for reviewing and recasting its present activities to develop those that assure greatest continuity in bridging to the future phase; and (b) A.I.D. Central and Regional Bureaus and A.I.D. Missions would have a timely, conceptual and operational basis for beginning to negotiate their commitments to the next phase.

Using the SOW of tomorrow, A.I.D. can begin preparing for the next round of competitive bidding; and AED can begin putting more emphasis on and energies into those activities that streamline its methodology and redress the imbalance between audience-oriented, e.g., mothers, and client-oriented activities, e.g., MOH (as the next chapter describes).

II. SUSTAINABILITY

A. General

Q #8. **Are sustainability issues a viable and essential part of the HEALTHCOM methodology?**

Q #9. **How well has the HEALTHCOM Project transferred its approach and methodology to host country institutions?**

As previously described, contract requirements to produce widespread behavioral changes in significant numbers of people within two years may have led HEALTHCOM to concentrate more on community-level effects and less on institutionalization. Thus, institutionalization and sustainability do not have the prominence in the Project as they should. Institutionalization must be promoted simultaneously with field programming, or HEALTHCOM will continue to develop programs (and build demand) ahead of government's capability to absorb and sustain them.

If A.I.D. were to accept the recommendation to begin now to use the lessons already learned, it could speed up the process of institutionalizing and sustaining new health practices.

For HEALTHCOM, the Project's goal is to support sustainable benefits to home health management; and its objective is to burrow its methodology conceptually and operationally into the national institutions that promote and deliver health services.

- Sustainability: The goal for, say, CDD is reached when a critical mass of mothers in all communities know what to do in diarrhoea home-health management and continue these life-saving practices after the project is gone -- relying chiefly on knowledge of, belief in, and access to PHC staff, village volunteers, and suitable, affordable retail products.

- Institutionalization: This objective for, say, CDD health education/communication is reached when policymakers continue supporting the methodology (a) as embracing all earlier forms of, and job descriptions entailed in, health information, education, and communication activities; and (b) with on-going sufficiency of resources for all aspects of service delivery that equate the quantum and quality of supply with the quantum and quality of demand, which is deliberately stimulated.

In the long run, institutionalization will also be attained when: a) health education, including the HEALTHCOM concept and methodology--or a variation of them--is integrated into the teaching of primary health care problems to graduates and undergraduates at universities and other professional schools; b) when the formal education system includes subjects on health and disease and health education concepts for teaching Grade- and High-school children.

In the countries visited, institutionalization activities showed mixed results. For example:

In Honduras, where the Project has been active for 10 years, studies show that a significant number of mothers know about Litrosol and use it; professionals at MOH, both at the central and field level, know of the methodology; medical students are being trained in HEALTHCOM methodology.

In Indonesia, there is a systematic training of health care providers on the concepts and uses of the methodology.

In the Philippines and in Nigeria, where the projects are relatively young, there does not seem to be as yet widespread knowledge of the Project among MOH officers.

The team found that in all countries visited, institutionalization has not been developing simultaneously with community-level activities. We believe that both processes should be developed from the beginning of each project.

The Report refers to the most important aspects of the methodology to be institutionalized and the constraints for implementing them. The team believes that the concepts underlying the HEALTHCOM strategy are well established and universally applicable. As such, more time and resources can and must be given to institutionalization.

Despite rather weak institutionalization efforts, the team believes that the HEALTHCOM strategy is better established and applicable than probably do its sponsors. By saying this, the team means that they

- Do not doubt that people are affected by the mass media.
- Do not doubt that merely learning the local language and meanings of CDD/EPI concepts can add to media effects.
- Do not doubt that mass media messages, competently reinforced through trusted face-to-face contact, can have even greater effects.
- Do not doubt that a communications strategy combining these few ingredients can produce substantial increases in awareness and, at least, some temporary changes in behavior.

However the team does doubt the wisdom of looking past policymakers whose policy changes are necessary to sustain health education programming long past a media blitz.

For "HEALTHCOM-II" A.I.D. should reaffirm the importance of the objective of developing institutional willingness and capability of sustaining project achievements in the home. Certainly, the Project contract and its various plans for Implementation, Communication, and

Evaluation all say the right words, but--as some Resident Advisors have explained--these plans often have secondary importance to implementing activities such as field research and campaigns.

B. Financial sustainability

The projects in Honduras and Nigeria are worth examining with reference to financial sustainability defined as the decision of governments and the private sector to continue investing in sufficient amounts to maintain, and hopefully expand, health education interventions based on the HEALTHCOM methodology once A.I.D.'s assistance ends.

In relation to its population, Honduras has a large Health Education Department (DES in the Spanish acronym) at the MOH with 18 staff members, thanks largely to HEALTHCOM's assistance over the past eight years. To this we should add 12 health educators stationed in the field, one or two per region, who work with the Regional Committees for Health Education (CRES in the Spanish acronym) having three to four members each--usually health professionals of the MOH staff. Organized three years ago, their purpose is to integrate health education into different primary health care programs.

Of the 18 members at the MOH/DES, we were informed that only one is a trained health educator; the others represent various other professions, including reporters, lawyers, school teachers, accountants and graphic artists. The DES Director, a physician, although able, is not full-time. The MOH/DES is, in the team's opinion, clearly held together, oriented, and motivated by the HEALTHCOM Resident Advisor. Without his day-to-day involvement, we believe that DES would have serious problems being effective. Because there are relatively few outreach workshops for rural health workers and face-to-face sessions to explain printed materials to mothers, and other field interventions reflecting the need for greater support of the HEALTHCOM Project in the field, the team strongly recommends that the Resident Advisor be provided with an assistant.

Despite assurances from the MOH officials that all DES staff are paid by the Government, we discovered that only eight of them at the Central Department are in this category. Two others have their salaries financed by UNICEF and the rest by A.I.D. through ESF funds. Most likely, this may not be known by the MOH staff. Still, the payment of salaries of DES members, plus the 12 field health educators by the Government, shows a distinct official interest in the Project, all the more stronger because we were repeatedly told of no intention to backtrack.

The use of Mission ESF funds can be looked at in both positive and negative lights: positive when it strengthens the regular budget process of host country ministries financing certain positions; negative when there is no indication that the Ministry will include them in the regular operating budget, thus institutionalizing the Program. This is the situation in Honduras. Unless financial sustainability is planned starting now so that progressively all needed DES staff become paid by MOH, if and when A.I.D.'s assistance in health

education comes to an end, prospects do not seem bright. We should add that, at present, the Project buys radio time on 30 private radio stations broadcasting CDD, EPI, and ARI messages, with an annual cost of $150,000. A new Sanitary Code, pending approval in Congress, includes the obligation of private and public radios to broadcast free of charge information on health issues. If approved, not only these funds will be saved but the Government will be able to involve more radio stations, and include messages for new PHC activities.

The Nigerian situation is different. While coordinated at the federal level, the principal planning and implementation takes place at the state level. We were unable to determine if ESF monies are being used to support MOH Health Education staff. According to MOH spokespersons in Lagos, all MOH personnel are funded by the Government of Nigeria. Support staff and administrative assistance are supplied to the HEALTHCOM Project by the CCCD organization in Lagos.

In Niger State the utilization of EPI flipcharts in face-to-face encounters between Niger State MOH/LGA (Local Government Administration) health workers and mothers was done in an unrehearsed and highly competent manner. Over 600 such EPI flipcharts are currently being utilized in seven Nigerian states, although we do not know how competently these flipcharts are being used elsewhere.

The program has not made significant inroads into developing the radio component of the HEALTHCOM marketing methodology. In Niger State, the radio component amounts to two 15-minute segments. It is widely felt by Nigerians interviewed that radio especially needs to be better developed. Radio programming for behavior modification was identified as an area of expertise in which Nigerians were lacking.

As regards TV, the director of National Television Authority's Programming Division believes that the time is right to begin experimenting with TV spots for health education. He believes that TV ownership in Nigeria is about to increase dramatically. He also maintains that the presently low percentage of TV ownership is deceiving in that their studies show that TV sets have many more viewers than simply the nuclear family. This phenomenon was mentioned by the Niger State TV Authority director, who indicated that TV-equipped community centers are being discussed for rural villages with electricity.

Because the Health Communication Program is in its early stages, it is recommended that the Government of Nigeria plans a financial sustainability strategy with the assistance of the Project.

C. Functional sustainability

For the Evaluation Team, sustainability and institutionalization are phases of the same process, whose objectives were already defined. This section will comment on what appears to us to be the most salient elements and constraints for a sound functional sustainability. In this examination, the team took into account the format of the AED

HEALTHCOM Paper "Institutionalizing a Methodology for Public Health Communication: a Mid-Project Report."

The most important aspects of methodology to be institutionalized are the following:

1. Developing a systematic planning process

Systematic planning is a process concerned with the development and implementation of plans of actions. The process includes: problem identification; goal setting; establishing objectives commensurate with resources; description and implementation of activities to reach objectives; monitoring activities; and evaluating outcomes. The Project's country Implementation Plans appear to us to be a misnomer. We find that they are probably better named Country Strategy Reports.

For reasons detailed below, the team recommends that, for a new project, a detailed Implementation Plan follow up an initial strategy report, with time-framed objectives, budgets by task, etc. to assist the monitoring and evaluation process.

