



# Annual Report

OCTOBER 1, 1989-SEPTEMBER 30, 1990

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The Futures Group; The Johns Hopkins University; and  
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HEALTHCOM

ANNUAL REPORT

October 1, 1989 - September 30, 1990

(combined HEALTHCOM I and HEALTHCOM II Report)

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## EXECUTIVE SUMMARY

This report covers the 12 months of work conducted by the Academy for Educational Development for A.I.D.'s Communication for Child Survival, or HEALTHCOM Project, under contracts DPE-1018-C-5063-00 and DPE-5984-Z-00-9018-00 from October 1, 1989, to September 30, 1990. The reporting period constitutes the overlap year of the two contracts, referred to below as HEALTHCOM I and HEALTHCOM II. Activities carried out exclusively under one contract or the other are described as such within the report.

### Terry Louis, Resident Advisor in West Java

The project suffered a great loss this year with the death of Mr. Terry Louis, HEALTHCOM's resident advisor since September 1987 in West Java, Indonesia. Mr. Louis became ill in late June and had to be hospitalized in Singapore where he died in early July. His dedication, drive, and ability to work well with all collaborating groups were key elements in the West Java project's success in overcoming difficult challenges and in achieving results. Terry will be greatly missed by his colleagues and friends.

### Washington-based HEALTHCOM Project Meetings

On October 13, 1989, the project organized a **HEALTHCOM II Kick-off Meeting**, bringing together officers from S&T/Health, the three regional bureaus, and several other A.I.D. offices, the programing contractors, and staff from other A.I.D. child survival programs. The participants reviewed A.I.D.'s support for health communication and the HEALTHCOM II scope of work. Some of the findings from HEALTHCOM I research were also presented. A discussion on future challenges for health communicators identified several issues for attention under the new project. Participants also shared strategies for integrating A.I.D.'s health communication efforts with other child survival projects and linking community efforts with mass media interventions.

On December 18-19, 1989, HEALTHCOM held a **Research Task Force** meeting to discuss the current state of the evaluation program as well as questions developed for the new HEALTHCOM II research agenda. Participants included HEALTHCOM staff, the new Senior Technical Director for Research, representatives from A.I.D./Washington and other A.I.D. projects, the Annenberg School for Communication, Applied Communication Technology, Birch and Davis International, and Porter Novelli. The Task Force discussed the overall global research agenda, an overview of key findings to date, an overview of other projects' research, cost effectiveness issues, measuring of campaign effects, evaluation of health worker training, HEALTHCOM's formative research program, models of behavior change, and approaches to segmentation analysis.

On January 26, 1990, a combined **HEALTHCOM I and HEALTHCOM II Technical Advisory Group** met, focusing its attention on the project's global research agenda. Participants included representatives from A.I.D./Washington, other A.I.D. projects, HEALTHCOM collaborating organizations, and outside experts in the fields of health communication, evaluation research, anthropology, behavior analysis, and so forth. Major sessions included a review and discussion of the global research agenda prepared by the Research Task Force, process and impact studies, cost studies, formative research, and a review of technical/methodological issues.

## Institutional Studies

The reporting period saw a number of long-term HEALTHCOM I sites come to an end. These included Guatemala, Lesotho, Papua New Guinea, Paraguay, the Philippines, and West Java. Long-term programs are continuing in Honduras, Central Java, Nigeria, Yemen, and Zaire.

- In **Guatemala**, HEALTHCOM assisted in conducting observations of mothers handling ORS liter bag prototypes, to provide information for a final design. A local advertising company, APCU Thomson Advertising Agency, collaborated in designing materials for the ORT program, the vaccination jornadas, for ongoing EPI activities, and for the tetanus toxoid campaign. In preparation for project close-down on August 15, 1990, the resident advisor focused on incorporating activities of the Promotion Unit into the Ministry of Health's office.
- An ever increasing number of interventions in **Honduras**, combined with the complexities of collaborating with a new resident advisor there under the Nutrition Communication Project, were further complicated by obstacles associated with a change in government. A measles epidemic also shifted resources and attention away from planned activities. However, the new government has strongly supported a new communication plan emphasizing regular vaccination services and reduction of missed opportunities. Notable developments in the area of CDD include implementation of a successful ORT strategy in Honduran refugee camps and pilot production by a local laboratory (QUIMIFAR) of HYDROSOL, a private sector ORS product. Family planning will be a new focus of HEALTHCOM II in Honduras.
- The untimely death of the resident advisor in **West Java, Indonesia**, combined with a delay in funding for project activities from A.I.D. and the MOH, brought the program to a premature end in September 1990. However, during the reporting period the West Java program continued to implement a number of innovative activities. These included rural screenings of a seven-minute video on CDD by a private mobile film company, radio broadcasts on CDD messages, and a tremendous response from kader to a mail-back questionnaire designed to find out whether direct mail can be useful as a channel for information and motivation to these volunteer health providers. The final wave of the KAP study in West Java was undertaken during March-April 1990.
- HEALTHCOM has received an additional year of "bridge" funding through the SOMAVITA Project in **Central Java, Indonesia**, for ongoing vitamin A social marketing activities. Vitamin A capsule interventions in February and August were supported with radio broadcasts, banners, and visits by kader. HEALTHCOM also designed radio messages for the CDD program and designed plastic bags with CDD messages to be distributed through small retailers. Recent KAP information shows that accessibility to a posyandu (health post) is directly related to vitamin A capsule consumption; alternative approaches to increasing distribution will be explored during the next year.
- In **Lesotho** the project assisted the Family Health Division in developing a new health record booklet for children including vaccination information and ORS and SSS mixing instructions. HEALTHCOM also collaborated with a local advertising agency in a promotion campaign for locally produced ORS, including print materials for mothers, clinics, and retail outlets. Assistance has also been provided to the Ministry's ARI Control Program. Annenberg completed a

summative evaluation of the project previous to close-down in September 1990. In June the resident advisor traveled to Zaire to co-facilitate a two-week radio workshop there in support of an upcoming EPI intervention.

- In **Nigeria**, a shift in strategies took place at the request of the USAID mission. HEALTHCOM was charged with focusing its program efforts on the development of communication interventions in support of primary health care in two local government areas (LGAs) in Niger State. Interventions in two LGAs, Rafi and Suleja, reached an advanced stage but had to be suspended at the end of September due to problems in funding. During the reporting period ARHEC was awarded a contract to conduct KAP baseline studies in the two LGAs. A review of the results prompted selection of measles, malaria, and school health as priority areas for interventions. UNICEF and HEALTHCOM collaborated in designing a school health component. Activities included extensive radio, print, and training activities.
- HEALTHCOM worked primarily in the areas of CDD and nutrition in **Papua New Guinea**. HEALTHCOM contracted with the Institute of Medical Research to conduct a nutrition research intervention project in two remote communities in Madang Province. The major goals were to test the use of arm circumference measurements for screening malnourished children and to develop a "buddy" system of support for mothers of malnourished children. HEALTHCOM also responded to requests to coordinate development of a mass media campaign about typhoid prevention and treatment after an outbreak in early 1990. Efforts in CDD included development of a poster, a card to show mothers how to treat diarrhea at home, and a video, "Making Things Clear," to teach interpersonal communication skills. The video was introduced during a WHO CDD training workshop in February of 1990. The project closed down in June 1990.
- As part of the project close-down process in **Paraguay**, HEALTHCOM helped prepare an ORT program implementation plan and a national breastfeeding plan and norms. Task forces were formed for the national ORT and breastfeeding initiatives. Formative research continued regarding mothers' beliefs and practices about breastfeeding. Based on the focus group discussions, messages were developed for a skit, for audio cassettes, and for illustrations. PATH conducted a materials development workshop to assist the MOH in designing breastfeeding materials in July of 1990. HEALTHCOM also conducted a three-day communication workshop in July for trainers of regional workers. HED staff made frequent visits to regional sites, supporting the community-level emphasis of the Paraguay program. The project closed down in August of 1990.
- Activities in the **Philippines** have focused on CDD, EPI, and ARI. During the past year the project finished its first three-month "Module A" awareness-raising campaign about dehydration and initiated the "Module B" (product) phase. The objectives are to promote packaged ORS in two health regions and a home fluid (am) in a third region which has little access to packets. Radio, television, and print materials were developed and pretested and conferences held for CDD coordinators and health educators. HEALTHCOM has also assisted in successful negotiations with Pascual Laboratories for production of a commercial ORS product. During this period the nationwide EPI campaign used measles as a "hook" to bring mothers to the health center. Extensive broadcast, print, and interpersonal training supported the campaign. The project ended in September 1990.

- Dr. Syed Jahangeer Haider was recruited to be the new resident advisor in **Yemen** and arrived in country in July of 1990. Dr. Haider spent two weeks in Washington receiving orientation before taking his post. The resident advisor, with assistance from Anne Roberts and Willard Shaw, revised the work plan and the in-country budget and created a staff development plan for the GDHE and local health workers. Computer training for health education staff has been organized locally. A roster of Arabic speaking consultants is being prepared. Dr. Haider developed and submitted to the MOH and USAID the work plan and preliminary review of available data. The final decision on intervention priorities in Yemen will wait until the results of the KAP survey. Priority interventions at this time appear to be CDD and breastfeeding.
- The **Zaire** project carried out numerous training workshops during this period. Especially noteworthy was a series of trainer-of-trainers workshops for nursing instructors of the 16 medical technical institutions. The project also initiated a program for Maman Tengeneza, or volunteer mothers, who provide information on EPI and CDD to others in their neighborhoods. Several training guides were also developed, including one for the nursing school instructors, one for TOT in IEC in the health zones, and one for training the Maman Tengeneza. In addition, Annenberg has conducted an evaluation of HEALTHCOM interventions in Lubumbashi in collaboration with local universities. During the next reporting period HEALTHCOM anticipates fielding a second resident advisor to coordinate activities at the national level.

HEALTHCOM plans to launch program activities in two countries during the next reporting period: **Mali** and **Senegal**. The HEALTHCOM Project in Mali has grown out of several years of short-term assistance to the Division Santé Familiale in nutrition-related IEC provided by the A.I.D. Nutrition Communication Project, also managed by AED. Mr. Soulimane Baro of Burkina Faso and previously a UNICEF communication officer there has been approved to become resident advisor. The mission sent the PIO/T to A.I.D./Washington Contracts Office in August, 1990, for final approval. HEALTHCOM provided the Ministry of Health in Senegal with a needs assessment in the spring of 1990. The project anticipates working at both the national and regional level. Start-up is pending approval of the PIO/T by the A.I.D. Contracts Office.

HEALTHCOM staff provided short-term technical assistance to **Peru** and **Mexico** during the year. HEALTHCOM has collaborated with the PRITECH Project in advising Mexico regarding a rural strategy for training of health workers. A HEALTHCOM team visited Peru in June and August of 1990 to conduct an assessment of health communication opportunities under the CSAP and to participate in the midterm evaluation.

### Health Practice Studies

During this reporting period, behavioral studies continued in Indonesia, Lesotho, Nigeria, the Philippines, and Zaire. Preliminary results from the study in **Central Java** indicate that radio spots are affecting the level of recognition of kader within the intervention villages and that kader performance is improving. In **West Java**, the study has shown that kader who were trained to use counseling cards were more apt to explain diarrhea treatment to mothers and more apt to demonstrate ORS mixing skills. The Lesotho study has indicated that mothers tend to give more ORS solution to children they consider moderately dehydrated than those who are less so, but that volume given is

fairly constant across age groups and the amount per weight of child therefore goes down with increasing age. A clinic-based study in **Nigeria** is attempting to explore whether personalized face-to-face communication can affect a mother's decision to complete the childhood immunization series. A final report is being prepared to report findings of the **Philippines** ARI behavior study. The goals of a new study in **Zaire** are three fold: to measure the impact of IEC training on health workers' communication skills; to measure the effectiveness of a TOT approach on skills and supervisors' ability to train health workers; and to demonstrate the use of observations as a planning guide for trainers and as a feedback mechanisms for both trainers and trainees.

### Applied Research Activities

The HEALTHCOM II contract calls for a separate, centrally funded activity to address the more global, methodological issues across countries and to guide the refinement and institutionalization of the communication methodology and the sustainability of behavior changes over time. The global research program is coordinated by the Senior Technical Director for Research and carried out under a subcontract with the Annenberg School for Communication, University of Pennsylvania. In addition, HEALTHCOM II will continue to collect and analyze data from the communication activities in Honduras, under a subcontract with Applied Communication Technology, and conduct cost-effectiveness studies through its subcontract with Birch and Davis.

During this period HEALTHCOM and its subcontractors reviewed the state of research to date and devised a comprehensive global research agenda to meet the requirements of the new applied research component. Key questions to be investigated concern the success of alternative ways of conducting CDD or EPI interventions; the responses of different target audiences to communication programs; the power of social context and individual explanations for changes in behavior; the independent and complementary roles of different channels in communication programs; institutionalization of communication methodologies; behavior of health personnel (both paid and volunteer); maintenance of behavior change; and the cost-effectiveness of health communication.