Currently, the HEALTHCOM country implementation plans appear to be weak with regard to the identification of problem areas within each category of primary health care programs, e.g. CDD, ARI, and EPI. At times, goals and objectives do not match adequately available resources to achieve them. The components of the communication strategy--radio/TV messages, printed materials, banners--have not been quantified in relation to the objectives to be reached. The implementation schedules do not reflect a time frame of events, using a project milestone time chart. Responsibilities of the RA's, national professionals, and supporting national subcontractors, are not fully specified in the plans. Budgets are not described by tasks, or by a monthly timetable, nor by detailed categories. Moreover, there is no section related to a monitoring process to assess the progress of the implementation plans. With regard to institutionalization, the plans fail to identify specific activities to reach stated objectives. They should describe the interventions to be undertaken in order to reach functional and financial sustainability.

The planning documents are important "roadmaps" that national counterparts and the AED Resident Advisor follow with regards to resource allocation, and are a basis for monitoring and evaluation. The plans should adequately reflect the program direction and be periodically updated. They should identify constraints as well as alternatives with reference to strategies responding to a "what if" situation. Planning is a living exercise not finalized or set in concrete. These plans serve for monitoring and evaluation of field activities, assess the performance of Resident Advisors as well as the flow and quality of information between Washington and the field. Plans need to be periodically reviewed to readjust objectives on the basis of program progress or the lack of it.

2. Integration of program elements

There is a generalized effort being made to integrate program elements which include the development of usable cultural information, graphic and broadcast materials, training programs designs and their implementation. How successfully program elements are being integrated vary from country to country. All countries visited were producing HEALTHCOM print and broadcast materials. In Honduras and Indonesia both visual and radio materials are good, but the training and face-to-face encounters need beefing up in rural areas. In Nigeria the training and face-to-face use of printed materials are better than the production and programming of broadcast materials.

3. Regular interaction and coordination at MOH level

Honduras and Indonesia are the only countries of the four visited where regular and close coordination between the HEALTHCOM Project and the Department of Health Education, MOH, at the central level, is in operation. In Honduras, the same relations are constructive with other relevant departments of the MOH, but in Indonesia it requires strengthening. At the department (state), and municipal levels, it can be improved in Honduras, while in Central Java and West Java in Indonesia the Resident Advisors and the professional staff work effectively. In Nigeria, personal observation suggested close cooperation and planning between MOH and HEALTHCOM at the state level (Niger State) but not at the federal level. In fact the senior MOH Health Education Officer in Lagos complained about "not knowing what was going on", which was explained to mean not being briefed by HEALTHCOM consultants; about not receiving reports written by them; about consultants not giving appropriate credit to Nigerians for work done by Nigerians. Another MOH staff person maintained that she knew very little about what the HEALTHCOM project was attempting to do in Nigeria. Obviously, institutionalization is badly impeded when this kind of thinking exists among top-level officials.

4. Use of ethnographic research to inform plans and strategies

Thanks to the outstanding academic credentials and native culture bearer status of the Nigerian medical anthropologist on retainer with HEALTHCOM, the quality of the ethnographic research and its potential to inform HEALTHCOM plans and strategies is excellent. In other countries, like Honduras for example, the ethnographic field research is done primarily by the MOH/DES staff, none of whom have been formally trained in sociological research methods. Such a situation is manageable when technical assistance for research is available to appropriate MOH staff, as it is in Honduras.

5. Focused instructional goals established around a set of specific behavior objectives

That the most general goal of the HEALTHCOM project is to modify the health behavior of mothers with respect to their children's survival during infancy was easily articulated everywhere. During discussions of goals and objectives the concept also emerged that the

HEALTHCOM methodology is not related to any one single health intervention but is applicable to a wide range of health and other development interventions. This is seen to be the case by project and non-project related persons, e.g., the owners of private radio stations in Honduras.

6. Careful testing of all educational materials

This was easily articulated by the RAs, but not as easily by counterpart MOH persons or lower-grade staff who are supposedly being trained by them.

7. Regular monitoring of program activities to identify and correct problems

There appears to be no system in place anywhere to formally monitor the program. One of the reasons for this is the apparent lack of emphasis on the collection of quantitative data regarding different aspects of the program in any of the four countries visited. Monitoring appears to be primarily described in terms of qualitative data, which are seldom adequate even for short-term observations. Quantitative data are a necessary complement to qualitative data. The team believes it is essential to know and record how many mothers and children are becoming involved in different interventions and how these figures compare with past and future involvements in those same communities.

D. Constraints

1. Prestige

Outside prestige and the involvement of expatriates who share in that prestige is a reason for focusing special attention on facilitating Project implementation. This occurs mainly in the early stages of a project when expatriate assistance is most needed. But with increasing political sensitivity in developing countries, outside prestige is frequently short-lived.

HEALTHCOM needs to assure that its communication strategies are representative of the target audience; that specific objectives are commensurate with available human, material, and financial resources, and that messages are sensitive to the culture in content and language. Furthermore, direction of the Project should be exercised by nationals with the cooperation of the RAs, from the beginning. When experts from abroad are needed because their experience is not available in the country, they should assist primarily local professionals with the aim of making them self-sufficient. The team believes that the Project is aware of this situation, and does attempt to strengthen national participation in the formulation and implementation of the communication strategy.

2. Technical Assistance Availability

During the course of the evaluation, outside technical assistance was criticized when it was considered to be: a) not needed; b) available in-country; c) regarded to be of inferior quality. It is true that government counterparts are not permitted to take the initiatives and liberties that contractors and their consultants take. What is essential is that any technical assistance provided includes the strengthening of specific national capabilities.

3. No Communication Slots or Budget Items

One of the most formidable tasks confronting development from the top down is the need for positions initially funded by external donors to become part of the regular ministry budget. This is much easier said than done, for in several cases even top officials do not know the real source of funds to finance some positions. In the discussion on financial sustainability we refer to this situation.

4. Paucity of Resources

This will vary from country to country. In discussing this particular constraint with Nigerians it was pointed out that "paucity" is frequently seen by outsiders in relation to a situation they perceive as normal but which nationals would perceive as super-abundant. The problem implied here is which standards should be used in the management and expectation design of any development program. Those proper to the donor, or the recipient nation? Planning should include resources needed to attain objectives and appropriate methodologies that are culture specific.

5. A Scarcity of Communication Expertise

The team's comments refer to the general unavailability of national professionals who know, can teach, and can apply the HEALTHCOM methodology for changing behaviors related to health problems. This situation became evident to the team in every country visited. Hence, the emphasis throughout this Report has been on the need for institutionalization of health education stemming from the in-service training of local professionals. However, this approach does not seem to be sufficient to ensure the sustainability of projects. The team, therefore, recommends that A.I.D. consider the identification of university centers where modern health education be taught, including the HEALTHCOM methodology.

E. Recommendations on Sustainability

If A.I.D. accepts the suggestion to review contract terms for the purpose of beginning now to study the feasibility of streamlining the Project, and, thereby, further operationalize the methodology, then all conclusions and recommendations that follow must be seen in the light of what is necessary to carry out successfully an expanded future project. As noted earlier, the team's evaluation is more useful for

looking ahead than as a critique of past contractor performance. The recommendations are as follows:

- Plan a strategy for financial sustainability should be planned and progressively implemented in every HEALTHCOM project.

- Review all components of functional sustainability on the basis of a streamlined HEALTHCOM methodology in order to develop strategies which will increase health education coverage and process outcomes at the national level.

- Review all in-country institutions needed for a durable health education program, as a basis for formulating comprehensive strategies for engaging them, as appropriate, in policy development, program/project planning, implementation and monitoring.

- Design a government-entry strategy in order to better facilitate the institutionalization of the HEALTHCOM methodology at the highest government policy levels.

- Increase resources to strengthen in-country diffusion activities, including workshops, professional journals, public presentations, conferences and professional exchanges.

- Devote more energy to building genuine interagency networks: less emphasis on fait accompli presentations and more emphasis on informing, seeking counsel, and finding areas of cooperation and commitments from donors, commercial, and private-voluntary organizations.

- Make innovative attempts to induce more active private-sector commitments beyond for-pay advertising and research. Seek comprehensive involvement in low-cost design, production, and distribution of communication materials and sponsoring professional workshops.

A more explicit statement may be needed on long-range sustainability beyond behavior change and demand, including institutionalization through community participation, professional training in health education at universities, and introduction of health concepts and practices in the formal education system for grammar and high-school students.

F. The Private Sector

Q #10. To what extent has the private sector been involved in the HEALTHCOM Project? What lessons have been learned in working with the private sector? How should the project utilize the private sector in future activities? What lessons have been learned about sustaining activities in the private sector?

1. The Role of the Private Sector

Throughout the course of the evaluation, the notion of the "private sector" was found to refer primarily to the for-profit part of the private sector, and only that part of the for-profit sector viewed as direct service providers for the HEALTHCOM marketing methodology. The potential of larger national and multi-national companies operating in the country was not being sufficiently considered.

International PVOs and NGOs are playing an essential role in the design and implementation of HEALTHCOM-related activities with AED (Helen Keller Foundation in Indonesia; MSH in Africa and Latin America). But the potential contribution to HEALTHCOM of national PVOs, including those dedicated to local educational radio, was also not given enough attention.