The Task Force on Research and the Technical Advisory Group Meeting provided input into a global research plan, drafted by Annenberg. The focus of Annenberg's activities under HEALTHCOM II will be on making use of available data for cross-site generalization. Annenberg will prepare reports or articles on a number of areas which will address the specific "major questions" described in the HEALTHCOM II contract.

### Diffusion

- HEALTHCOM held a three-day **Faculty Strategy Session** at the Academy for Educational Development in Washington, DC, on June 25-27, 1990. The purpose of the strategy session was to discuss curriculum needs in health communication and ways to strengthen resources, curricula, teaching, and related practical experience in the training of future health and communication practitioners. The meeting also served as a work group for developing follow-up ideas with participants. LDC participants came from INCAP/Guatemala; the University of the Philippines, School of Public Health; and ARHEC/Nigeria. These organizations are potential partners in the development of regional training programs, with the assistance of JHU, which is working under subcontract to AED.

- In December of 1989 and January of 1990, HEALTHCOM conducted a series of **in-service technical training meetings** for staff members. Presentations/seminars were conducted on the subjects of diarrheal disease control, ARI, immunizations, malaria control, breastfeeding and child spacing, maternal health, waterborne diseases, and vectorborne diseases. Numerous A.I.D. projects sent representatives to these meetings to provide information and to exchange ideas with HEALTHCOM staff.
- HEALTHCOM staff coordinated or assisted several LDC training workshops. **HEALTHCOM/Indonesia** staff and counterparts from the Community Health Education Department organized and ran a three-day workshop on "Improving Communications Research and Strategy Design for Child Survival," as an addition to a national conference of epidemiologists hosted by the Indonesian Epidemiological Network (JEN) and the Ford Foundation in Semarang, Indonesia, from November 16-18, 1989. The participants developed a draft communication research strategy for a breastfeeding intervention. In **Nigeria**, in March, 20 vaccinators and 20 screeners from each Local Government Area attended a one-week workshop designed to update vaccination techniques and strengthen interpersonal communication skills. And in May, HEALTHCOM completed a series of workshops in Rafi and Suleja to prepare MOH staff, community leaders, and school teachers for upcoming PHC interventions. In **the Philippines**, HEALTHCOM sponsored a series of seminars on social marketing with the Department of Health. The first was held January 22-26, 1990, and assisted by Mary Debus of Porter/Novelli. Health educators from the 13 administrative regions of the Philippines participated. A second workshop was held May 15-21 and a third in July 1990. Also in **the Philippines**, a workshop was held March 19-23, 1990, on face-to-face communication at health centers in Zamboanga City. All health education advisors and public information officers participated. In Lubumbashi, **Zaire**, HEALTHCOM conducted a workshop the first two weeks of June to develop broadcast media support for the vaccination acceleration campaign scheduled for late July, August, and September. HEALTHCOM's resident advisor from Lesotho, Ed Douglass, assisted. Also in **Zaire**, HEALTHCOM helped design and carry out nursing instructors' workshops on communication skills and curriculum development. The first two of the two-week workshops were held in late February and early April. Over 40 Maman Tengeneza in Ruashi health zone have received basic training in health education, vaccinations, diarrheal disease control, nutrition, and community outreach work.
- Numerous reports and publications were prepared during this period. These included the HEALTHCOM II Year I Work Plan, summary reports of the HEALTHCOM Task Force on Research and of the HEALTHCOM Technical Advisory Group Meeting, the Zaire Implementation Plan, and the special reports, Managing a Communication Program on Immunization: A Decision-Making Guide, and Consumer Demand and Satisfaction: The Hidden Key to Successful Privatization. Communication for Child Survival has also been translated and reproduced in Bahasa Indonesia by local volunteers. In addition, several field notes have been drafted or submitted for approval and a number of journal articles have been submitted or accepted for publication.
- A number of HEALTHCOM media materials won **prestigious awards**. In May of 1990, the Annual Indonesian Advertising Awards recognized the integrated child survival CDD campaign, assisted by HEALTHCOM, with a gold award for best use of Indonesian culture in an advertising campaign, and a bronze award in the best multi-media campaign category. This is the first time a public sector campaign

competed with leading commercial product advertisers in the competition. The HEALTHCOM Project received a second prize from the Academy for Health Services Marketing, a division of the American Marketing Association, in its "Flashes of Brilliance" competition, external publications category, for its manual, Communication for Child Survival, and an honorable mention for its video, "Partnership for Child Survival." The HEALTHCOM video also won awards in the John Muir Medical Film Festival and the Houston International Film Festival.

- HEALTHCOM staff members, subcontractors, and consultants gave numerous **presentations** at annual conferences and at other professional meetings during this period. The project developed a **comprehensive slide/script** and overhead presentation on the HEALTHCOM methodology, to be used for introducing audiences to health communication theory and practice. In addition, the project continued to distribute a large number of reports which are in high demand, in particular the HEALTHCOM manual, the EPI manual, and French and Spanish versions of the special report on focus group research, by Mary Debus. During this reporting period requests for videos, in particular the HEALTHCOM methodology video, and "Making Things Clear," (developed in PNG) were also high.

### Subcontractor Activities

- **The Annenberg School for Communication** assisted in development of a global research plan for the HEALTHCOM II Project. Significant efforts also went towards completing case study evaluations under HEALTHCOM I. Data analysis for the final report in Ecuador continues. In Guatemala, agreement was reached with INCAP to carry out a final survey, but the survey was canceled. Major activities in Central Java included carrying out the follow-up survey on vitamin A and diarrhea and preparing a preliminary report. A follow-up survey was also completed in West Java, in collaboration with Survey Research Indonesia. The primary activity in Jordan was development and implementation of a follow-up survey on breastfeeding. Annenberg completed a plan and questionnaire to help study institutionalization results in Lesotho; analysis of the data from the follow-up survey continues. A work plan for data collection has been written for Nigeria. A case study evaluation is being written on information gathered in PNG. Annenberg has written a manual and several short technical notes on evaluation issues for the Philippines program. An institutionalization section of the final report is also underway. Presentations and technical assistance have also been given to the Zaire counterparts regarding evaluation issues.
- **Applied Communication Technology (ACT)** assisted during this period with a review of research findings to date and development of a research agenda for HEALTHCOM II. Dr. Foote traveled to Honduras to present data from the CDD resurvey and discuss timing of follow-up surveys under HEALTHCOM II. However, funding restrictions have postponed further resurvey activities at this time. ACT completed a number of research deliverables for HEALTHCOM I during the year, including resurvey reports from Honduras and The Gambia, institutionalization studies from both countries, and a case study evaluation from Paraguay.
- **Birch and Davis International, Inc.**, is a new subcontractor under the HEALTHCOM II Project. During this period, Birch and Davis assisted HEALTHCOM in defining potential cost study approaches and goals and in outlining concrete next steps. At this time, the best opportunities for cost studies are in Indonesia and Honduras. However, implementation of these studies has been postponed due to funding problems.

- **The Futures Group** is a new subcontractor under the HEALTHCOM II Project. During this period the Futures Group presented a concept paper on computer modeling of health communication cost effectiveness, which presents an approach for developing: 1) a global model/presentation about health communication for child survival as an educational and promotional tool; and 2) a RAPID-type computer model of the cost effectiveness of health communication, to be applied to individual countries.
- **The Johns Hopkins University** is a new subcontractor under the HEALTHCOM II Project, focusing primarily on development of a health communication curriculum. During this period JHU/CCP recruited for a Senior Health Communication Curriculum Advisor; however hiring has been postponed for the present. JHU held an annual workshop, "Advances in Family Health Communication," which included two registrants nominated by the HEALTHCOM Project. In addition, JHU participated in the three-day "HEALTHCOM Faculty Strategy Session" held at AED in June of 1990.
- **PATH/PIACT** conducted a workshop on IEC materials development on breastfeeding for the staff of the regional Ministry of Health, Health Education Department, in Paraguay. The workshop included focus group discussions with rural mothers and pretesting of a drama, an audio cassette, and illustrations developed on the theme of breastfeeding.
- **Porter/Novelli** recruited and hired a market research specialist, Dr. Cecile Johnston, to become the Formative Research Coordinator for HEALTHCOM II. Dr. Johnston presented a strategy for new directions the project could take in formative research, developed a research training module, and traveled to Indonesia to assess research being conducted in two sites. Other Porter/Novelli staff assisted with a five-day social marketing workshop in the Philippines and in the design of future work in Mexico.

### Collaboration with Other Organizations

The project has engaged in numerous collaborative efforts with other A.I.D. projects during this period. Following a presentation at PRITECH on the results of HEALTHCOM's behavioral studies, HEALTHCOM has begun a serious dialogue with PRITECH and PRICOR about collaboration in strengthening training programs for health personnel in diarrhea case management. HEALTHCOM collaborated with the REACH Project in preparing a set of papers on sustainability for the 1990 meeting of the Global Advisory Group of the WHO Expanded Programme on Immunization. HEALTHCOM joined with several projects working under S&T/Health to assist the office to prepare a strategy paper on acute respiratory infections.

HEALTHCOM's resident advisors continued to support the CCCD programs in Nigeria, Lesotho, and Zaire. The HEALTHCOM director and resident advisors from Zaire and Lesotho attended the annual CCCD consultative meeting in Swaziland in April and held joint review meetings with host country and CCCD counterparts.

HEALTHCOM began a major collaborative effort with the WHO/EPI Program in June 1990. Two HEALTHCOM staff members traveled to Geneva to begin plans for the development of a training module on improving the face-to-face communication skills of immunization workers. WHO/EPI also invited HEALTHCOM to produce a communication concept paper for its annual Global Advisory Group meeting in Cairo in October.

HEALTHCOM continued its support of the social science research component of the WHO/CDD Program in Geneva through its subcontractor, the Annenberg School for Communication.

HEALTHCOM continued to collaborate with Helen Keller International under the ROVITA Project in Central Java and helped HKI secure funding from the FVA Bureau for at least another year of activity. HEALTHCOM also met with the representatives of several other PVOs, including CARE, World Vision, Project Hope, and Rotary International, to discuss possible collaboration. HEALTHCOM is moving ahead in the development of a package of communication training modules specifically targeted at field staff of PVOs.

The project began the first steps of collaborative activity in curriculum development and training with universities or research institutions in several countries during the year. Representatives from the University of the Philippines, University of Ibadan (Nigeria), and INCAP (Guatemala) attended a Faculty Strategy Session at HEALTHCOM/Washington in June to share experiences and perceived needs in health communication curriculum development. In May, HEALTHCOM met with faculty members from three universities in Indonesia--University of Indonesia, Diponegoro University, and Gajah Madah University--to explore mutual interests in improving teaching capacity in health communication and social marketing. HEALTHCOM also met with the School of Public Health in Kinshasa (Zaire) to develop plans for collaboration in teaching and research.

The project made contact with a number of USAID missions, including those in Kenya, Zaire, Egypt, Honduras, Jamaica, and El Salvador, to determine mission and host government interest in promotion of child survival services in the private sector. HEALTHCOM has been requested to assist the Jamaican Family Planning Association market an integrated child survival/family planning service to private employers in that country.

Lastly, HEALTHCOM continued to work with the private pharmaceutical sector to help launch new ORS products in Honduras, Lesotho, and the Philippines.

### Major Issues and Lessons Learned

Major issues addressed in this report fell into both technical and management categories. **Institutionalization** of a modern communication methodology in host country organizations will continue to be the primary goal and one of the evolving issues of HEALTHCOM work. HEALTHCOM/Honduras, the longest running site, demonstrates that institutionalization is an ongoing long-term process rather than a "goal" which can be "achieved" at one point in time. Many professionals have become so well trained and highly valued that they have been hired away by international donors or private commercial organizations. Honduras also illustrates the precariousness of government-based programs. Although the LAC region has generally been viewed as more conducive to institutionalization than, for example, the Africa region, HEALTHCOM's experiences this year in Honduras, Guatemala, and Paraguay demonstrate that the struggle for policy maker support and understanding must be a continuous one.

On the positive side, HEALTHCOM has increasing experience with different models of institutionalization and with the advantages of working with a broad range of players, particularly in the private commercial realm. The project has now collaborated extensively with private market research organizations, advertising agencies,

universities, pharmaceutical companies, and so forth, often introducing ministries to the the complex processes of cooperation and contracting.

HEALTHCOM's many research components (the case study evaluations, the longitudinal studies in Honduras and The Gambia, and the health practices studies, among others) continue to provide insights into the complexity of promoting and **maintaining new health practices** among large populations. One of the enduring realities is the importance of a strong and accessible service delivery network as the foundation of any communication effort. A number of countries have focused on coordination with health delivery personnel to increase the effectiveness of a single visit to the health center.