In Honduras, the major reason given for keeping distance from PVO radio education stations, was the apparent strong political bent of these stations--most of them associated with the Catholic Church. Similar complaints have long been made by Guatemalan authorities about that Country's radio stations.

As regards the actual collaboration with the private sector, this is limited to the contracting of services. The for-profit private sector's involvement with the HEALTHCOM marketing strategy was discussed with respect to advertising and research firms, and to local broadcasting stations. In Honduras, for example, the MOH/DES contracts with a total of 30 of 160 for-profit private radio stations in the country. These are paid varying amounts for 30 second pre-recorded slots. The total radio budget for the current fiscal year was said to be L300,000 or US$150,000.

A representative of a newly formed association of Honduran radio broadcasting station owners maintained that they were planning to jointly develop advertising capabilities in addition to radio transmission services. Their plans included employing several theatre groups for acting out a wide range of commercial and social action announcements. Numerous owners involved in this association were among those transmitting HEALTHCOM messages for the MOH. Monitoring of radio transmission by MOH/DES is being improved.

2. Recommendations on the Private Sector

- **Innovative attempts are needed to induce more private sector participation in health education programs.** HEALTHCOM should be at the cutting edge of advocacy efforts to involve the for-profit and non-profit private sector to a greater extent in supporting the use of multiple communication channels for the cause of health behavior modification. The involvement of larger national and multinational companies should be pursued

as an integral part of its efforts to develop a sound policy environment of mass media education, as should the use of non-profit radio education broadcasting stations.

- As governments, with the assistance of HEALTHCOM, formulate health education policies, plans, and programs, these should serve as a basis for stimulating the cooperation of the private sector according to a time-framed strategic plan. Private sector involvement should include financial contributions to the costs of mass media promotion as well as to the distribution of printed materials.

- HEALTHCOM needs to assist the counterpart MOH officials in assuring that health-related products being promoted are disseminated and distributed in accordance with Government policies and specifications.

- HEALTHCOM needs to encourage the distribution and use of government health education materials in retail stores, pharmacies and private clinics sponsored by physicians, national and international PVO/NGO organizations.

III. INTEGRATION

A. Working with Other Groups

Q #11. **How well has HEALTHCOM worked with host country governments, local PVOs, other donor agencies such as UNICEF and WHO, and other AID projects, such as PRITECH, SUPPORT, REACH, SOMARC, ADDR, DHS, ISTI, PRICOR, etc.? Are there frequent information exchanges between groups, organizations and projects? Does HEALTHCOM know in what ways it might be helpful to other organizations? How could HEALTHCOM improve its working relationships with other groups, organizations and projects in the future?**

With reference to host country governments, it can be stated that the relations of the Project's Resident Advisors with officials are good and smooth. In the four countries visited by the team, conflicts were not apparent. In the Philippines, relations are excellent with officials of the MOH Information Service but almost non-existent with key officials of the Health Services. Steps are being taken to improve the situation. Both in Nigeria and the Philippines (as in Honduras), we believe it essential that a seasoned professional, preferably from the MOH, be added to the HEALTHCOM Project to assist the RA in representing the Project in outside forums; thus, to strengthen MOH institutionalization and integration into the Community Child Survival Program. The RAs have enormous workloads. In Nigeria, the arrival in the near future of an assistant to the Resident Advisor to be stationed in the field, in Niger Province, will establish a better balance between the federal and local levels with regard to the inputs of the Project.

As mentioned previously, the team heard complaints that federal officials were not briefed, nor did they receive corresponding reports. In the Philippines, while national health leaders were very supportive of the Project, the staff of the central public health services did not seem to be informed and active. Overall, the relationships with the multigovernmental agencies, specifically WHO and UNICEF, could be improved. The representatives of these agencies did not seem to know the HEALTHCOM methodology nor the goals or outputs of the Project with sufficient detail. The team recommended to the Resident Advisor to make a comprehensive presentation to the staffs of the agencies, and to keep them regularly informed.

UNICEF was an extremely cooperative partner in the Garut District in West Java, considered to be a demonstration area for the HEALTHCOM Project. It financed all the educational materials stemming from the application of the methodology. The results thus obtained were the basis for the extension of the health education methodology in CDD to three new districts in the same province, while stimulating the recent decision of the health authorities of West Java Province--population 31 million--to include four more districts.

The policy decisions of WHO and UNICEF related to CDD, EPI, and other child survival programs are of great importance to the MOH and the HEALTHCOM Project. A.I.D. takes them into account, and even joins forces with these agencies in some countries for larger coverage and investments. Better information exchange on HEALTHCOM methodology with these organizations would be very useful.

S&T/H has launched a series of centrally-funded projects stemming from the AID Child Survival Policy, e.g., PRITECH, SUPPORT, REACH, SOMARC, ADDR, DHS, ISTI, and PRICOR. An organized coordinating mechanism does not seem to be in place at this time. Relations among them are irregular. At best, they participate in the Technical Advisory Groups (TAGs)--e.g. HEALTHCOM and PRITECH--exchange documents and information and, in some countries, work together.

The Evaluation Team recommends a networking process among AID projects with common goals and interested in exchanging information, examining relevant issues, designing effective solutions and joining forces with governments to implement them. Networks should not be organized as rigid pyramidal structures with a complex administration. On the contrary, they are to be mechanisms for bringing together people and institutions with similar purposes, members being genuine peers ready to examine issues of importance to all.

Information is the essential instrument for effective networking and the starting point and common denominator of a process that should last as long as projects are in operation. HEALTHCOM already has sound relations with CCCD, PRITECH, and REACH. The team was informed of the close and effective association with PRITECH. Some HEALTHCOM staff members were previously with PRITECH and know its objectives and means of operation. AED subcontracts with PRITECH for health education expertise in some countries. In others, technical advisory services are ad-hoc, e.g. Indonesia, Jordan, and Papua New Guinea. However, PRITECH does not develop communications activities in CDD in non HEALTHCOM countries. The team believes that it should. An ongoing network between projects could facilitate planning and implementing the educational input. HEALTHCOM, PATH, and REACH met three times this year to examine issues of common interest--a good beginning of an effective network.

To bridge the gap between knowledge and practice, research and development projects should be planned together by PRITECH and HEALTHCOM. The TAGs of both, having common members, should have this responsibility. Thus, issues of common interest and significance could be investigated for the benefit of both projects.

At the African Bureau, The team was informed about the very good relations between Combating Childhood Communicable Diseases Project (CCCD) and HEALTHCOM. The former is operating at present in 10 countries in ORT, EPI, malaria, and other interventions. Nigeria is a good example.

CCCD planned programs with the government for EPI and HEALTHCOM stimulated demand for products and/or services once messages were disseminated. PRITECH is also working in Nigeria, and one CCCD representative speaks for the three projects. However, the three are not working in the same states, except in Niger State.

The role of the PVOs and NGOs--national and international--as potential or actual users of the HEALTHCOM methodology in primary health care deserves a comment. In general, the association with these agencies is more the exception than the rule and, where there has been a relationship, results are significant. Helen Keller International in Indonesia, particularly in Central Java, is a good example. The team could observe the communication strategy in the field in one of the two regencies (kabupatens) selected. It was based on radio messages and banners developed with HEALTHCOM assistance, complemented by training of voluntary health workers (kaders). The team had the opportunity to attend one of the training sessions and observe the active participation of several of the trainees.

Because cultural patterns do not seem to vary throughout Central Java, there was agreement that messages not be disseminated to other regencies in the province, until a careful balance of the promotional effort with the supply of Vitamin A could be ensured.

The above demonstrates how a deliberate effort by the Project to associate with major international PVOs and NGOs who are engaged in child survival programs can be complementary to project outputs, especially those requiring a health education component. The same approach should be followed at the national level with private agencies sponsoring primary health care programs, thus enlarging national resources and the field of application of the HEALTHCOM methodology. Pediatric societies, physicians, nurses, and other professional groups, medical and public health associations, need to be viewed as outlets for promoting health education and training as well as distributing information.

Q #12. **HEALTHCOM works with four subcontractors and a number of consultants to carry out project activities. Do contractors and consultants have clearly defined scopes of work? Is there adequate administrative and managerial support given to support these relationships? What project mechanisms are in place to address both accountability and communication issues? Are these sufficient? If not, what improvements are recommended? What kind of feedback has project management staff received from subcontractors and consultants regarding their respective relationships? Have they perceived any organizational problems or made suggestions for improved systems?**

The four subcontractors have clearly assigned responsibilities established in general terms in the Contract and refined by AED. For Annenberg and ACT these are more specific than for the other two.

AED initiates any activity to be undertaken by a subcontractor or consultant. The SOW specifies the nature and objectives of the assignment, time frame, and responsibilities.

Relationships between AED and the subcontractors and consultants are sound and positive. They provide a type of expertise that AED professional staff does not have. They contribute, therefore, to strengthen project development in the field, enrich the knowledge of Resident Advisors and their counterparts, and provide recommendations related to specific issues useful for AED Washington because they may be of significance for other similar HEALTHCOM projects.

In the Philippines, Porter Novelli is advising on qualitative formative research, while Annenberg is concentrating its services on summative evaluation. Some problems of overlapping have occurred resulting from normal professional competition difficult to sort out. This seems to be an unusual situation. Still, it should be avoided through better planning and active participation of the national counterparts.

The team was informed that in the MMHP phase of the A.I.D.-sponsored project, the implementation contracts were separate from the evaluation contracts. When the HEALTHCOM project was designed to follow MMHP, it was decided to merge both activities. A.I.D. required the evaluation of outputs and outcomes, and Annenberg was subcontracted to carry it out for the Project as a whole. The type of evaluations Annenberg is conducting--large scale, quantitative studies--is not considered part of HEALTHCOM's methodology per se. However, both HEALTHCOM and the team believe that some type of appropriate outcome evaluation be included in all project designs.

With reference to the administrative and managerial relationships between AED Washington and the subcontractors, contractors and the field, they seem to be effective. Project members in the Philippines and Nigeria warmly praised the back-up support they get from AED/Washington, including the HEALTHCOM Project Director. The level of backstopping has increased over time. At present, one professional is in charge of three countries. Despite the high level of expertise and quality of work of the RAs, the MOH would prefer more active technical assistance from the Central Office. The team suggests more frequent visits to the field. Regional meetings of Resident Advisors and "backstoppers" to interchange experiences on progress and constraints of the different project activities could also be very useful.

Consultants are appointed on ad-hoc bases. They provide specific knowledge usually not available in the professional staff of HEALTHCOM. In some cases, the Resident Advisors request not only the type of assistance needed but suggest the consultant desired, i.e., Professor John Elder of the University of California in San Diego, to plan a study on kaders' behavior in Central Java.

In comparison with the beginnings of the Project, today fewer consultants are needed because the regular staff and subcontractors are able to handle most requests for technical assistance.

Accountability, including quality of subcontractor and consultant performance, is determined through different project mechanisms. SOWs are specific. Detailed trip reports, debriefing sessions, quarterly and semiannual reports show a clear trend of the services rendered in relation to the objectives of each mission. Some consultants suggest Project Field Notes which refer to "particularly interesting aspects of project implementation or evaluation." The ones published are of interest to other projects. Furthermore, there is the feedback from the RAs and the professional backstopping staff. The latter are in close contact with the subcontractors, in some cases in weekly or bi-weekly meetings.

Contracts have been renegotiated with Porter Novelli and PATH, and are being negotiated with Annenberg on the basis of lessons learned in the first three years of the Project.

The Evaluation Team believes that the mechanisms in place seem sufficient to determine the quality and performance of the subcontractors and consultants. Perhaps the frequency and content of submitted reports could be reviewed to ensure that all reports are necessary and provide the required information. This review could help to assess whether the Project is evolving as expected. Further, AED should mandate MOH-briefings in the scopes of work, and should ensure that reports are delivered to key officials.

As already mentioned, in the Philippines, there has been an overlapping in the SOW of Annenberg and Porter Novelli, the former in charge of summative evaluation and the latter with qualitative formative research. Both subcontractors are conscious of this situation and have made concrete suggestions to improve the system.

Annenberg staff point out that data analyses for KAP surveys take time. However, they would like to become more involved in providing data as the project moves along, i.e., to participate in a monitoring process of the communications strategies, without impairing their summative evaluation responsibilities. Porter Novelli, in developing formative evaluation, would like to rely more on local research firms, even at the risk of having less data analysis but more timely results of value for the national and international staff. The Evaluation Team believes that both proposals should be carefully considered, keeping in mind the advantages of strengthening local experience toward institutionalization of the HEALTHCOM methodology.

Elsewhere in this Report the team has referred to the need for shortening the analysis time of the KAPs, for reviewing when, where, and how often they should be developed, and to re-examine with greater depth the data beyond the descriptive analysis of the communication strategy outcomes as it has been done so far with a "before-after" design. Perhaps with the exception of the evaluation of the projects in Swaziland and Peru, others do not include analysis on causal

inference in order to identify determinants of the responses and to better interpret the outcomes.

It is of concern to the team that Annenberg does not usually report the statistical significance of differences between "before and after" samples on any of the criterion variables, even in the evaluation of the project in Swaziland, where they were calculated and found highly significant.

In general, evaluation reports should establish whether the communication objectives of each project are being attained. Recommendations resulting from this exercise have given valuable feedback to Project management staff both in the Central Office and in the field, including national authorities and health education counterparts.

Some examples are worth mentioning. In Indonesia, the second Annenberg KAP report shows a rather limited effect of training reflected in behavior of the respondents. In Niger State, Nigeria, results needed strengthening. In Ecuador, the ORT and EPI communication strategy led to better accomplishments of objectives. A manual for measles vaccination followed the plan. In Mexico, a new and more educational ORS packet was designed, Porter Novelli advising the Ministry of Health.

B. Demand Creation/Supply and Training

Q #13. **How well does the project take into account the supply side of the equation as well as the demand side? What are the mechanisms for coordinating demand activities with supply activities?**

In the apparent absence of a systematic planning process it was difficult for the Team to ascertain whether regular supply and demand of products and/or services in terms of social marketing principles were successfully implemented in every project site. The Team was informed of few cases when this did not happen, for example, vaccination campaigns in which the logistic component is not carefully planned and more prone to an excessive promotional effort guiding mothers to places where vaccines are not available. This situation does not only impair the image of the Project but, more importantly, deprives children of an essential service for child survival.

The team strongly recommends that a systematic planning process be established for every health communication project and for each of the health practices that influence the survival of children, as they appear in the Contract. Monitoring of interventions will facilitate the correction of imbalances of supply and demand during the course of the project. Evaluation of processes and outcomes will provide the feedback to readjust objectives in relation to available resources. The supply-demand equation must be carefully planned and, to this end, the systematic planning process is essential.

Q #14. **What has HEALTHCOM's role been with respect to the training of health professionals? Have their efforts been sufficient and appropriate? Has this training followed the general principles of the methodology?**

The Evaluation Team reiterates that sustainability and institutionalization of health education activities, based on the HEALTHCOM Project's approach, will not occur if professional and para-professional health providers are not trained in-service and the methodology incorporated into the curricula of undergraduate and graduates at the universities and other teaching centers.

This process which is short and long-term, seems to be at different stages in the Project countries. In Indonesia, it appears to be more systematized in a pyramidal arrangement that trains first the trainers--namely health professionals--and then the trainees, particularly the voluntary collaborators (kaders), retailers, TBAs, and others. Curricula at all levels stem from HEALTHCOM methodology. Both in West and Central Java, thousands of kaders have been trained. Unfortunately, there is a large turnover of approximately 50 percent requiring the training process to prepare the newcomers. A study on kaders' behavior is being developed in Central Java that may lead to better incentives to retain them. The Family Planning Program seems to be a good model.

The Center for Community Health Education in Indonesia, with assistance from two of the RAs, developed a system of training kaders to teach neighborhood mothers about correct case management of childhood diarrhea, emphasizing ORT. Teaching techniques included role-playing of scripted micro-lessons, discrimination games to promote identification of correct and incorrect practices, trainee self-assessment, and homework. The method was highly cost-effective; it reduced the teaching phase to one day and, in a comparative analysis, was more successful than the traditional training based more on lectures than on an active participation of kaders.

In Honduras, the team attended a class of third-year medical students on health education for CDD, based on the methodology. A nurse was conducting the session. Students come in groups throughout the year. Based on the outcomes registered in the Report from Stanford University on the Mass Media and Health Practices Evaluation in Honduras (June 1985), it could be stated that professional and paraprofessional health care providers knowledgeable in the methodology have contributed to mothers' knowledge.

The team found that in the Philippines training on interpersonal skills focusing on community health workers needed strengthening. Health professionals, including educators and communicators, should also have a more organized system of in-service training. The Director of PIHES strongly recommended a model similar to the Field Epidemiology Training Program funded by A.I.D.. The Evaluation Team concurs.

Still, training is a long-range undertaking. Any priority health problem identified by the Government as requiring a strong health

education component must include a teaching-learning process at all levels, once the communications strategy has been designed, following the sequential phases of the methodology. ARI, just starting in Honduras is a good case in point. USAID/Honduras has also expressed great interest in incorporating nutrition into the HEALTHCOM Project.

The Evaluation Team wants to point out that the 13 indicators selected by WHO for CDD Programs include "Training coverage rates: (i) proportion of current health staff with supervisory skills; (ii) proportion of current health staff with responsibility for treating diarrhea cases who have been trained in diarrhoea management, where training includes actual practice. Figures related to this indicator should be part of monitoring of ORT/CDD programs."

The team would like measurement of the schools that have incorporated health communication in the core curricula for those graduates and undergraduates whose programs of study include diarrheal case management. In the countries visited, the team did not encounter Project monitoring based on the WHO indicators on training.

Q #15. **Does the HEALTHCOM effort fit appropriately within the overall child survival program so that communication, training and supply are adequately coordinated and mutually reinforcing?**

The emphasis in most Project countries on ORT/CDD and EPI, mainly vaccination campaigns, responds directly to AID's child survival policy. The application of the methodology to ARI, and eventually to nutrition, as in Honduras, will strengthen this approach. Furthermore, the primary health care programs outlined in the Contract all require a strong and modern health education component integrated with each one of them. This shows the extent and significance of the Project in order to effectively impact mothers' behavior.

Conceptually, HEALTHCOM is scientifically sound. It results from an original combination of anthropological and behavioral sciences and social marketing principles and methods. It is solidly based on research leading to a communication strategy that is country and/or region culture-specific and to a balanced supply and demand of products and services.