Several of the HEALTHCOM health practice studies have observed and designed interventions to strengthen health worker interactions with mothers. HEALTHCOM continues to gain a better understanding of the importance of face-to-face communication and the role which can be played by neighbors and volunteers in affecting caregivers' practices. Evaluation data from Annenberg suggest that health practices must be seen as belonging to the community as well as to individuals.

Child survival communication programs neither develop **technologies** nor set national health intervention policies--yet they must be based upon agreements among others regarding both of these. Communication programs must in essence wait for protocols to be agreed upon by the medical community. On the other hand, HEALTHCOM has conducted ethnographic research and simple pilot studies particularly in the area of ARI, to investigate what mothers presently do and whether selected messages can be useful. Experiences in Zaire, Lesotho, and other countries have shown that communication programs can help influence adoption of appropriate technologies, especially regarding CDD, when national policies are in a state of change.

**Integration** can mean many things. One or more themes (ORT, ARI, EPI) can be linked logistically--delivered together as a single administrative package. Themes might be linked conceptually through an umbrella concept. Or themes could be linked behaviorally--e.g., urging mothers to breastfeed and give ORS during the same time period. Integration of any kind has two elements: management and consumer acceptance. Integration may be useful if it permits governments to take advantage of a single delivery system for several interventions, but harmful if combining topics weakens each of the integrated themes. Planners must also consider whether diseases are linked in the mind of the mother in terms of timing or causality.

The overriding **management issue** for HEALTHCOM is one of financial management under the current system of buy-ins. Many projects are now competing for ever-higher percentages of mission buy-ins and in some countries, such as the Philippines, HEALTHCOM I succeeded to the extent that the mission decided to put a health communication component into its new bilateral child survival project. Even as the competition for mission funds has grown keener, the process of moving them from mission budgets into central project contracts has become more highly regulated and thus much more time and labor consuming. It now often takes from three to six months after a PIO/T from a mission has arrived in the A.I.D./Washington Contracts Office before it is negotiated with the contractor. Recognizing the major issues that this financial context posed for the successful implementation of HEALTHCOM II, the project's management has agreed with its CTO to meet early in the new fiscal year to determine whether any major changes may be required in the project's scope of work and/or funding.

## Administrative and Budget Report

The HEALTHCOM I Project received a no-cost extension from the A.I.D. Contracts Office to continue activities through March 31, 1990.

Fiscal year 1990 posed complicated and painful management issues for HEALTHCOM. An already complex "overlap" year, entailing both completion of final deliverables and launching of new activities for HEALTHCOM II, was made even more problematic by the discovery early in the year that a shortfall in funding from S&T/Health and several USAID missions buying in to HEALTHCOM was going to prevent the completion of some scheduled activities.

Project management was forced to take a series of extreme cost-cutting measures, including reducing home office staff by four full-time positions; requiring senior professional staff to reduce their billable days on the project by 15-20 percent; postponing all new initiatives by project subcontractors (including curriculum development by The Johns Hopkins University, cost studies by Birch and Davis, computer modeling by the Futures Group, follow-up research in Honduras by ACT, and formative research coordination by Porter/Novelli); postponing procurement of computer equipment in the home office; denying requests for centrally-funded project extensions in PNG, Philippines, Zaire, and Guatemala; curtailing the development of promotional material and travel for project development; reducing the scope of HEALTHCOM I evaluations in three countries; and postponing planning and implementation of selected HEALTHCOM II deliverables.

Having taken these austerity measures, HEALTHCOM completed FY 1990 in a fiscally sound but reactive posture; the project has been unable to explore and promote new initiatives which will serve the project's health in the long run. Thus, project management's first priority in FY 1991, when full funding is expected, will be to turn HEALTHCOM's now streamlined home office team to the task of actively marketing the project's considerable experience in new areas of identified need, including curriculum development, communication training, and marketing and promotion of health services in the private sector.

## SECTION I

### BACKGROUND

#### A. MASS MEDIA AND HEALTH PRACTICES PROJECT

In 1978 the United States Agency for International Development (A.I.D.) initiated a project (#931-1018) to apply state-of-the-art knowledge about communication and social marketing to selected child survival practices. The Academy for Educational Development was contracted by A.I.D. to implement the project under the name Mass Media and Health Practices (MMHP).

From 1978 to 1985 MMHP developed a methodology for conducting public health education in developing countries to effectively reach large numbers of people and applied it in seven project sites--Honduras, The Gambia, Ecuador, Peru, Swaziland, Lesotho, and Indonesia. The methodology integrates communication (radio, graphic print materials, and interpersonal communication) and social marketing with traditional channels of health education, training, and product distribution. It relies on the systematic development, testing, and monitoring of communication strategies, messages, and products to bring about positive changes in health-related practices. The original country programs all focused on the promotion of oral rehydration therapy (ORT) and other key objectives of national diarrheal disease control efforts.

#### B. HEALTHCOM I

In August 1985 A.I.D. extended the project under a new name--Communication for Child Survival (or HEALTHCOM I). The Academy was contracted to administer HEALTHCOM for an additional five-year period, and the project's mandate was broadened to include additional countries and a range of child survival technologies, in addition to ORT. The project continued to be jointly managed by the Office of Health and the Office of Education in A.I.D.'s Bureau for Science and Technology.

HEALTHCOM's primary purpose was to increase our understanding of how best to use modern communication, social marketing, and behavior analysis to modify existing child care practices. HEALTHCOM's experience to date, as well as that of health communication programs in other countries such as Egypt and Bangladesh, has shown clearly that communication strategies can improve child care practices. As the project continued to refine its communication methodology, it also addressed such questions as the following:

- How can audience and market research be used more efficiently?
- What role should mass campaigns play in relation to sustained communication efforts?
- How can we best measure the impact of such programs?
- What are the most relevant intermediate variables of success?
- In what organizational context are these communication skills best institutionalized?

HEALTHCOM pursued a significant research and development agenda which included a series of country-specific studies. Each HEALTHCOM intervention was designed to provide some significant insight into one or another of several key issues. In Honduras, for example, institutionalization and the longitudinal effects of communication pulsing were studied. Using case studies and survey data collected over six to eight years, HEALTHCOM has been able to provide insights into issues of institutional and campaign effects which shorter interventions have been unable to provide. In Ecuador, campaigns were compared with non-campaign periods to determine the costs and advantages of each approach. In addition, the health practices studies component of the program used behavior analysis techniques to investigate how to influence child survival practices such as immunization schedule compliance, ORT administration, and new health worker training and incentive systems.

HEALTHCOM I's objectives were:

- to complete development of the HEALTHCOM methodology by applying it to an expanded array of child survival technologies and to the multiple practices that influence child survival, including diarrhea control, infant feeding, breastfeeding, child spacing, handwashing and related personal hygiene, participation in immunization programs, the use of food rich in vitamin A, and cooperation with water supply, sanitation, and vector-borne disease programs;
- to complete the integration of social marketing, product promotion, and consumer education into the health communication methodology;
- to expand the applicability of the methodology by using it at approximately ten new sites which represent different institutional and/or technological environments, such as where there is no strong health services infrastructure in the poorest countries, or where there is an expanded reliance on the private sector, or where increased access to television is available;
- to support further the process of institutionalization of the methodology at all project sites, in so far as possible;
- to undertake "diffusion" activities, so that knowledge and use of the methodology is spread to other A.I.D. projects, U.S. academics and practitioners, and the broad community of donor agency professionals.

To achieve these objectives, work was divided into three components: Institutional Studies, Health Practices Studies, and Diffusion Activities.

Under **Institutional Studies I** the project was to conduct health communication interventions in a minimum of ten new countries. New country sites were selected to allow:

- increased involvement with private sector institutions, both for-profit and non-profit;
- adaptation of the methodology for use in the poorest of countries with a minimum level of human and institutional resources;

- adaptation of the methodology for use with educational technology other than radio, such as television and satellite telecommunications.

Under **Institutional Studies II**, the project was to support efforts at the seven established sites--Honduras, Ecuador, Lesotho, Peru, The Gambia, Swaziland, Lesotho, and Indonesia--to continue application and institutionalization of the methodology.

Key institutional questions emphasized were:

- How long does institutionalization require?
- What is the best local agency or institution in which to place responsibility for developing and implementing the methodology?
- What institutional procedures and plans demonstrate adoption of the methodology?
- How do personnel and budgetary allocations reflect adoption of the methodology?
- What are key elements in the process of institutionalization?

Of the original seven project sites, Honduras, Ecuador, Indonesia, and Lesotho, continued to have HEALTHCOM resident advisors working in country, while Peru, Swaziland, and The Gambia received short-term technical assistance from the project.

A typical HEALTHCOM I program provided a resident technical advisor in communication for two to three years. This person worked with local institutions, both public and private, to plan and implement an effective health communication program to train local counterpart professionals in HEALTHCOM strategies and methods. Short-term advisors in marketing, behavioral analysis, anthropology, and so forth, were provided to supplement the long-term assistance as needed, and an evaluation of project process and impact was conducted using both qualitative and quantitative methods.

Under the **Health Practice Studies** component of HEALTHCOM, the project was to carry out a minimum of ten studies pertaining to the behavioral problems encountered and resolved in adapting the methodology at existing and new sites to achieve acceptance of public health practices related to Child Survival. The studies were integrated into specific country interventions as part of the investigative and formative evaluation stages of the methodology applied at a given site. The health practices studies were expected to modify and improve the methodology over the long run, as well as support the interventions.

Under HEALTHCOM's **Diffusion** component, the project was to carry out a wide range of activities designed to share the project's methodology and disseminate its field results among communication and public health practitioners and academics throughout the world. These activities included:

- short-term technical assistance to developing countries;
- seminars for LDC health sector decision-makers and professionals;
- faculty seminars for university teachers and health education policy-makers;

- instructional videotapes on the project's methodology and field experiences;
- publications, papers, and presentations about the project methodology and findings.

Four subcontractors worked with AED on the HEALTHCOM I Project:

- the Annenberg School of Communications of the University of Pennsylvania (for case study evaluations of the communication programs in each HEALTHCOM country);
- Applied Communication Technology (ACT) (for continued analysis of data from Honduras and The Gambia and follow-up studies of the programs in those countries);
- PATH/PIACT (to help develop print materials and appropriate health technologies for these programs);
- Porter/Novelli (P/N) (for marketing and advertising assistance).

In addition, seven institutions agreed to work as collaborating institutions with AED on the project. They included: Ciba-Geigy, The Futures Group, Management Sciences for Health, the John Snow Health Group, University Research Corporation, the Wilmer Institute (ICEPO), and the Department of International Health of the Johns Hopkins University.

### C. HEALTHCOM II

On August 31, 1989, the Academy was awarded a five-year contract representing the third phase of A.I.D.'s support for health communication and marketing. Fiscal year 1990 constituted an overlap year for the two contracts. The project is managed by the Office of Health in A.I.D.'s Bureau for Science and Technology. HEALTHCOM II focuses increasingly on sustainability of behavior changes and institutionalization of the methodology. The project continues efforts to assist public and private sector agencies in developing comprehensive communication strategies. Formative research remains an essential component of the project, providing essential data for the development of communication messages. In addition, the project continues the use of multiple communication channels (face-to-face, print, and broadcast), while strengthening the face-to-face component. HEALTHCOM II will further the development of the communication methodology and seek to refine it to make the approach more sustainable by host country governments and other institutions.

This phase of the HEALTHCOM Project has several components: Technical Assistance, Applied Research Activities, and Dissemination activities including extensive training.

Under the **Technical Assistance** component of the project, HEALTHCOM will conduct the following activities:

**Intensive Long-term Assistance:** to approximately six core countries, consisting of multiple long-term advisors, support staff, and short-term technical specialists. Assistance will allow for additional activities, such as development of a training curriculum. In each intensive site which received assistance under HEALTHCOM I, communication programs will be developed for at least two additional child survival interventions.

**Less Intensive Long-term Assistance:** to approximately nine countries through one resident advisor, limited support staff, and short-term technical specialists. Assistance will allow for up to three child survival interventions. Research and evaluation will focus mainly on immediate program priorities. Technical assistance will be phased.

**Short-term Technical Assistance:** up to three months for discrete activities to missions, ministries of health, PVOs, and other organizations. These TA activities should be part of a longer-term plan in the country.

Under the Applied Research component of the project, HEALTHCOM II will conduct separate, centrally funded activities to address global, methodological issues across sites and to guide the refinement of the methodology; the institutionalization of methods within the public and private sectors; and the sustainability of behavior changes over time. This global research activity will comprise both further analysis of data collected under HEALTHCOM I and some new data collection. It will address key questions such as:

- What do mothers know and why do they believe and act as they do regarding their children's health?
- What influences and changes mothers' behaviors?
- How do changes become recurrent--timely, correct, and habitual?
- How do community context and interpersonal health networks affect mothers' behavior to ensure adoption of desired health practices?
- In what ways can the communication approach be refined so that it can be adapted by LDC institutions that exist in an environment of scarce resources? What can reasonably be simplified within the communication methodology while still maintaining appropriate quality and impact standards? How best can the communication methodology apply across a range of child survival interventions in many different settings?
- What is the optimum mix of communication channels (face-to-face, print, broadcast media, folk/traditional)?
- What level of evaluation capability can be institutionalized within a country?
- Can communication approaches be systematically applied to train health providers?

- What incentives can be built into a program to motivate and sustain the active involvement of health communication staff?
- What are the minimum essential elements of an effective formative research program?
- How can the demand that is created by an effective communication program be met with an appropriate and sufficient supply?

In addition, HEALTHCOM II will collect and analyze further data from the communication activities in Honduras, including analysis of long-term behavior change.

Under the **Dissemination** component of the project, HEALTHCOM will carry out numerous publication and training activities including:

- a second edition of Communication for Child Survival emphasizing issues of institutionalization and sustaining behavior change; issue reports concerning key health communication areas; and major articles published in scientific journals;
- regional workshops for long-term advisors and host country counterparts; an international workshop for long-term advisors and counterparts; and seminars on key communication issues for A.I.D. and other interested parties;
- country-level workshops/courses; and training sessions for U.S. and LDC university faculty (with the goal of faculty incorporating communication courses into existing curricula) and for short- and long-term communication advisors;
- presentations in other formats (slide-tape shows, videos, etc.) to educate health professionals, schools, and other institutions about the methodology.

The project will also conduct technical advisory group meetings, task force meetings including experts in various disciplines, and monthly technical meetings with the Chief Technical Officer.

Six subcontractors have agreed to work with the Academy in carrying out the HEALTHCOM II Project. They are:

- the Annenberg School for Communication, University of Pennsylvania (for applied research);
- Applied Communication Technology (to continue the longitudinal study in Honduras);
- Birch and Davis International (to conduct cost studies);
- The Futures Group (for policy maker and private sector support);
- The Johns Hopkins University (for curriculum development); and
- Porter/Novelli (for social marketing).

In addition, a number of organizations have agreed to collaborate with the Academy. The U.S.-based collaborators include: Management Sciences for Health; PATH/PIACT; Tulane University, School of Public Health; and Helen Keller International. LDC collaborators include: University of Ibadan, Department of Preventive and Social Medicine (Nigeria); The Priestman Group (Nigeria); C.E.R.COM (Cote d'Ivoire); DEMACOM Services (Kenya); University of the Philippines, Institute of Mass Communication (Philippines); Asian Institute of Management (Philippines); Asian Mass Communication Research & Information Centre (Singapore); University of Indonesia, Epidemiology Network (Jakarta); Center for Development Communication (Egypt); El Amouri Institute of Applied Psychology (Tunisia); CIESPAL (Ecuador); INCAP (Guatemala); Aragon & Associates (Guatemala); and FORUM & FORUM (Peru).

## SECTION II

### WORK ACCOMPLISHED THIS PERIOD

#### A. INSTITUTIONAL STUDIES: EXISTING HEALTHCOM COUNTRY PROGRAMS

Descriptions of project activities are provided here for the ten countries with established HEALTHCOM programs: Guatemala, Honduras, Indonesia, Lesotho, Nigeria, Papua New Guinea, Paraguay, the Philippines, Yemen, and Zaire. Most of the reports cover the fiscal year reporting period. However, those countries which were closed down by end the of the year provided a final report covering the entire period of technical assistance.

1. <u>GUATEMALA</u>	<u>Period: October 1, 1989 - September 30, 1990</u>
Date of Letter of Agreement:	July 31, 1986
Project Start-up Date:	September 15, 1986
Project Closing Date:	August 15, 1990
Child Survival Activities Focus:	Expanded Program of Immunization (EPI) and Oral Rehydration Therapy (ORT)
Collaborating A.I.D. Projects:	USAID Child Survival Project
Collaborating Donor Agencies:	UNICEF, PAHO, Rotary International
Primary Institution:	Ministry of Health
Collaborating Institutions:	
INCAP	Research assistance
Johnson and Johnson	ORT program support
Resident Advisor:	José A. Romero
Date of Arrival:	September 15, 1986
Date of Departure:	October 30, 1990
Consultants:	
Robert Hornik	August 1986: Redesigned KAP caretaker survey regarding EPI and ORT.
Robert Hornik	December 1986-January 1987: Reviewed protocol and questionnaire for KAP caretaker survey.

Robert Hornik	March 1987: Supervised final revision of questionnaire for KAP caretaker survey and supervised training and plans for carrying out survey.
Casey Margard and Nancy Newton	May 1987: Assisted ADAMED in identifying areas of collaboration with the local HEALTHCOM Project and the national ORT program.
Ann Jimerson	July 1987: Trained MOH artists in material design for nonliterate audiences.
Daniel Chauche	July-September 1987: Trained MOH photographer.
Hugo Tipiani	August 1987: Trained MOH publicity staff in mass media communication techniques.
John Elder	November-December 1987: Trained research staff in behavioral analysis and plan development.
Diane Urban	December 1987: Preselected advertising agency and developed extension of HEALTHCOM buy-in.
Maria Claudia de Valdenebro	February 1988: Trained MOH artists in material design and helped design graphic materials for EPI campaign.
Diane Urban	March 1988: Assisted MOH personnel in the development of audiovisual materials for EPI campaign.
Diane Urban	April 1988: Assisted MOH personnel in the development of audiovisual materials for EPI campaign and helped set up the project office.
Maria Claudia de Valdenebro	April 1988: Trained MOH artists in material design and assisted in the design of materials for EPI campaign.
Robert Hornik	April 1988: Reviewed KAP community survey for EPI/ORT. Trained MOH personnel in evaluation techniques. Designed project impact evaluation.

Nancy Morris	April-May 1988: Trained MOH personnel in the process of campaign evaluation. Introduced WordStar and SurveyMate software and designed the evaluation of the first <u>jornada</u> .
Diane Urban	May 1988: Trained MOH personnel in audiovisual production for the second <u>jornada</u> and observed the first <u>jornada</u> .
Lorenzo Arbeit	May-June 1988: Trained MOH personnel in creative impact strategies for EPI and ORT campaigns.
Nancy Morris	June-July 1988: Trained MOH personnel in the analysis of the evaluation results and in the design of reports. Assisted in the design of a survey to evaluate the second vaccination <u>jornada</u> . Assisted in the evaluation of the tetanus toxoid campaign for pregnant women. Conducted follow-up training in the use of SurveyMate in communication campaign evaluation.
John Elder	July 1988: Trained MOH personnel in behavior analysis and its application for ORT in one specific health area (San Marcos).
Patricio Barriga and Hector Espinal	July 1988: Conducted workshop on "Administration of Objectives" for MOH personnel.
Ximena Sheehy Downey	July 1988: Provided administrative and development training for support personnel.
Diane Urban	September 1988: Reviewed project activities and schedule for 1989.
Hugo Tipiani	March 1989: Trained MOH personnel in media strategies for EPI. Selected advertising agency to buy time in mass communication media for the vaccination <u>jornadas</u> .
Maria Claudia de Valdenebro	March 1989: Trained MOH personnel in graphic design and offset printing.
Maria Claudia de Valdenebro	April 1989: Conducted follow-up training and exchanged experiences with the Honduras Promotion Unit.

William Smith	April 1989: Made presentation at the LITROCOM/Guatemala 1989 conference. Trained personnel in global strategies for coordinating ORT activities. Reviewed ORT activities in the country.
Felipe Mota	April 1989: Made presentation at the LITROCOM/Guatemala 1989 conference on the ORT experience in Mexico.
Diane Urban	April 1989: Made a presentation at the LITROCOM/Guatemala 1989 conference.
Margaret Parlato	April 1989: Attended the LITROCOM/Guatemala 1989 conference.
Hugo Tipiani	May-June 1989: Developed follow-up to May activities and presented report on the use of mass communication in the first and second vaccination <u>jornadas</u> .
Diane Urban	June 1989: Identified health education needs in development of community participation.
Felipe Mota	August 1989: Made presentations at the seminar for creation of ORUs in 22 departmental hospitals. Coordinated training courses for ORU hospital personnel.
Joseph Valadez	August 1989: Trained Promotion Unit and MOH personnel in development of ORT communication plans.
Diane Urban	August-September 1989: Assisted ORT health education activities. Continued to examine opportunities for coordinating the development of community participation.
Joseph Valadez	October 1989: Reviewed monitoring activities of the Promotion Unit and supported presentation of the national plan of monitoring and supervision of the MOH Supervision Unit to heads of area.
John Elder	November/December 1989: Developed and implemented, with the Promotion Unit and Mother and Child Health Department, the observation study of mothers' handling of the liter bag prototypes. Assisted in the presentation of results to the members of the ORT Interagency Committee.

Diane Urban	December 1989: Reviewed 1989 activities and designed 1990 plans. Continued planning of community participation activities. Supported A.I.D. donation of radio and TV space to the MOH.
Hugo Tipiani	January 1990: Reviewed monitoring and billing of Publimerca for child survival campaign activities in December; reviewed ratings; with the Ministry and Publimerca, jointly planned the standards for the relaunch of the tetanus toxoid campaign and the ORT launch.
Robert Hornik	February 1990: With the MOH and INCAP, organized the 1990 pre-campaign KAP. Reviewed the survey questionnaire and designed the research sample.
Diane Urban	February 1990: Coordinated community participation activities, conducted a face-to-face communication workshop, and reviewed 1990 activities for Apcu Thompson Advertising Agency.
Lorenzo Arbeit	February 1990: Reviewed activities of the Promotion Unit and Apcu Thompson creative teams, conducted a creativity workshop, and analyzed the campaigns.
Maria Claudia de Valdenebro	March 1990: Trained the MOH artists in graphic design for nonliterates and developed a drawing handbook for EPI and ORT that will be used in the health areas.

## PROJECT SUMMARY

In 1985 the Guatemalan Ministry of Health (MOH) drafted a national immunization plan which incorporated community outreach techniques with mini-campaigns. A multi-departmental national coordinating committee oversees Guatemala's child survival activities, now expanded to include oral rehydration therapy. The objectives of the child survival program are to increase knowledge of and demand for EPI and ORT services among caretakers of children under the age of five and to improve the delivery of such services by MOH personnel. The Ministry of Health invited HEALTHCOM to assist in the design of its child survival communication strategy, including KAP studies, pretesting of materials, local production and marketing of ORS, and training of MOH personnel. Communication strategies combine two approaches--one for the Latino population and another for indigenous groups.

In early 1986, prompted by the outbreak of a polio epidemic, the Government of Guatemala issued an order for the MOH to hold three national immunization mobilizations (jornadas) in May, June, and August 1986. The MOH faced significant challenges in administering the national mobilizations while maintaining its own EPI activities. HEALTHCOM provided the MOH with short-term technical assistance to incorporate audience research into its long-term child survival activities. HEALTHCOM's Diane Urban worked in Guatemala during June and August to provide such technical assistance and to establish the HEALTHCOM office.

The HEALTHCOM resident advisor undertook his responsibilities in September 1986. The project's main goals were to increase immunization coverage for six diseases and to reduce deaths due to diarrhea-related dehydration. To meet these goals, HEALTHCOM provided technical assistance to the Promotion Unit of the Ministry of Health, on a short- and long-term basis.

This assistance included conducting or planning to conduct the following programs and activities: a 48-month public health communication effort focusing on two health themes and utilizing mass media, print materials, and interpersonal support; training workshops for community health workers on the health themes; collaboration with new private and public sector initiatives for ORT; training for Promotion Unit staff in behavior observation and analysis, improved qualitative and quantitative research design, application, and analysis, communication planning and management, materials design and pretesting, administration, training program design, photography, and buying media time, monitoring and supervision of the advertising agencies, integration of health education and Promotion Unit plans for the vaccination jornadas, and launching of ORT activities.

In March, 1990, USAID and the MOH agreed to suspend financial aid for the Project 520-0339, EPI/ORT Child Survival, and to begin an administrative audit of the granted funds. At that time, HEALTHCOM shifted its focus to the integration of the Promotion Unit and the Health Education Department and to designing plans to ensure institutionalization.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administrative/Management

HEALTHCOM was appointed a member of the Board of Directors of the EPI/ORT activities of the Child Survival Project by the Ministry of Health to help design plans for an agreement between USAID and the Ministry of Health. The meetings are carried out at USAID, with members of the Human Resources Office, the coordinator and administrator of the project, and representatives from MSH.

HEALTHCOM organized, with the MOH, a conference for the design of the liter bag to be used as a measuring tool for mothers administering ORS.

HEALTHCOM is the USAID representative on the Social Mobilization Committee with UNICEF and Johnson & Johnson, to support ORT activities. The project worked with Johnson & Johnson and the Mother and Child Health Department of the Ministry of Health in seeking financing for manufacturing the liter bag.