Training at all levels should be based on the methodology and the strategy. A situation that could lead to imbalances in the application of the HEALTHCOM methodology, already occurring in Indonesia, shows decision-makers extending health education activities to newer geographic areas at a speed that may not be commensurate with the availability of resources. Although it could be considered as a sign of success of the Project it may create difficult situations raising hopes in mothers that are not satisfied.

C. Recommendations on Integration

Because the HEALTHCOM Project has been in operation for only three years, relations with international organizations--both multilateral and bilateral, public and private--at the central and field level have not sufficiently been developed. And they should be.

Responsibilities of subcontractors and consultants have been better defined during the development of the Project. Scope of work objectives to be accomplished by each one of them, report content and time frame, including data analyses and expected effects of the recommendations to improve and extend the application of the HEALTHCOM methodology, are more specific. Still, there is room for improvement.

With better experience of the regular staff in Washington and the field, the number of consultants has significantly diminished. Recommendations on integration are as follows:

- Strengthen network links with those multi- and bilateral organizations requiring health education components for specific projects. Information exchange should be timely and ongoing, neither pro forma nor fait accompli.

- Resident Advisors with their counterparts should undertake an analysis of all available human and institutional resources needed to implement the Project's methodology, identify technical assistance requirements, and make appropriate recommendations to AED.

- Add at least one senior national professional to each Project to increase its presence in government and in the donor/NGO community.

- Develop a process of systematic planning, in order to better balance the relationship between supply and demand for each health problem selected by the government. This should include health education interventions. The formulation and implementation of plans should be done by MOH with the assistance of the Project.

- Strengthen training of professional and non-professional health services providers in order to speed up the process of changing mothers' health practices. The Team reiterates that the process of institutionalization of health education must be developed simultaneously.

- Make training and study opportunities available to appropriate Ministry of Health officials, national health educators, and AED Resident Advisors at various project field sites to facilitate and enhance cross-fertilization of knowledge and experience.

- Conduct an in-depth review of the need, role, and responsibilities of subcontractors and consultants for the

remaining life of the Project--and a future one if so decided. In this analysis, consideration should be given to extending coverage or initiating the application of the methodology to current targeted child survival problems as well as to new ones in every emphasis country. Direct relations to the proposed streamlining of the methodology--if approved and developed--should be another guiding principle. It is expected that the Project should become less research oriented and more effectively operational. Summative evaluation stemming from KAP studies should be complemented with causal inference analysis to identify determinants--dependent variables--of respondent's behavior regarding the effective use of products and services for child survival.

IV. MANAGEMENT

A. Organizational Structure

Q #16. (a) **How is the HEALTHCOM Project structured?**

In each of the Project's field operations project sites, activities are conducted within the framework of national health education programs and objectives. One of the Project's objective is to strengthen national health education and communication capabilities for child survival.

The relationship of the Resident Advisor (RA), the official representative of the Project in-country, to the national staff works effectively when there are common goals, supported by the Ministry of Health. The operational workplace for the Resident Advisor, and thus the locus for all Project activities, is determined by an agreement between the host government and the AID Mission.

The HEALTHCOM Office in Jakarta, Indonesia, is located within the Center for Community Health Education. In West Java and in Central Java Provinces, it operates within the offices of the Provincial Health Departments; the second works jointly with Helen Keller International. In the Philippines, it is situated within the Public Information Health Education Services (PIHES), of the Office of the Chief of Staff and the Undersecretary for Health. In Papua New Guinea, the Office is located within the Primary Health Services. In Nigeria within the Federal Health Education Division of the Federal Ministry of Health; and in Honduras, in the Division of Health Education of the Ministry of Health, which is located in a different building.

The role and effectiveness of the Advisor is influenced by the support received from national staff for health education activities within the Ministry. For example, in the Philippines the Director of the Department of Health, along with the Chief of Staff and Undersecretary of Health provide enthusiastic support for the HEALTHCOM project. However, organizationally the separation of the PIHES and the Office of the Undersecretary of Health for Health Services--where EPI and CDD programs are managed by the MCH Division--can result in uncoordinated activities. In addition, separation of program responsibilities traditionally cause suspicion of one another resulting in a lack of cooperation thereby affecting the mission of the Ministry.

Decentralization of health activities at the provincial/regional level may have a constraining impact on HEALTHCOM programs. Problems can range from a lack of national support for health education posts at the regional level to a reduction in funding support from the national office. For example, decentralization of health activities in Papua New Guinea (1983) resulted in a weakness in management capability and, as the result of a budget cut (1985), the position of health educator was phased out.

In Indonesia the interaction between the provinces and the Center for Health Education is not strong because the provinces are not convinced that the Center has much to offer them. This is a typical problem between national and provincial governmental structures where there is a natural wariness of central bureaucracies. Overly centralized governments tend to distort resource allocations favoring central units over field units, and reduce opportunities for local initiatives. A workshop to examine a National Communication Strategy for Diarrheal Disease Control, prepared by the Center of Health Education with effective assistance from the Resident Advisor--a sound contribution of HEALTHCOM--provided an excellent opportunity to initiate a dialogue among health educators. By developing a formal dialogue on approving a national communication strategy for diarrheal disease with the provinces, a forum is now beginning.

Q #16. (b) Is the current management structure appropriate for successfully carrying out project goals and objectives?

The present organizational structure of HEALTHCOM is working properly with adequate staff and activities, project direction, administration, contract management, budgeting and finance, and field operations composed of Resident Advisors and country program managers, located in Washington, who serve as back-up support to the Advisors. The Project is technically supported in evaluation, marketing, advertising and print materials, and appropriate health technologies development by subcontractors, and other short-term technical assistant specialists such as behavior analysts.

The team envisions that if there is a streamlining of the HEALTHCOM methodology, due consideration be made to reviewing the present organizational structure in existing HEALTHCOM countries, including the use of subcontractors and consultants. As an outcome, it may happen that the available manpower and financial resources with a different organizational arrangement could become more productive.

The Resident Advisor within the national or regional Office of the Ministry of Health is crucial to facilitating the implementation of communication strategies. Ideally, the Advisor should collaborate directly with the health education office, while at the same time he should participate in policy and program decisions taken by the health services dealing with child survival activities. Thus, the integration of the communication strategy into the health care programs could occur.

One suggestion is establishing an advisory group, say in diarrheal disease, bringing together health services and health education/ communication organizational units. In this way, the separation of health programs and health educational strategies could be improved functionally.

B. Relationship to the Field

Q #17. (a) **Has the relationship between HEALTHCOM/Washington and the field been effective?**

The HEALTHCOM project is described in its organization chart as composed of AED headquarters project staff which include country program managers, and field Resident Advisors. The evaluation and technical subcontractors provide field support to the Advisors as requested by them and the program managers. The working relationship between AED/Washington and the field has been effective. However, the team is concerned that the activities presently undertaken by the Resident Advisors are reaching their "span of control" and that consideration of additional in-country support staff, where needed, be carefully assessed, especially if there is an expansion of Project activities determined by MOH as in Indonesia. Therefore, planned expansion should be jointly developed by the government and the HEALTHCOM project, thus determining the contributions and responsibilities of both.

Q #17. (b) **Does HEALTHCOM/Washington and HEALTHCOM/field have full appreciation for one another's activities, constraints, environment, opportunities, etc.? If not, how can communication and understanding be improved?**

HEALTHCOM/Washington country program managers and the Resident Advisors recognize each other's responsibilities in the implementation of country programs. There has been, however, according to field staff, a significant number of requests from Washington, besides requests for monthly and semiannual reports and other documents.

In some cases, reporting to the AID Mission occurs at different time periods than to Headquarters Washington, and may require additional or different information. The Team recommends that similar reports be sent to AID and AED/Washington whenever possible. The visits of subcontractors and consultants require the active participation of the Resident Advisor during and after the visit to implement the suggested recommendations. The Advisors are responsive to all of the above needs, but are concerned with the time taken away from crucial field activities.

Perhaps one reason for the affinity between AED/Washington and field teams, is the very good orientation and training program that AED has developed for new RAs. The program includes six weeks of field-site familiarization with the country program in Honduras.

All Washington-based staff have extensive overseas experience and relevant skills, and periodically make trips to the field, which is also another factor in maintaining good communication.

In Honduras, Indonesia, Nigeria, and in other countries, Resident Advisors conduct qualitative formative research, assist in the development of KAP investigations designed by subcontractors for

evaluation purposes, develop behavioral studies for pretesting communication messages in the field, and manage other research activities. The team recommends that, where appropriate, training in qualitative and quantitative research, questionnaire development, and management be provided to the Resident Advisors.

The Director of PIHES in the Philippines spoke strongly about the need for a training program similar to that of the Field Epidemiology Training Program funded by A.I.D. The purpose of this program is to strengthen epidemiologic services of the Ministry of Health, thereby improving its capabilities in a wide range of activities to reduce infant and early child mortality. The team recommends that this approach be considered to develop national capabilities in communication research and management.

C. Financial Matters

Q #18. **Is the project making the best use of available resources?**

Have project expenditures been in line with project costs in the budget?

Has the staff exercised sound judgment? Does it have the necessary technical, fiscal and management skills in implementing the project?