HEALTHCOM also worked with PAHO/Washington to support implementation of ORUs (Oral Rehydration Units) and ORT activities.

As requested by USAID/Guatemala, the project organized a ceremony to celebrate the donation of media space to support the Ministry's child survival activities.

HEALTHCOM has supported the Dirección General de Servicios de Salud (General Directorate of Health Services) to design strategies for the management of media during emergencies.

HEALTHCOM has assisted the Ministry of Health with the design of materials for radio and TV. HEALTHCOM participated in the administration of contracts with APCU Thompson and Publimerca to produce the broadcast materials. The project worked with USAID to incorporate the Ministry of Health in each of the contract tasks.

HEALTHCOM, as requested by USAID, restructured its scope of work to focus on institutionalization activities. The project coordinated with the General Directorate of Health Services, Human Resources Unit, and the Health Education Department, in administrative aspects of incorporating the Promotion Unit into the Ministry of Health's office.

Administrative matters (financial, legal, and personnel) concerning the closing of HEALTHCOM activities were discussed with USAID. The project officially closed in Guatemala on August 15, 1990.

### Formative Research

In October, the research team of the Promotion Unit and HEALTHCOM published the results of the KAP study carried out in Tactic, Baja Verapaz. In December and February, the Annenberg School for Communication, together with the research team of the Ministry of Health, began a plan to develop the 1990 Community KAP survey, to be implemented before the launching of the EPI and ORT campaigns. However, when A.I.D. suspended funding to the MOH, this survey was cancelled.

John Elder, behavioral consultant, and the research team observed and analyzed mothers' handling of the ORS liter bag prototypes. They observed 32 mothers in four cities in the interior. The results of the analysis were presented in the conference of the ORT interagency committee. A research plan was developed for the final design of the liter bag.

In February and March, HEALTHCOM and the research team of the Promotion Unit planned and initiated focus group discussions in seven cities. They conducted 41 interviews involving 131 mothers. The eight focus groups helped design the texts and graphics to be printed on the liter bag. Microbiological analyses were performed on samples of water taken throughout the country in an effort to determine the number of times a plastic liter bag could be used.

From February through May, the research team of the Promotion Unit, APCU Thompson, and HEALTHCOM, carried out plans of DATA and Aragon & Asociados pretesting materials. Forty-three focus groups pretested the audiovisual and graphic materials prepared by the APCU Thompson Advertising Agency for the 1990 vaccination jornadas.

## **Intervention Activities**

### **EPI**

Together with the APCU Thompson Advertising Agency, HEALTHCOM designed the graphic material for EPI vaccination jornadas, for ongoing EPI activities, and for the tetanus toxoid campaign for women aged 15 to 45 years. The "Mama Feliz" ("Happy Mother") tetanus pamphlet was redesigned and printed larger. For the vaccination jornadas of May and June, the following material was produced: four TV spots; 14 radio spots (including Spanish and four Mayan dialects); two types of posters; one guide file for providers; two versions of banners; four press messages; two versions of advice for broadcasters (of both permanent and mobile units).

HEALTHCOM and the Promotion Unit also designed and printed material to promote mass vaccination against measles and a pamphlet for different audiences susceptible to dengue. The pamphlet will be printed by Pepsi-Cola.

At the Feria Internacional de Guatemala (International Fair of Guatemala), HEALTHCOM distributed fliers and balloons containing EPI information.

Lastly, HEALTHCOM designed alternatives to the Health Sector bulletin promoted by PAHO and supported by the international and private interagency committee.

### **ORT**

The project designed the text and graphics for the ORS liter bag and pretested these with mothers (as described in the previous section).

Pamphlets, fliers, and balloons about ORT were designed, printed, and distributed to mothers in the exhibit booth of the Feria Internacional. At the fair, the Promotion Unit and HEALTHCOM also broadcast three additional microprograms of the series "El mejor regalo es la salud" ("Health is the Best Gift"), describing the availability of oral rehydration salts.

### **Interpersonal Training**

The Health Education team and the Promotion Unit received training from HEALTHCOM in designing comprehensive plans for the development of the liter bag and for communication and social mobilization activities.

The Departments of Health Education, Training, and Community Participation continued to receive information from HEALTHCOM about community participation and health communication.

The Promotion Unit received training from HEALTHCOM in the analysis of graphic and audiovisual material for the EPI and ORT campaigns.

Three members of the Promotion Unit, two from the Health Education team and one from the Dirección General de Servicios de Salud, received training in designing a handbook for artists preparing health-related sketches for nonliterate people.

Two members of the Promotion Unit continued designing scripts for audiovisuals and documentaries on health issues.

HEALTHCOM conducted three conferences for the research team of the Promotion Unit on effective interagency coordination to support tetanus toxoid and ORT interventions.

The Mother and Child Health Department, along with the Promotion, Epidemiology, and Health Education Units, received training in effective contract management of private communication agencies.

The APCU Thompson Advertising Agency received training in social marketing and KAP survey interpretation for the EPI and ORT campaigns.

The Promotion Unit, the Dirección General de Servicios de Salud, the coordinator of the EPI/ORT project, the Epidemiology Department, and the Mother and Child Health Department received training in the formation of a joint technical committee for approving the work of APCU Thompson Advertising Agency.

The project trained one member of the Promotion Unit in the analysis and monitoring of communication strategies and two members in planning ORS programs. HEALTHCOM also trained Publimerca Agency and a member of the Promotion Unit in monitoring radio broadcasts.

#### Other

HEALTHCOM has promoted coordination among international donors, the private sector, and other groups to promote activities of the Child Survival Project. HEALTHCOM, the Promotion Unit, and the Mother and Child Health Department have supported collaborative development of ORT activities.

HEALTHCOM and the Health Education Department have developed a social mobilization plan to be proposed to the Johnson & Johnson project administered by UNICEF. HEALTHCOM, the Promotion Unit, USAID, ADAMED, UNICEF, LAPROMED, APCU Thompson, members of the Mother and Child Health Department, and Johnson & Johnson analyzed the results of the observation research on the liter bag prototypes.

HEALTHCOM and the Promotion Unit have developed a strategy to introduce the 1990 ORT jornadas material to the health districts throughout the country in order to establish consensus regarding communication goals. HEALTHCOM, the Mother and Child Health Department, the Promotion Unit, and APCU Thompson also presented the launch and ongoing ORT plans to the ORT Interagency Committee at INCAP.

The project developed a six-month action plan focusing on institutionalization of efforts by the Promotion Unit within the Dirección General de Servicios de Salud.

#### **Monitoring and Evaluation Activities**

The Promotion Unit research team published and presented to the Health Area of Baja Verapaz results from the Tactic KAP. Annenberg, the Promotion Unit, and HEALTHCOM developed the sample for the 1990 KAP, designed the questionnaire, and trained interviewers in data collection. They also presented the 1987 Community KAP results on ORT and EPI to APCU Thompson Advertising Agency.

HEALTHCOM and the Promotion Unit reviewed information about the EPI coverage survey and designed questions for communication purposes. The research was suspended due to a shortage of funds.

The monitoring of materials for the vaccination jornadas (May and June), was carried out and the advertising agency presented the results to the interagency committee. Asistencia Ejecutiva was contracted to carry out the monitoring of radio and TV spots nationwide. The results indicated that promotion of vaccination jornadas should continue for 20 days. The Promotion Unit monitored distribution of the 14,000 posters in the 24 health areas.

### Diffusion Activities:

The resident advisor:

- submitted monthly and semiannual reports;
- conducted a workshop for the MOH personnel on conference design (Rio de Janeiro);
- prepared conference presentations about the activities carried out in ORT;
- collaborated with PAHO in publishing the health sector bulletin;
- collaborated with the Office of the Minister of Health for the official ceremony in the National Palace for the donation of mass media time;
- presented HEALTHCOM's methodology to the Joint Technical Committee in charge of the approval of the contract between APCU Thompson and USAID;
- conducted conferences on public health communication related to EPI, ORT, AIDS, and to other social issues;
- participated as a speaker in the training meeting of APCU Thompson Advertising Agency;
- designed and wrote information for the United States Ambassador about the communication activities of the project and the Ministry of Health.

### **INSTITUTIONALIZATION ACTIVITIES/PROGRESS**

The HEALTHCOM methodology has been used to train the Promotion Unit team of the Health Education Department in implementing integrated communication plans. Upon completion of training, presentations were given to the Ministry highlighting the increased technical knowledge of the promotion group.

Five hundred health workers were taught to apply the health communication methodology in their EPI and ORT education activities. Creative educational skills have been developed to enrich the communication activities.

The political authorities of the Ministry have acquired a new appreciation for the importance of research and systematic communication efforts in effecting changes in health care knowledge and behaviors. The Ministry is interested in pursuing the integration of modern communication methods into the health care system.

An institutionalized communication methodology has proved beneficial not only for the health care system itself, but also for those in the private sector, such as producers, advertising agencies, and so forth. In the international sector, dialogue has been generated about themes that had not been discussed previously, such as the payment of media, promotion evaluation, systematic communication planning, and so forth.

Principal problems hindering institutionalization are political and technical. The frequent rotation of personnel within the Ministry makes quick and effective decision making difficult. The lack of coordination among private sector agencies presents another obstacle. In the international sector, implementation is delayed by lack of leadership, lack of communication, and, therefore, the duplication of tasks.

## LESSONS LEARNED

- The MOH should make efforts toward better coordination amongst the collaborating organizations involved with ORT education.
- Face-to-face communication is an essential factor in institutionalizing health education strategies. Adequate resources must be committed to these efforts.
- It is essential that the Ministry of Health delineate clearly to the advertising agency its communication objectives. The ad agency was not well versed in social marketing strategies. The MOH should have responded by training the agency staff in health issues and in the specific attitudes and needs of the target audience. For instance, the MOH should have educated the ad agency staff in how the results of the KAP studies inform material design and implementation. As a result, the ad agency would not have made the mistake of focusing its efforts on TV diffusion, when research shows that radio is the primary medium used by the population. With leadership from the MOH, the ad agency would have produced material much more accessible to its target audience.

<b>2. <u>HONDURAS</u></b>	<b><u>Period:</u> October 1, 1989 - September 30, 1990</b>
Project Start-up Date:	October 1985
Child Survival Activities Focus	Diarrheal disease management, immunizations, acute respiratory infections, and growth monitoring
Collaborating A.I.D. Projects:	Health Sector I and II, Management Sciences for Health
USAID Support:	Robert Haladay Thomas Park Marvin Hicks Gustavo Bardales
Collaborating Donor Agencies:	UNICEF, PAHO/WHO, EEC, Government of Italy
Primary Institution *	Ministry of Health, Division of Health Education (HED) Division of Epidemiology (ED) Division of Mother-Child Health (MCH)
Collaborating Institutions:	
Ministry of Education	Secondary school students participate in community mobilization and promotion
Armed Forces	Provides logistical support for child survival campaign
Local Governments	Participate in promotion and actual mobilization
Resident Advisor:	Patricio Barriga
Date of Arrival:	September 1985

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\* Acknowledgments:

Principal counterparts

Dr. Cesar Castellanos (Minister), Dr. Marco Tulio Carranza, Dr. Luis Alonso Lopez, Dr. Daniel Davila Nolasco, Dr. Jorge Higuero, Marco Montenegro, Arturo Diaz, Dr. Jorge Melendez, Dora Rubi, Dr. Ricardo Kafie, Hector Espinal, Roberto Pineda, Luis Merlo, Rhina Andino, Carlos Montoya, Luis Sarmiento, Victor Murillo, Marcella Castillo, Santos Cubas, Celica Martinez.

HEALTHCOM/Honduras

Nalda Chavez, David Nietc

## Consultants:

Susan Saunders	April 1986: Conducted prefeasibility study for social marketing of ORS.
Susan Saunders	September 1986: Assisted in start of six market research studies in Phase II for social marketing of ORS.
Germana Sanchez	June 2-6, 1986: Trained researchers for ARI ethnographic study.
Germana Sanchez	September 2-6, 1986: Designed ethnographic study for ARI.
Susan Saunders	August-October 20, 1986 and March 3-April 10, 1987: Managed the private sector feasibility study for social marketing, Phase III.
Rodrigo Arce	February 23-March 4, 1987: Served as production specialist for the above study.
Hank Weiss	March 3-14, 1987: Served as distribution specialist for the above study.
Alberto de Aragon	September 6-October 15, 1987: Conducted the social marketing research for Phase III.
John Elder	October 12-15, 1986: Described behavioral potential objectives found in the ARI ethnographic research.
Robert Porter	November 3-7, 1986: Assisted development of methodology to confirm behavior found in ethnographic research regarding ARI.
Dennis Foote	February 9-18, 1987: Designed HEALTHCOM impact evaluation.
Carol Baume	February 9-21, 1987: Designed HEALTHCOM impact evaluation.
Carol Baume	April 21-June 2, 1987: Implemented a follow-up study of oral rehydration therapy (ORT) practices and a baseline survey of acute respiratory infection (ARI).