AED is utilizing its available resources in line with its budget to meet the program requirements both in Washington and in the field. In several projects it was noted that disbursements may be behind or relatively slow for the implementation of different activities. The systematic planning process provides a framework against which to measure program progress against objectives and funds allocated to date.

The team recommends that the national plans--setting forth resource allocation--serve as the basis for evaluating the cost and efficiency of operations, financial accountability as well as the Resident Advisors' management skills for implementing projects. The HEALTHCOM plans and their budgets do not facilitate this exercise.

Q #19. **Are the current methods of financial tracking adequate? Are there appropriate financial controls in the field to track expenditures and to inform HEALTHCOM of any possible shortage of funds?**

AED has designed and is using a good financial tracking system developed for the project. For the Washington and field operations, budgetary line items are clearly identified, and an internal financial tracking system maintains current obligations against line projections.

D. Recommendations on Management

- Should the decision be made to streamline the HEALTHCOM methodology, the Evaluation Team recommends a comprehensive review of the present organizational structure.

- In order to make the participation of the private sector more cost-effective, the Team recommends that specific criteria be established in order to select the companies which will provide the materials and products for health interventions.

- In order to strengthen the relationships between HEALTHCOM/ Washington and the field, the Team recommends that there be regional workshops for the interchange of lessons learned, analysis of common problems and their potential solutions. Visits of national counterparts and Resident Advisors to different projects are highly advisable.

- Because disbursements of funds in several projects have been behind schedule (suggesting several possible management problems) the Team recommends that the systematic planning process referred to in this Report be the basis for evaluating financial accountability.

- Project reporting requirements for AID and AED should be coordinated in time and substance to reduce the Resident Advisor's workload.

- Training in research methods should be given to Resident Advisors, when appropriate.

- Spatial proximity does not always breed the desired levels of psychological proximity and program coordination. AED should undertake in-depth study of each field project, looking beyond physical location to the quality and comprehensiveness of Project collaboration to MOH operations and services.

V. CONCLUSIONS

A.I.D. should be commended for building into its Child Survival policy a systematic, long-term, cross-cultural approach to health communication and education. No other international agency has taken the initiative, nor invested the necessary resources for such an important, bold undertaking.

The audiences serviced first by the HEALTHCOM initiative are among the poorest and at greatest risk of death and disease. Changing behavior for better health practices is a complex, prolonged process--and all the more so in poverty-stricken communities lacking basic services and resources. The institutions the Project deals with are often poorly staffed, lack equipment, and have a low standing.

The team strongly endorses the HEALTHCOM concept and the continuation of the project. A.I.D.'s front-running audacity in creating and sustaining the project are applauded as is AED's professionalism in carrying out the terms of the contract. But the collective mind of the team is more often in the future, the direction in which the project should be moving apace. In this context, suggestions are made about future activities.

The Project represents the operational application of an innovative methodology developed in the earlier MMHP research phase, in only a few countries. Thus, given the uncertain nature of how the methodology might take hold in other environments, this approach is appropriate as the initial stage in developing a long-term innovative communication program.

As noted previously, current contract requirements have led HEALTHCOM to stress audience effects rather than emphasize the institutionalization process. Due in part to the Contract's stipulation of significant changes among large numbers in too-brief a time, the Project has concentrated mostly on:

- Audiences: The Project has developed a "home strategy" that tends to look past its client (the MOH) to concentrate mainly on its principal audience (mothers). As a result, simultaneous institutionalization efforts have been largely deferred.

- Mass Media: The home strategy emphasis has resulted in an disproportionate use of, and allocation of funds to, mass media to reach large audiences, which has curtailed efforts to enhance face-to-face communication to translate media messages into daily uses of MOH staff and recipients.

- Community Research: The home strategies have led to an undue emphasis on research and development. Still, operations research--i.e., looking for the most cost-effective alternatives to different components of the methodology has not yet been developed.

The team reiterates that the HEALTHCOM methodology is based on knowledge of health behavior which must be changed. However, this research should be developed to the extent that the knowledge is lacking and is necessary to design an effective communication strategy.

- Outside Expertise: Although outside experts are necessary because the extensive use of the methodology is original and new in health education, its application has not given sufficient attention to upgrading national research and communication planning capabilities. From its earliest days in-country, HEALTHCOM should be working earnestly toward the time when technical assistance is no longer needed.

- Campaigns: It is advisable to combine health education interventions in the established health infrastructure--including outreach to home--with campaigns that are highly visible, but that may have short-term effects on awareness and on behavioral changes.

This is not to gainsay the many impressive HEALTHCOM achievements, but there is wisdom in reviewing contract terms and conditions for the purpose of refocusing HEALTHCOM activities, redirecting its resources, and moving to a phase which stresses sustainability of communications. In particular, in a series of five-year contracts, 15 to 20 years would be a more realistic time frame for achieving widespread behavioral changes in host institutions as well as in community health standards, practices, and opportunities.

On the basis of their experiences in four countries, the team feels that more caution should be taken by the Project to keep national and regional authorities duly informed about objectives, interventions, and monitoring indicators in order to avoid the image of a foreign-financed and -managed enterprise.

Surveying the conceptual base established by MMHP and the accumulating field evidence of HEALTHCOM in the context of the history of mass-cum-interpersonal communication projects in development, the team's view is that enough past lessons have been learned to begin applying them more quickly to the present methodology. As such, despite contract focus on "studies," the team sees the Project as a pilot demonstration project, not a pilot study. Its purpose is to test alternative methodologies more than to test alternative research hypotheses. And the team wonders whether the total methodology has to be applied in all settings in order to benefit any individual setting.

If A.I.D. decides to extend the HEALTHCOM concept at mid-term of the present Project, it is time to begin sifting accumulated evidence of the previous phases for a solid transition to a next phase.

Integrating health education on the bases of the methodology into policies and plans of primary health care, reviewing the methodology to

decide whether it can be streamlined, strengthening face-to-face communications, retraining health education staff, building MOH commitments, and other issues related to the team's recommendations, should receive increased attention in the current as well as the future Project.

The result of the Project would be, over a long period of time, to introduce and sustain a new communication "ethic" requiring innovative government and private-sector commitments to improve health services that take greater account of the needs and circumstances of the public served. The contribution that HEALTHCOM has made to this process is highly significant. The clock cannot be turned back. The research-based use of mass- and interpersonal-communication media, combined with marketing principles, is a permanent and desirable condition of the development process.

The team reiterates that the findings and recommendations already discussed would not alter the basic intent of the Project, while suggesting: (1) a new framework for reviewing the terms and conditions of the contract that have driven the Project <u>for</u> (2) the purpose of timely development of a more simplified operational version <u>as</u> (3) a surer basis for a third, expanded phase of application.

ANNEX 1

Scope of Work

HEALTHCOM Mid-Term Evaluation

ANNEX 1

Scope of Work

HEALTHCOM Mid-Term Evaluation

EVALUATION GOALS:

1. To assess the accomplishments of the HEALTHCOM Project from its inception up to the time of the evaluation, in relation to specific items in the contract agreement, namely:

   a. Goals and Objectives
   b. Scope of Work
   c. Reports/Deliverables
   d. Evaluation

2. To recommend future actions to be taken to strengthen program activities.

3. To determine priorities for continued assistance and future activities in the field of health communications.

EVALUATION GUIDELINES:

1. The team, consisting of four professionals, will be responsible for reviewing and revising the scope of work with the CTO, for conducting an evaluation, and for preparing and writing an evaluation report.

2. The team will meet in Washington, D.C. for an initial planning meeting to:

   - clarify scope of work;
   - design the evaluation process;
   - make individual team member assignments;
   - develop a plan for action;
   - draft a preliminary outline for the Final Evaluation Report.

Assignments will be made for each section of the report, designating the amount of time requried for each person to collect and analyze data, write and finalize the report. In collaboration with the CTO, team members will select countries for site visits. They will spend time at the Academy for Educational Development (AED) interviewing staff and reviewing documents, in addition to meeting with subcontractors and A.I.D./W staff.

3. Members of the Team will need expertise in one or more of the following areas:

- Communications,
- Social Marketing,
- Behavior Analysis,
- Public Health,
- Management,
- Evaluation,
- Anthropology,
- Field experience,
- Report writing.

4. Site visits will be made by two-member teams to four of the following countries:

o Ecuador	o Lesotho	o Indonesia
o Guatemala	o Nigeria	o Phillipines
o Honduras		
o Mexico		

Timetable

- One week to be spent in Washington, D.C. meeting with A.I.D. and HEALTHCOM staff.

- One week at each of four sites, talking to USAID, HEALTHCOM, MOH personnel, and others as appropriate.

- Eight days to write, finalize and submit draft evaluation report to A.I.D./W for review and comment.

- Final evaluation report due two weeks after draft submission.

- One-half day debriefing of A.I.D./W staff post-finalization of report.

BACKGROUND:

The Communication for Child Survival, or HEALTHCOM Project, is the major health and child survival communication project of A.I.D., managed jointly by the Offices of Health and Education in the Bureau of Science and Technology. HEALTHCOM is an outgrowth of an earlier project entitled Mass Media and Health Practices (MMHP), which was initiated to apply state-of-the-art knowledge about communicaiton and social marketing to selected child survival practices.