Dennis Foote	May 20-June 4, 1987: Arranged for local entry of data and drew up contracts for follow-up work in connection with data collection.
Peter Boddy	February 3-March 9, 1988: Designed multiple baseline for ARI.
Peter Boddy	June 12-18, 1988: Assisted in the development of ARI first phase intervention
Mark Rasmuson	June 13-18, 1988: Reviewed project progress.
Maria Claudia DeValdenebro	August 1-13, 1988: Conducted graphic design workshop for HED personnel.
Camille Saade	August 14-23, 1988: Assisted in ORS social marketing for pharmaceutical laboratories.
Reynaldo Martorell	December 5-9, 1988: Presented 1987 resurvey results and evaluated degree of HEALTHCOM institutionalization.
Peter Boddy	December 3-10, 1988: Revised data collection and instruments for ARI behavior study. Assisted HED in the implementation of data collection activity in the selected areas. Participated in field data collection.
Camille Saade	December 18-23, 1988: Developed promotional strategy for Hydrosol (commercial ORS product), which will be launched in 1989.
William Smith	April 10-12, 1989: Discussed HEALTHCOM institutionalization issues with MOH and A.I.D. officials.
John Elder	September 23-30, 1989: Compiled, analyzed, and interpreted the available ARI data (ethnographic research, focus group survey, preference study, and multiple baseline).
Maria Claudia de Valdenebro	October 16-27, 1989: Prepared HEALTHCOM methodology graphic design manual.

Julia Rosenbaum	February 18-March 3, 1990: Monitored HEALTHCOM Project activities; helped develop HEALTHCOM II Scope of Work.
William Smith	February 20-23, 1990: Supervised project activities.
Julia Rosenbaum	July 28-August 8, 1990: Monitored activities; helped in strategy development of new HEALTHCOM Project components; helped revise ongoing interventions.

## PROJECT SUMMARY

Honduras was among the American nations with the highest rates of infant mortality in 1980. Preventable conditions and diseases accounted for the principal causes of premature death. The situation required not only improvements in health service delivery, but also the modification of attitudes and behaviors of health personnel and consumers.

Working with the Division of Health Education (DHE) of the Ministry of Health (MOH), the Mass Media and Health Practices Project (MMHP) (1981-1985) developed a systematic communication methodology which effectively targeted changes among health personnel and caretakers of children under five years of age. The initial phase utilized this methodology to introduce ORT in Honduras. A second phase of the project included new areas of intervention including malaria, immunizations, and tuberculosis.

The initiation of HEALTHCOM in 1985 coincided with the beginning of the Ministry of Health's child survival program sponsored by UNICEF. The principal areas of emphasis were immunizations (EPI), oral rehydration therapy (ORT) for diarrheal disease control, and the control of acute respiratory infections (ARI). The main task of HEALTHCOM was to assist the MOH in the design and implementation of communication plans for the EPI, ORT, and ARI interventions. Audience research (ethnographies, focus groups, and so forth) played an important role during this phase. Social marketing and behavioral analysis concepts contributed to the preparation and implementation of the plans.

The objectives of HEALTHCOM I were to:

- institutionalize health communication activities;
- expand ORT coverage through the use of both public and private sector channels;
- develop a health communication strategy for acute respiratory infections (ARI).

In addition, HEALTHCOM, along with its counterparts, has conducted longitudinal studies to monitor the ORT-related behaviors of a large number of families. Institutionalization has progressed significantly through the ongoing training of DHE personnel and the development of management mechanisms.

The Academy was asked to extend its technical assistance in Honduras to integrate nutrition themes into child survival communication. In December 1989, Dr. Peter Boddy joined the AED staff in Honduras as resident advisor for the Nutrition Communication Project. Dr. Barriga serves as chief of party for this integrated communication effort.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administrative/Management

- HEALTHCOM and the new MOH appointees conducted regular negotiating and planning meetings in order to preserve and broaden the application of the communication methodology developed over the last ten years.
- HEALTHCOM and DHE personnel have conducted weekly planning and evaluation meetings.
- Efforts have been made to alleviate vast ORS shortages. PANI (the government pharmaceutical laboratory) resumed the production of ORS at the minister's request, but stopped production shortly thereafter. Other sources of ORS that have been secured include UNICEF/UNIPAC international purchasing system and Ciba-Geigy. It is expected that these efforts will satisfy ORS needs for the next two years.
- The measles epidemic in Honduras generated political momentum for strengthening EPI communication efforts. As a result, the eighth and ninth national immunization campaigns were strongly supported by the new government, which took office in January 1990. The government also approved a new communication plan developed by the MOH and HEALTHCOM, emphasizing regular vaccination services and reduction of missed opportunities.
- The MOH signed an agreement with the Armed Forces, who help with logistics and transportation of supplies, to stop the spread of measles.
- HEALTHCOM and the Nutrition Communication Project are working together both technically and administratively. HEALTHCOM has helped in the design of the NCP plan, which is almost completed.
- The official ARI norms were revised as part of the agreement with PAHO/Washington and WHO/Geneva to implement the ARI communication plan nationwide.

### Formative Research

HEALTHCOM has started the formative research component of the reproductive risk/family planning communication activities. To date, exploratory focus groups and an extensive literature search have helped to define research objectives.

Family planning will be a new focus of HEALTHCOM II. AED advisors have worked extensively with MOH and USAID officials to develop an overall strategy to include family planning activities with a more comprehensive "reproductive risk" intervention. Advisors are now working with MCH, MSH, and USAID officials in the design of a communication plan which began with a search for policy consensus among the cooperating organizations. They also designed the formative research component of the plan, including focus group research and possibly a KAP survey. This formative research will set the stage for the preparation of the communication strategy.

### Intervention Activities

To implement the ORT, EPI, and ARI communication strategies, the DHE and MCH have conducted the activities described below.

#### CDD

Print and broadcast activities in support of CDD have included:

- 500,000 Litrobolsa mixing bags, which complement the LITROSOL product. The bags make LITROSOL more attractive and easier to use, and thus encourage proper mixing;
- 25,000 promotional posters for LITROBOLSA;
- 90,000 brochures for mothers on ORT;
- 100,000 ORT mothers' certificates;
- 10,000 community health worker manuals;
- 700 ORT flipcharts for health workers;
- 10,000 ORT promotional mobiles;
- Nine ORT radio spots.

The DHE "technical committee," made up of seven communication/education specialists, trained more than 460 health workers in about 385 health establishments in ORT communication.

At the request of the United Nations, DHE personnel implemented the ORT communication strategy in Honduran refugee camps, providing educational materials and training for their health personnel.

QUIMIFAR, the private laboratory selected for ORS commercial production, started pilot production of HYDROSOL (a private sector product). Quality control and production problems have been solved. As soon as mass production begins, the product will be marketed through private pharmacies and grocery stores. In the interim, the Ministry of Health has placed orders amounting to three million packets of salts to be distributed to the public sector health centers. The problem of acquiring packaging materials has also been resolved, but a reliable source of hard currency to guarantee a steady supply of production materials has not yet been found.

## **EPI**

Print and broadcast activities in support of EPI have included:

- 20,000 immunization campaign posters;
- 100,000 flyers for mothers;
- 50,000 promotional stickers;
- 450 flipcharts for health workers;
- Five radio spots for EPI and the National Mobilization promotion;
- One TV spot on polio.

## **ARI**

HEALTHCOM and the MOH helped to develop two new pages of the ARI flipchart reflecting the new norms. They have been printed and included in the 1,400 charts being distributed to health workers.

## **Interpersonal Training**

Interpersonal training activities have included the following.

- Four hundred and fifty health workers were trained in ORT communication strategies, including person-to-person and mass media techniques. The training workshops took place in the eight health regions and health centers.
- Follow-up workshops for local radio disc-jockeys and radio managers were conducted in the health regions. Participants were briefed on the basic messages of the EPI, ORT, and ARI campaigns.
- The Metropolitan Health Region and Region Two conducted training sessions for new regional health education personnel in HEALTHCOM methodology and provided basic information on the ARI and ORT communication plans.
- The HEALTHCOM resident advisor and HEALTHCOM counterparts conducted seven workshops on low-cost educational materials production for regional health workers in several health regions. Creativity, structured learning experiences, and production aids constituted the main focus of the workshops. This effort was aimed at improving face-to-face communication skills, as requested by MOH officials.

The HEALTHCOM methodology in Honduras has fully integrated face-to-face communication methodology, which includes materials and guidelines; and folk media utilizing indigenous means of communication. This strategy offers health educators a wider range of training and educational possibilities and often allows them to design and

develop tailor-made educational activities. All of the structured learning experiences conducted by trained health workers aim at the development of new attitudes and behaviors among caretakers of infants. The study also implies that health personnel need to develop new behaviors, attitudes, and skills.

### Monitoring and Evaluation Activities

A monitoring system has been developed to provide regions with appropriate technical assistance to keep communication methods relevant. The system includes a series of planning and control mechanisms, as well as corrective actions to take when plans veer off course.

Supervision visits to the field have shown that ORS usage has increased, as has home therapy, as a result of the dissemination of the LITROBOLSA. An auxiliary nurse who works in a health center near Comayagua said: "This is the first rainy season that we have not had any children die from dehydration. All mothers now can have their LITROSOL."

As a result of the work HEALTHCOM conducted in the refugee camps, Dr. Edgardo Valeriano, physician in charge of the health programs in these camps, informed the advisor that during the three months after the intervention started, not a single infant had died of dehydration caused by diarrhea in contrast to previous months when five to eight children died of dehydration each week.

USAID/Tegucigalpa has been instrumental in improving health communication planning through the introduction of the "critical path planning model," a computer generated pert chart illustrating the interrelationship between the many stages of projects. Dr. Stanley Terrell has worked with the advisors and MOH divisions on this planning and monitoring tool.

### Diffusion Activities

A series of HEALTHCOM methodology sessions has been conducted by DHE members and the HEALTHCOM resident advisor for various groups outside of the MOH. Among others, these were for: 120 participants in the Third International Congress of Traditional (Natural) Medicine; two groups of visitors from the Guatemalan MOH; and 50 medical students and faculty who attended meetings during the scientific week organized by the National University.

The HEALTHCOM resident advisor and Honduran counterparts have lectured on health communication methodology in eight courses and seminars for health planners and implementors from the MOH.

"The Learning Community," a field note on the HEALTHCOM institutionalization process, will be published in the project collection. It demonstrates the value of the participation of local professionals and stresses that a permanent learning process must take place in order to achieve self-sustainability. A second field note on public and private sector collaboration for the marketing of commercial oral rehydration salts will also be included. This field note will provide valuable insight to other country projects considering private sector production and distribution of ORS.

## **INSTITUTIONALIZATION ACTIVITIES/PROGRESS**

The Honduran Division of Health Education, HEALTHCOM's major counterpart, has been receiving technical assistance for almost a decade. Because of this history, many see the Honduran experience as a dynamic case study for lessons about institutionalization and sustainability. Institutionalizing the health communication methodology is a complex task in an ever-changing work environment.

A new government party was elected in November 1989 and took office in January 1990, causing a virtual work stoppage for several months while policy changes were made. While the new minister of health is still formulating official policy changes, he appears to support private sector collaboration. Dr. Luis Alonso López, the new director of the Division of Health Education, is a physician with extensive television and radio experience but little exposure to a social marketing approach to public health issues. To ease the transition, HEALTHCOM sponsored a training visit for Dr. López at the Academy office in Washington, where he had the opportunity to meet with staff at AED A.I.D., PAHO, PRITECH, The Johns Hopkins University Population Communication Services, and other child survival communication specialists. Several new health education team members joined the division, needing orientation and training in the HEALTHCOM methodology.

Ironically, the growth of national communication capabilities has presented an obstacle to institutionalization, as trained Ministry of Health personnel are hired by other multilateral or development organizations as short-term technical assistants or permanent staff. Their absence has diminished the success of MOH educational and overall institutionalization efforts. The integration of the Nutrition Communication Project with the existing HEALTHCOM Project design has also presented challenges. The number of child survival interventions has grown faster than the capacity of trained personnel within the MOH to develop and monitor the interventions.

An advantage of the integration of HEALTHCOM and the Nutrition Communication Project is that different teams are working together with the MOH on previously separate but potentially overlapping child survival issues. The divisions of the MOH are therefore learning to work together in communication methodology.

National level personnel are decentralizing activities by training regional teams in the HEALTHCOM methodology. Several training events were conducted in 1989 by the DHE personnel and HEALTHCOM for regional health educators and social workers. Periodic half-day training sessions included methodological and management skills development.