In August 1985, A.I.D. extended the MMHP Project under the new name - HEALTHCOM. The project's mandate was broadened to include additional countries (activities will be conducted in up to 17 countries over the life of the contract) and a range of child survival technologies, in addition to ORT. This midterm evaluation, scheduled to begin in

10

September of 1988, will aid in directing the course of the project for the remainder of the contract, which is scheduled for completion in 1990, as well as to provide guidance for follow on communication activities to be financed by A.I.D.

Major areas to be considered for this assessment fall under the broad categories of: I. Methodology, Selection and Evaluation Issues; II. Sustainability; and III. Integration. Other areas to be examined include: IV. Information and Dissemination/Diffusion Activities; and V. Management/Financial Matters.

SUGGESTED KEY QUESTIONS:

I. METHODOLOGY, SELECTION AND EVALUATION ISSUES

A. General

1. Given the primary purpose of the HEALTHCOM project, is the project meeting its stated goals and objectives?

2. Is the communication methodology developed by the project appropriate for the goals and objectives of the project?

3. Is the project methodology utilizing the best communication mix for reaching its target audiences? In other words, is there an appropriate balance between radio/TV, print and face-to-face communication?

B. Research and Development

4. Are HEALTHCOM's current research and development efforts appropriate and on target? Where should HEALTHCOM focus its research efforts in the future?

5. Have the health behavioral studies been an effective tool for improving the implementation of field activities? Have they played a role in the development and refinement of the project methodology? What has been learned by the project from these studies?

C. Evaluation

6. What should be the evaluation criteria used by the project to measure its effectiveness, i.e., are demonstrations of changes in knowledge and attitudes enough or should HEALTHCOM be expected to demonstrate impact on health practices? In countries where priorities or constraints make quantifiable changes in health practices an unlikely outcome, what is an appropriate evaluation approach and level of effort for assessing accomplishment of other program objectives? What kind of changes over time should be expected? How much time should be allowed to demonstrate these changes? How much impact should be expected?

7. What portion of project funds should be devoted to documenting impact?

II. SUSTAINABILITY

A. General

8. Are sustainability issues a viable and essential part of the HEALTHCOM methodology?

B. Institution Selection

9. How well has the HEALTHCOM project transferred its approach and methodology to host country institutions?

10. To what extent has the private sector been involved in the HEALTHCOM project? What lessons have been learned in working with the private sector? How should the project utilize the private sector in future activities? What lessons have been learned about sustaining activities in the private sector?

III. INTEGRATION

A. Working with Other Groups

11. How well has HEALTHCOM worked with host country governments, local PVOs, other donor agencies, such as UNICEF AND WHO, and other A.I.D. projects, such as PRITECH, SUPPORT, REACH, SOMARC, ADDR, DHS, ISTI, PRICOR, etc.? Are there frequent information exchanges between groups, organizations and projects? Does HEALTHCOM know in what ways it might be helpful to other organizations? How could HEALTHCOM improve its working relationships with other groups, organizations and projects in the future?

12. HEALTHCOM works with four subcontractors and a number of consultants to carry out project activities. Do contractors and consultants have clearly defined scopes of work? Is there adequate administrative and managerial support given to support these relationships? What project mechanisms are in place to address both accountability and communication issues? Are these sufficient? If not, what improvements are recommended? What kind of feedback has project management staff received from subcontractors and consultants regarding their respective relationships? Have they perceived any organizational problems or made suggestions for improved systems?

B. Demand Creation/Supply and Training

13. How well does the project take into account the supply side of the equation as well as the demand side? What are the mechanisms for coordinating demand activities with supply activities?

14. What has HEALTHCOM's role been with respect to the training of health professionals? Have their efforts been sufficient and appropriate? Has this training followed the general principles of the methodology?

15. Does the HEALTHCOM effort fit appropriately within the overall child survival program so that communication, training and supply are adequately coordinated and mutually reinforcing?

IV. MANAGEMENT

A. Organizational Structure

16. How is the HEALTHCOM project structured? Is the current management structure appropriate for successfully carrying out project goals and objectives?

B. Relationship to the Field

17. Has the relationship between HEALTHCOM/Washington and the field been effective? Does HEALTHCOM/Washington and HEALTHCOM/field have full appreciation for one another's activities, constraints, environment, opportunities, etc.? If not, how can communication and understanding be improved?

C. Financial Matters

18. Is the project making the best use of available resources? Have project expenditures been in line with projected costs in the budget? Has the staff exercised sound technical, fiscal and management skills in implementing the project?

19. Are the current methods of financial tracking adequate? Are there appropriate financial controls in the field to track expenditures and to inform HEALTHCOM of any possible shortage of funds?

ANNEX 2

Bibliography

ANNEX 2

Bibliography

1. HEALTHCOM Project Deliverables. Master List-Required, Approved, and Drafted. Current as of September 14, 1988. Washington, D.C.

2. HEALTHCOM Semiannual Report 5. October 1, 1987-March 31, 1988. Bureau for Science and Technology, Office of Health and Office of Education. AID. Washington, D.C.

3. Communication for Child Survival. HEALTHCOM. Evaluation Plan: West Java, Indonesia. Office of Health and Office of Education. Bureau for Science and Technology. AID. Prepared by Jeffrey McDowell, Annenberg School of Communications. University of Pennsylvania for the Academy for Educational Development. Washington, D.C., March 1988.

4. Communication for Child Survival. HEALTHCOM. A Project of the United States Agency for International Development conducted by the Academy for International Development. Prepared by M. R. Rasmuson, R. E. Seidel, W. A. Smith, and E. Mills Booth. June 1988. Washington, D.C.

5. Communication for Child Survival. HEALTHCOM. Summary Report. Office of Health and Office of Education. AID. Washington, D.C. Summary Report. Technical Advisory Group Meeting. February 9, 1988. Academy for Educational Development. Washington, D.C.

6. HEALTHCOM. Honduras Implementation Plan, 1986-88. a program of the Bureau for Science and Technology, Office of Health and Office of Education. AID. HEALTHCOM Project DPE-1018-C-00-5063-00. Academy for Educational Development. December, 1986. Washington, D.C.

7. HEALTHCOM. Indonesia. Implementation Plan, 1986-88. A program of the Bureau for Science and Technology, Office of Health and Office of Education. AID. HEALTHCOM Project DPE-1018-C-00-5063-00. Academy for Educational Development. October, 1986. Washington, D.C.

8. ORT Plus: Combining Themes in Public Health Communication. Final Report. Honduras Primary Health Care Communication, 1983-84. Submitted to the USAID/Honduras and the Office of Education and the Office of Health, Bureau for Science and Technology, AID, by the Academy for Educational Development. Communication for Child Survival-HEALTHCOM. Tegucigalpa, Honduras, December 1985.

9. Communication Community and Health. Final Report. Honduras Water and Sanitation Communication Program, 1981-85. Submitted to the AID Mission Honduras and the Office of Education and the Office of Health, Bureau for Science and Technology, AID, by the Academy for Educational Development. Communication for Child Survival-HEALTHCOM. Tegucigalpa, Honduras, December 1985.

75

10. HEALTHCOM. Communication for Child Survival. Field Notes. A program of the Office of Health and Office of Education, Bureau for Science and Technology, AID and the Academy for Educational Development. October, 1985. Washington, D.C.

11. HEALTHCOM. Communication for Child Survival. Lessons from Five Countries: Honduras, The Gambia, Swaziland, Ecuador, Peru. Office of Health and Office of Education, Bureau for Science and Technology, AID. Academy for Educational Development. October, 1985. Washington, D.C.

12. HEALTHCOM. Communication for Child Survival. The Mass Media and Health Practices Evaluation in Honduras: A Report of the Major Finds. Applied Communication Technology by Stanford University. Office of Education, Bureau for Science and Technology, AID. Academy for Educational Development. June, 1985. Washington, D.C.

13. HEALTHCOM. Communication for Child Survival. Patterns and Persistence of ORT Use During Intensive Campaigns in Hon uras and the Gambia, 1981-83. Draft. Applied Communication Technology. Office of Education, Bureau for Science and Technology, AID. Academy for Educational Development. June, 1985. Washington, D.C.

14. HEALTHCOM. Communication for Child Survival. Institutionalizing a Methodology for Public Health Communication: A Midproject Report. Draft. Office of Education, Bureau for Science and Technology, AID. Academy for Educational Development. June, 1985. Washington, D.C.

15. A Behavioral Approach to Acute Respiratory Infection (ARI) Control in Honduras. Elder, J., Boddy, P., Barriga P., Aguilar, A.L., Espinal H., Noren, N., and Barahona, F. Draft. San Diego State University-Academy for Educational Development-Honduras Ministry of Health.

16. Proyecto de Desarrollo Administrativo para la Divisi n de Educaci n. Draft. Ministry of Public Health, Honduras.

17. Evaluaci n Conjunta de la Cooperaci n Tcnica de la OPS/OMS en Honduras. Anexo. Informaci n Estadstica. Honduras Ministry of Public Health-Pan American Health Organization. September, 1988. Honduras.

18. Evaluaci n Conjunta de la Cooperaci n Tcnica de la OPS/OMS en Honduras. Programa. Situaci n del pas, de salud, del sistema y del proceso de desarrollo de las reas prioritarias en salud. An lisis de la cooperaci n tcnica de la OPS/OMS. Lineamientos para el an lisis prospectivo de la cooperaci n de la OPS/OMS a mediano plazo. Honduras Ministry of Public Health-Pan American Health Organization. September, 1988. Honduras.