The interdivisional team working on health communication activities--or "the learning community"--held weekly planning and evaluation meetings until recently. These meetings facilitated the development of project planning, management, and evaluation skills by changing the way the group interacted and approached problem solving. The meetings have been an important self-sustaining mechanism, allowing members of the team to monitor projects and develop new ideas.

Maria Claudia de Valdenebro, graphic designer from AED Washington, provided assistance in the preparation of a graphic design manual which will be produced in the near future. The manual serves as a "how-to" guide for local producers of health education materials. The manual has served to collect and disseminate the experiences of the DHE team with other health personnel.

The DHE made errors in use of transportation and per diem funds in 1989. USAID has suggested that HEALTHCOM develop a control system to monitor these funds. Although this does not encourage sustainability, as it takes control out of the MOH's hands, this step appears to be necessary for the time being.

## MAJOR ISSUES AND LESSONS LEARNED

The sustainability of the HEALTHCOM methodology depends to a great extent on the direction and strength of the new management. Dr. Luis Alonso López is developing a new management policy oriented towards the delegation of responsibilities and the sharing of authority. New DHE personnel will also be trained in health communication. Thus, although the change in government has slowed the process of decision making, the change is advantageous since it provides an opening for significant improvements in management and sectoral policy making.

It is crucial that HEALTHCOM's role is balanced between facilitating action and encouraging Honduran counterparts to take initiative in program planning, implementation, and monitoring. This balance is difficult to maintain, due to "permanent emergencies" and system failures. HEALTHCOM must continue to provide technical assistance without creating dependency.

The need to respond to the measles epidemic has shifted resources and attention of the divisions of MCH, Education, and Epidemiology away from planned activities. Furthermore, spoiled vaccine has shown that the cold chain does not work efficiently.

HEALTHCOM and the MOH completed the process of contracting radio time through the regional government offices. Signing contracts with local radio stations proved to be very difficult without proper and timely assistance from the central level. The requirement that the president of the republic must approve every contract delays the buying process. Dr. Luis Alonso López, the new head of the Division of Health Education, is investigating possibilities for contracting with a private advertising agency to handle some MOH radio spots and program placement in order to expedite the next stage in the process.

<b>4. <u>INDONESIA-WEST JAVA</u></b>	<b><u>Period: October 1, 1989 - September 30, 1990</u></b>
Project Start-up Date:	October 1985
Field Activities Start-up Date:	June 1986
Project Close-Down Date:	September 1990
Child Survival Activities Focus:	Diarrheal disease control
Collaborating A.I.D. Projects:	Field Epidemiology Training Project; Health Training, Research and Development Project; Expanded Program in Immunization; Rural Health Project (CHIPPS); SOMARC; PRITECH; PATH
Collaborating Donor Agencies:	UNICEF, WHO
Collaborating Private Sector Agencies:	Survey Research Indonesia AdForce - JWT Nusarisc - Research Sinivisi
Primary Institution for Resident Advisor:	Center for Community Health Education (PKM), Department of Health and Sub-Directorate for Diarrheal Disease Control (CDD) West Java
Collaborating Institutions:	
	Department of Health, National Level:
	Task Force for Integrated Health Services
	Center for Community Health Education
	Directorate General of Communicable Disease Control
	Directorate for Diseases of Direct Transmission
	Directorate for Immunization and Epidemiology
	Sub-directorate for Diarrheal Disease Control (CDD)
	Sub-directorate for Immunization
	Sub-directorate for Epidemiology
	Directorate General for Community Health
	Directorate for Nutrition
	Sub-directorate for Community Participation
	Department of Health, West Java Province:
	Community Health Education Division
	Communicable Disease Division
	Nutrition Division
	Immunization Division

Resident Advisor:

John Davies

Date of Arrival: October 1985  
Worked part-time on West Java from  
Jakarta base until 10/87

Terrence Louis

Date of Arrival: September 1987  
Deceased: July 1990

Consultants:

Robert Hornik

January 12-24, 1986: Designed  
evaluation.

Elizabeth Booth

March 13-26, 1986: Reviewed  
communication design.

Robert Hornik

June 1986: Designed evaluation.

Jeffrey McDowell

May 1986: Designed evaluation.

Elizabeth Booth

October 1986: Reviewed project  
progress.

Terrence Louis

December 1986: Assisted  
communication design.

Jeffrey McDowell

February 1987: Designed evaluation.

Anthony Nathe

February 1987: Assisted communication  
design.

Tom Reis & Elizabeth Booth

May 1987: Reviewed progress and  
assisted planning.

Jeffrey McDowell

September 1987: Assisted evaluation.

Thomas Reis

December 1987: Assisted Central Java  
ROVITA Project.

Robert Clay (A.I.D./W) and  
Mark Rasmuson

Reviewed project progress.

Jeffrey McDowell

June 1988: Assisted with evaluation.

John Elder

August 1988: Assisted in planning  
behavior analysis studies.

Judith McDivitt

September 1988: Assisted with  
evaluation and reviewed KAP result  
presentation.

Cathy Wolfheim and  
Elizabeth Herman (WHO/CDD)

January 1989: Observed research and  
communication activities.

Renata Seidel	January 1989: Assisted with field note development.
Willard Shaw	May-June 1989: Organized HEALTHCOM Asia Regional Conference
John Elder	June 1989: Assisted with behavioral analysis activities.
Judy McDivitt	September 1989: Presented key findings of West Java KAP study.
Willard Shaw	June 1990: Reviewed project progress.

## PROJECT SUMMARY

USAID is assisting the Health Department to strengthen its communication activities aimed at improving diarrhea case management in homes and in Health Department facilities. USAID assisted the Health Department to decentralize many activities, including communication planning to the province level. The major goal of USAID's work in West Java was to assist the West Java Provincial Health Department to apply communication strategies based on social marketing concepts to improve child survival activities focusing mainly on diarrheal disease control (CDD). Dehydration caused by diarrhea is a leading cause of infant mortality in Indonesia and accounts for several hundred thousand deaths among children under five years of age every year. The West Java Health Department is committed to lowering the fatality rate from diarrheal disease to less than one percent by intensifying the CDD activities with emphasis on increasing access and use of case management.

In 1986 the pilot project selected Garut regency (population 1.6 million) for the launch of its intensification program. A baseline KAP study was followed up with a six-month intensification program and a post-test in 1987. The Annenberg School for Communication produced a report of the evaluation in 1987. Also in 1987 the West Java Health Department intensified training activities in three additional regencies. In 1988 a third wave of KAP evaluation was fielded.

In late 1987 a comprehensive Social Marketing Plan for Control of Diarrheal Disease was developed. This plan provided for a phased approach to intensifying CDD activities in up to eight regencies. Field activities were targeted to begin in April after a March-April baseline KAP study. The baseline KAP survey was completed, and based on that data, the creative and communication strategies were developed. The creative strategy utilized West Java cultural symbols such as the village alarm bell (kentongan) and a popular theater group to link the messages to the local culture. The communication plan outlined a multichannel approach that combined mass media (radio, billboards, advertisements), print, and interpersonal channels targeted at different segments of the population.

A key component of the program was the revision of the support materials and training system for community health volunteers (kader). Based on thorough research and testing, a set of counseling cards for the case management of diarrhea was carefully developed. Similar testing produced a trainer's manual for the implementation of counseling card training. In 1989 over 20,000 MOH staff and kader were trained in the

use of the cards. Delays in the launch of initial project activities combined with the development of high quality communication interventions led to an extension of the program from 1989 to 1990.

USAID's objective was to strengthen provincial-level institutional skills for continuing intensification of child survival activities, especially CDD activities. The specific goal was to assist in the education of mothers, community health volunteers, and Health Department officials, with the objective of increasing correct case management, including oral rehydration therapy (ORT), in the home and at health facilities. The health communication methodology is based on marketing, behavioral, and anthropological concepts.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administration/Management

Staff development activities continued. MOH staff worked with research organizations on the design of several formative and monitoring studies and assisted the Annenberg consultant and Survey Research Indonesia, Inc. staff in the planning of the final KAP.

A major problem encountered during this period was the delay in receiving funding for project activities from A.I.D. and the MOH. Because of administrative problems between the two cooperating agencies, funds were not sent out to West Java on a timely basis. This delay halted the implementation of the second phase of the communication program which was to be launched in the third quarter of 1989 but had to be delayed until February of 1990. The halt in funds also hindered the implementation of the research program. Several studies which had been in the planning stage for over a year had to be cancelled.

The project suffered another grievous blow when the HEALTHCOM resident advisor, Terry Louis, became ill in late June and had to be hospitalized in Singapore where he died in early July. Mr. Louis' dedication, drive, and ability to work well with all collaborating groups were key elements in the West Java project's ability to overcome or work around the many problems it faced. His untimely death coupled with the halt in the flow of funds ended HEALTHCOM's full-time participation in the West Java program. Tom Reis, the HEALTHCOM resident advisor for Central Java, made several trips to West Java to close down the site and to provide support as needed to the West Java team. Because the halt in funding stopped the implementation of activities and because the Indonesian counterparts were well prepared to implement the detailed plans when and if funding was available, it was decided not to field a replacement for Mr. Louis.

### Formative Research

A number of studies were planned for this period, but were not carried out due to the halt in the flow of funds to the project. The project had planned to carry out five studies which a) monitored the impact of the communication program through a random sample of 200 parents of children under five years old; b) analyzed how well existing ORS packets communicate with mothers with low literacy; c) developed a detail brochure for physicians on Oralit; d) assessed the best channels for communicating with caretakers of children; and e) looked at communication between health providers and mothers through in-depth discussions with clinic workers and kader as well as observation of clinic processes.

## Intervention Activities

The launch of the second phase of the media campaign was scheduled to begin in September-October 1989 but did not start until February 1990 because of the halt in the flow of project funds from Jakarta. The activities that were carried out included the following.

### **Radio Broadcasts**

CDD messages were aired on 47 selected radio stations throughout the project area from February through August. The messages covered the themes of the danger of diarrhea, the use of Oralit, and the availability of help from village kader. Twelve 60-second spots were broadcast five days a week at a frequency of eight spots a day for six weeks.

### **Mobile Film Units**

The contract was renewed with Sinivisi to have its nine mobile film units show the project's seven-minute video on CDD in the eight target regencies as part of their regular showings of a full-length movie and commercials. Screenings were six days a week for 27 weeks during this period.

### **Direct Mail**

Based on a previous experiment that showed that at least 76 percent of kader could be reached via mail, the project undertook to do a mass mailing to kader. During the 1989 training sessions, the names and mailing addresses of 20,000 kader were compiled and computerized. In the first stage of the mailing, packets were sent to 18,000 kader. The packet contained: a) a letter from the provincial head of the health department thanking kader for their work and outlining future activities they should undertake; b) prints of the four CDD press advertisements; c) the 1990 calendar insert for the envelope-cum-calendar used to hold the counseling cards; and d) a short questionnaire on the counseling cards and ORS packets. The response of the kader was tremendous. Over 8,500 of them took the time to fill out the questionnaire, find and buy a stamp, and mail the questionnaire back to the project office. Hundreds of kader took the time to write lengthy letters with details of their work, problems, and support needs. This activity demonstrated that direct mail could play an important role in providing information support, supervision, and perhaps even increased motivation to kader in the villages.

### **Face-to-Face**

During this period, the 20,000 kader trained in the use of the counseling cards in mid-1989 continued to counsel mothers on the treatment of diarrhea and to operate posyandus (village health posts) one day a month in cooperation with local puskesmas staff. The plans to develop two additional counseling cards on preventive measures based on the information learned in the 1989 handwashing and feeding studies were delayed because of the funding halt.

## Monitoring/Evaluation Activities

The project was able to complete a final draft of its study of the effectiveness of the kader counseling cards. This study compared a group of kader trained in the counseling card system with group of senior kader who had undergone the regular training through observations conducted in role playing situations, actual counseling sessions, and interviews conducted with mothers who had been counseled. Observations showed that both groups did well in covering the major points of CDD case management in counseling sessions, with the counseling card kader committing fewer errors. The validation interviews with mothers who had been counseled found a substantial difference in their abilities to actually mix ORS. The mothers trained by the card kader were only one fourth as likely to commit errors as mothers trained by the other group of kader. Another interesting part of the results was that the card kader provided instruction to all of the mothers they had promised to see as part of this study; the control group contacted less than 94 percent of their self-assigned mothers and actually provided diarrhea counseling to only 81 percent. This provided anecdotal evidence to project staff members who felt that the provision of a "tool" for counseling might actually give kader more confidence in their ability to counsel and thus make it more likely that they would carry out their responsibility to assist mothers.

The final wave of the KAP study in five regencies in West Java was undertaken during March-April 1990. Researchers from Survey Research Indonesia, assisted by a consultant from HEALTHCOM subcontractor, the Annenberg School for Communication, conducted interviews with a sample of 1,000 caretakers, 50 health center workers, 100 kader, and 200 retailers. The survey covered reported incidence, symptoms, and severity of last diarrhea episode; treatment of last case; feeding patterns before and during diarrhea; and mass media and interpersonal media channel impact on treatment. The final report of this survey will be completed by Annenberg in December 1990. Preliminary results indicate strong increases in mothers' awareness of the key themes of the communication campaign: dangers of diarrhea, role of kader, and availability of Oralit.