76

19. Plan de la Estrategia de Comunicaciones para el control de infecciones respiratorias agudas (IRA), perodo 1987-89. Honduras Ministry of Public Health. General Health Directorate. Division of Epidemiology-Division of Health Education. July, 1987. Honduras.

20. Encuesta Nacional de Nutricin. Cuadros de frecuencias por regiones de salud y nacionales, 1987. Honduras Ministry of Public Health. Scientific Publication No. 0020-06-88.

21. Encuesta Nacional de Salud Maternoinfantil, 1984. Honduras Ministry of Public Health-Honduran Association for Family Planning. Scientific Publication No. 0011-02-88.

22. Patterns and Persistence of ORT Use During Intensive Campaigns in Honduras and the Gambia, 1981-83. Applied Communication Technology- Academy for Educational Development. California.

23. National Communication Strategy for Diarrhea Case Management at the Community Level: A Social Marketing Approach. The Center for Community Health Education and The National Program for Control of Diarrheal Diseases. Department of Health, Republic of Indonesia. Draft updated August, 1988.

24. Communications Management for Diarrheal Disease Control, January 1988-September, 1989. Approved Plan for Assisting the National CDD Program. Center for Community Health Education, Department of Health, Jakarta, Indonesia, 1988.

25. West Java Province. Control of Diarrheal Diseases Plan (January-September 1988. A Social Marketing Approach. Diarrhea Disease Control Working Group, West Java Province Health Department, Indonesia, March 1988.

26. Social Marketing Strategy, 1988. Office of Population and Health. AID/Indonesia.

27. Rovita Implementation Plan. Rovita Project. Rehidrasi Oral Dan Vitamin A. A Double Intervention of Oral Rehydration Therapy and Vitamin A in Two Kabupaten in Central Java. Indonesian Ministry of Health-Department of Health, Central Java Province-School of Medicine, Diponegoro University-School of Public Health, University of Indonesia-Helen Keller International-Communication for Child Survival (HEALTHCOM) Project, AID. March, 1987.

28. Bastien, J. W. Cross-Cultural Communication Between Doctors and Peasants in Bolivia. Soc. Sci. Med. 24:12;1109-18, 1987.

29. Evaluation of the Expanded Program on Immunization Information System and KAP Survey Coverage Analysis. AID/Quito. Resources for Child Health Project (REACH). November, 1987.

30. Immunization Coverage Analysis. AID/Quito. August 17-September 20, 1986. Resources for Child Health Project (REACH). November, 1987.

31. Kendall, C. The Implementation of a Diarrheal Disease Control Program in Honduras: Is it 'Selective Primary Health Care' or 'Integrated Primary Health Care? Soc. Sci. Med. 27:1;17-23, 1988.32.Bastien, J.W. Cross-Cultural Communication Between Doctors and Peasants in Bolivia. Soc. Sci. 24:12;1109-1118, 1987.

33. HEALTHCOM. Communication for Child Survival. Public Health Communications Program. Offices of Health and Education. Bureau for Science and Technology. Agency for International Development.

ANNEX 3

List of Persons Contacted

ANNEX 3

List of Persons Contacted

U.S.A.

A.I.D.

Barth, Kenneth	S&T/Health
Block, Clifford	S&T/Education
Clay, Robert	S&T/Health
Johnson, Charles	ANE/Health
Klement, Julia	LAC/Health
Lin, Kimmie	S&T/Health
Moser, Tricia	LAC/Health
Roseberry, Wendy L.	Africa/Health
Tinker, Anne	S&T/Health

AED

Clift, Elayne
Graeff, Judith
Hall, Clarence
Morales, David
Rasmuson, Mark
Seidel, Renata
Shaw, Will
Smith, William
Urban, Diane
Verzosa, Caby

Porter/Novelli

Debus, Mary

Path/PIACT

Kazi, Carol
Moore, Mary Beth

Johns Hopkins University

Kendall, Carl

Annenberg School of Communications

Hornik, Robert
Yoder, Stanley

MSH/PRITECH

Alden, John

San Diego State University

Elder, John	Consultant AED

Applied Communications Technology

Foote, Dennis Read

PHILIPPINES

Philippines Pediatric Society/CDD Committee

Aquila, Felicitas
Antonio, Zenaido

PIHES/DOH

Alano, Pacita	
Dayrit, Manuel	Chief
Lelis, Remedio	
Nito, Edna	
Soldevilla, Aida	

DOH/CDD

Bagasao, Teresita	
Mora, Bernardo	Chief, Biological Production Service
Sullesta, Enriqueta	National Coordinator, Maternal and Child Health

DOH

Aranas, Consuelo	Ass't. Secretary for Public Health Service

IMS Pacific Ltd.

Algium, Imelda
Ferry, Olivia

PAC/BBDO Inc.

Norales, Louie

MCH/DOH

Dayrit (SN), Elvira

NCR/DOH
Reodica, Carmencita

81

Consumer Pulse, Inc.

Estrada, Darrah	CDD Research

Kabalikat ng Pamilyang Pilipino

Bagasao, Teresita

HEALTHCOM

Hernandez, Jose	Resident Advisor
de Guzman, Nora	Staff

USAID/MANILA

Farr, Kenneth	
Johnson, William	
Banez, Eireen	PHC Financing Project

WHO

Piesche, Sergio	Manila

INDONESIA

HEALTHCOM

Davies, John	Resident Advisor, Jakarta
Reis, Thomas	Resident Advisor, Semarang
Terry, Louis	Resident Advisor, Central Java

MOH

Gunawan, H.	West Java, AID Project Coordinator
Jones, Warren	West Java, Health of Health Education, Bandung
Rustandi, Dr.	West Java, Chief, Regional Health Office
Sudarmadj, Dr.	CDD Project Officer
Sutoto	Jakarta (CDD Program)
Titi	Jakarta (Program manager, CDD)
Yayat, Djajnika	West Java, CDD Program Chairman

USAID/Jakarta

Perla, Joy Riggs	Office of Population and Health
Penniston, Anne	
Voulgaropoulos, Z.	Chief

CDD

Pratama	Program Manager, Semarang

82

Helen Keller International

Palmer, Ann	Semarang
Wilbur, Steve	Jakarta

Center for Health Education

Gerda, Gertrude	
Tjep, Marku	
Sutarto	Field Director, Semarang

Vitamin A Program

Sudaryono	Manager, Semarang

NIGERIA

NTA, Minna

Adaba, Shaka	Producer of Child Survival Unit
Abdulkadir, Hafsatu	Producer of Child Survival Unit
Abubarkar, Aminar	Producer of Child Survival Unit
Garba, Yakubu	Controller of Programmes, Niger State

NTA/Lagos

Atsen, Anua, Johnaton	Program Coordinator

HEALTHCOM/Nigeria Resident Advisor

Agboola, Anthony	Resident Advisor
Olajide, Olu	Resident Advisor
Daramoola, Deji	Resident Advisor

University of Ibadan/Chairman Social Sciences

Ajanyi, Simeon	Chairman, Social Sciences

Niger State Radio

Dauda, Sulaiman	Radio Programmer

83

MOH

Ademuwagun, Zacheus	Director, African Regional Health Education Center
Henshaw, Felicia	Chief, Health Education Division, Lagos
Isah, Mohammed A.	Chief, Health Education Officer, Niger State
Kasso, Mallam M.	Manager, EPI, Niger State
Nagia, Idris K.	HEALTHCOM, Niger State
Odunsi, Dr.	Lagos
Saba-Ojomo, Susan	Director General, Niger State
Salawu, Dr.	Lagos
Shehu-Baro, Ahri,	EPI, Niger State
Yuwafu, Kokoyi Alhi	Village Clinic, Chanchaga

CCCD

Nelson, John

HONDURAS

USAID/HONDURAS

Haladay, Robert

Ministry of Health

Alvarado, Wilfredo	Ex-Jefe (DES)
Barahona, Fidel	Epidemiologia
Bonano, Maria Rosa	CDD
Davila-Nolasco, Davil	Director, Division Educacion de Salud (DES)
De Noren, Nora	ARI
Diaz, Arturo	DES
Espinal, Hector	DES
Gavidia, Roberto Cruz	EPI
Medina, Ana Julia	Village Clinic, Comunidad de Monte Redondo
Melara, Alejandro	Salud Materno-Infantil
Melendez, Jorge	Atencion de Nino
Mendoza, Irina	S&T/Epidemiologia
Montenegro, Antonio	DES/Radio
Murillo, Victor	DES
Ordonez, Elora	S&T/Epidemiologia
Pinel, Marco Antonio	S&T/Epidemiologia
Pineda, Roberto	DES
Sagastume, Rene	DES
Sarmiento, Luis	DES
Sierra, Victor	DES
Villeda-Bermudez Ruben	DES

94

HEALTHCOM

Barriga, Patricio	Resident Advisor

MSH

Cross, Peter
McCarthy, David

UNICEF

Fuentes, Patricio	
Gamboa, Ruben	Materno-Infantil

OPS/Epidemiologia

Gosset, Guilermo

CESAMO/San Miguel

Irias, Jaime
Ordonez, Fra. Elena

JSI

Klinicki, Anna

PAHO

Loyola, Luis