## Diffusion Activities

In May the Resident Advisor made a presentation to UNICEF on the planning, activities, materials, and results of the West Java program. UNICEF intends to support CDD activities in 11 provinces and was interested in taking advantage of the West Java experience.

The West Java CDD program received two prestigious awards from the Indonesian Association of Advertising Agencies. The national awards ceremony, the advertising equivalent of the U.S. "Academy Awards," was held in early 1990 to honor the best advertising work of 1989. The West Java program received a gold medal for "use of culture in a campaign" and a bronze medal for "integration of multichannel media." This was the first time that a public sector project had received these national awards from the Association. The announcement of the awards and their subsequent presentation to the Minister of Health received a high degree of coverage by the newspapers and television network.

West Java program officials traveled to South Sulawesi and South Sumatra to share the training and mass media experience of the program with MOH officials.

## **INSTITUTIONALIZATION ACTIVITIES/PROGRESS**

The process of having counterpart staff work closely with the HEALTHCOM resident advisor and with a variety of private and public sector entities has resulted in a high degree of skill transfer. Several members of the West Java staff have spent considerable time working on the advertising and research components at the offices of private sector subcontractors. They have not only acquired skills and knowledge in the area of communication but have also developed important personal private sector contacts and gained experience in using and managing private subcontractors. The West Java staff even developed a contractual procedure that addressed both U.S. and Indonesian government requirements and developed special documents for all contracts entered with private sector organizations. Other departments of the Ministry of Health in other provinces have recognized the technical value of the procedure and documents and plan to use them in their own contracting.

## **MAJOR ISSUES AND LESSONS LEARNED**

### **Major Issues**

A major issue that has plagued the project for most of this and previous years has been cash flow. Funds are not received at the provincial level in a timely manner that allows for the orderly implementation of project activities and the attainment of the desired impact upon health behavior. The current fund distribution system requires that the province request payment from CDD Pusat (Central) for activities planned for a three-month period with supporting and approved documents/estimates. In turn, CDD Pusat requests funds from USAID. CDD Pusat's request is based on having used or disbursed 60 percent of the previous advance and providing USAID with payment disbursement vouchers. USAID/Jakarta then requests payment from the regional office in Bangkok. This three-tiered system, if correctly followed, takes six to eight weeks to complete; however, the experience has been that the process breaks down at various levels leading to the necessity of postponing planned activities.

The resident advisor has been forced to spend a significant portion of his time in Jakarta helping to facilitate the funding process--therefore taking time away from his supervision of field activities. A dispute between USAID contracts and CDD Pusat in late 1989 led to a complete halt in the flow of cash which resulted in a lengthy delay in the launching of the second phase of the communication program.

Another problem that occurred was with the selection and implementation of subcontracts with organizations. USAID contracts require a competitive bidding process. While such procedures are essential for supplies and some services, they hinder procurement of creative services such as advertising agency services. The regulations require competitive bids each time advertising activities are planned during a new fiscal period. Unfortunately, an agency that has provided good creative and functional media placement service cannot automatically continue to provide such service in the successive program period even if the same materials developed by the agency are used. A new bidding and selection process is required. Each new agency requires orientation to the program and to social marketing. Most importantly, the program loses the long-term commitment and continuity that client and agency build working together. Qualified creative service organizations may not bid if they see the work as a discrete activity.

## Lessons Learned

**Management:** This period has confirmed the need for effective program coordination. The program coordinator who took office in February 1989 mainly has been responsible for the many administrative procedures required for contracting activities. The important lesson learned was to recognize rigid Indonesian government regulations and ensure that procedures equally met USAID bidding and contracting procedures. Difficulties were resolved through the development of a contract form for conducting business with advertising agencies, research organizations, and media groups.

**Pretesting of messages:** The value and importance of pretesting messages and teaching material was clearly established during the development of the advertising campaign and training materials. The completed research studies helped government officials who observed the studies in the field to recognize the importance of systematic field work.

**Maintaining Quality of Training In a Large, Multi-Tiered System:** The West Java CDD program faced this problem by standardizing the content and process of the training so that personnel at all levels (provincial, regency, district, village) went through a similar training experience. Each group went through the same learning process they would later direct as trainers. This training process was codified in a manual. By making the counseling cards the core of the technical aspects of training, the quality and uniformity of the basic technical information was standardized. Post-tests of the kader trained at the village level showed that they had mastered the counseling cards with 90-95 percent degree of accuracy indicating that the quality of training had been maintained down to the base of the training pyramid.

**Direct Mail:** The project's experience with direct mail and the extremely enthusiastic response by kader to the mailing are evidence that direct mail has a strong role to play in the provision of informational and supervisory support. It is doubtful that Indonesia will ever develop a supervision structure of the size needed to provide regular support of over a million kader. Direct mail can be an important communication channel for sending and receiving timely information. It also appears that it may be effective in supplying recognition of the importance of kader and motivating them into carrying out their responsibilities as volunteers.

4.	<b><u>INDONESIA-CENTRAL JAVA</u></b>	<b><u>Period: October 1, 1989 - September 30, 1990</u></b>
Date of Letter of Agreement:		February 11, 1988
Project Start-up Date:		April 15, 1988
Date Broadcast Start-up:		July 25, 1988
Child Survival Activities Focus		Diarrheal disease control, vitamin A
Collaborating A.I.D. Projects:		ROVITA, PRITECH
Collaborating Donor Agencies:		Helen Keller International (HKI), UNICEF, WHO
Primary Institution:		Center for Community Health Education (PKM), Department of Health, Central Java Province
Collaborating Institutions:		
	Helen Keller International	Overall project management and administrative assistance
	Department of Health, National Level: Center for Community Health Education (PPKM) Sub-directorate for Diarrheal Disease Control (CDD) Directorate for Nutrition	Program policy directives, technical assistance
	Department of Health, Central Java Province: Community Health Education Division (PKM) Communicable Disease Division Nutrition Division	Program policy directives, technical assistance
	Private Sector Agencies: Survey Research Indonesia (SRI) PATH (Program for Appropriate Technology in Health)	KAP field data collection  ORS product technical assistance, commercial ORS promotion
Resident Advisor:		
	Thomas Reis	Date of Arrival: April 18, 1988

Consultants:

Tom Reis  
Elizabeth Booth

May 1987: Assessed social marketing technical assistance needs for ROVITA Project.

Tom Reis

August 1987: Assisted ROVITA Project with January 1988 ethnographic research field work and analysis, kader training manuals development, and strategy development for communication intervention.

Jeff McDowell

September 1987: Assisted in planning of Central Java KAP evaluation and instrument design.

Jeff McDowell

July 1988: Assisted in KAP instrument design, KAP methodology, and selection of KAP control area.

John Elder

August 1988: Assisted in planning and designing behavioral studies and observations regarding kader behavior in posyandu (rural health posts).

Judy McDivitt

September 1988: Assisted in finalizing design of KAP evaluation instrument, pretesting instrument, training field interviewers, and managing field data collection start-up activities.

Renata Seidel

January 1989: Assisted ROVITA team in writing two HEALTHCOM field notes.

John Elder

June 1989: Assisted ROVITA team in analysis of first phase of kader behavior study results and designing a proposed behavior intervention as the second phase of the kader behavior study.

Judy McDivitt

September 1989: Assisted in finalizing KAP post intervention evaluation instrument, training of field interviewers, managing start-up activities. Also discussed baseline KAP results with ROVITA team and interviewed ROVITA team members on issues related to Annenberg's final HEALTHCOM report/narrative to AED/USAID.

Cecile Johnston	December 1989: Reviewed qualitative marketing research activities within the ROVITA project and assisted with planning of <u>kader</u> behavior study, phase two.
John Elder	January 1990: Assisted ROVITA team with design of <u>kader</u> behavior study, motivational intervention (phase two of study).
Judy McDivitt	February 1990: Reviewed post KAP initial key findings and completed interviews of ROVITA team members for Annenberg's final HEALTHCOM report to AED/USAID.
Willard Shaw	May 1990: Reviewed Central Java vitamin A program and discussed future curriculum development activities with local universities.

## PROJECT SUMMARY

HEALTHCOM Central Java is collaborating with the Government of Indonesia (GOI), the Universities of Diponegoro and Indonesia, and Helen Keller International (HKI) within a USAID-funded child survival project called ROVITA. HKI is providing overall management and administrative assistance to the project while HEALTHCOM is providing long-term social marketing assistance through a resident advisor, various short-term consultants, technical assistance from the Annenberg School for Communication in conducting and analyzing a baseline and post-intervention evaluation of mothers' KAP, and home office technical and administrative support.

"ROVITA" is the acronym for Rehidrasi Oral dan Vitamin A, corresponding to the two targeted project interventions of diarrheal disease control through ORT and vitamin A promotion. The project is located in the province of Central Java in Indonesia. The targeted intervention areas are two regencies (counties), Demak and Jepara (population 1.5 million).

The ROVITA Project officially began in October 1987. HEALTHCOM assisted with initial project planning input as it related to the social marketing component. Further, three short-term HEALTHCOM consultancies took place from August 1987 to February 1988 before placement of the HEALTHCOM resident advisor in mid-April 1988. Thus ROVITA had already been in existence for more than 18 months before HEALTHCOM began its in-country residence, with the majority of typical project start-up activities already completed before the resident advisor arrived. This facilitated a quick initiation of social marketing activities for HEALTHCOM in Central Java.

The ROVITA Project addresses the health problems of vitamin A deficiency and mortality due to diarrheal diseases in children under five years of age. Target intervention groups are children under five years of age, their mothers/caretakers, volunteer health workers (kader), health workers in the community health centers, community leaders, and all others involved in the distribution of vitamin A (200,000 IU) capsules and promotion of proper oral rehydration therapy.

The objectives of the ROVITA Project are to:

- improve the distribution of megadose vitamin A (200.000 IU) to achieve a coverage rate of 90 percent of children from age one to five years old;
- improve diarrheal disease outcome in children under five years of age, through improved case management and improved supply and distribution of ORS;
- apply social marketing techniques including systematic coordinated communication to achieve the first two goals;
- measure the change in incidence and severity of diarrhea in a small cohort of children before and after vitamin A supplementation;

The HEALTHCOM resident advisor is attached to and works with the Central Java provincial health department's Center for Community Health Education (PKM). The HEALTHCOM resident advisor counterpart is the head of PKM for Central Java province.

The ROVITA Project officially ended on August 1, 1990. A new project, SOMAVITA (Social Marketing of Vitamin A), took its place. This is primarily a USAID "funding mechanism" change due to different sources of funding within USAID's office of Food and Voluntary Assistance (FVA). However, the SOMAVITA Project will have one significant difference from the previous ROVITA Project, namely that diarrheal disease control will no longer be part of the project's ongoing activities. SOMAVITA will focus exclusively on vitamin A related health problem activities.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administrative/Management

AED assisted the HKI country director and the ROVITA project manager with a proposal to USAID/FVA office for ongoing vitamin A social marketing activities (SOMAVITA Project). HEALTHCOM received one additional year of "bridge" funding.

### Formative Research

With assistance from Dr. John Elder and Dr. Rahardjo (HKI anthropologist), HEALTHCOM conducted a six-month behavioral intervention study targeted towards motivating kader within the posyandu (rural health post) system. Intervention was based upon previous interviews with mothers with small children, health workers, and village kader. All interviews (approximately 60) were one-on-one. In addition, ten observations of kader during normal posyandu sessions were conducted.

### Intervention Activities

- HEALTHCOM developed, pretested, produced, and distributed two diarrheal disease control fliers, the first stressing fluids and diet, the second ORS.

- HEALTHCOM developed and distributed vitamin A deficiency guides for health workers and a second version for kader.
- HEALTHCOM developed two "direct mail" fliers for kader, the first related to vitamin A, the second to diarrheal disease control. Packets of these fliers were sent by mail to each village leader who, in turn, hand carried small numbers of fliers to each kader in the village.
- HEALTHCOM designed and distributed over 100,000 plastic bags with a message for mothers: "Diarrhea? Drink oralyte!" These were distributed through small retailers (free of charge) throughout the project area.
- HEALTHCOM designed, tested, and produced approximately 1,000 cloth banners with the message "Diarrhea? Drink!" These banners were sent to over half the posyandus in the project area.
- The use of the large vitamin A capsule banners continued during the months of February and August, the two capsule distribution months in Central Java.
- A poster with general educational messages about diarrheal disease control was developed and pretested for use in primary schools. (This activity has not yet been finalized, primarily due to inter-ministerial constraints and to shortage of funds.)
- Radio messages for the project's CDD program were developed, resulting in a three-phased strategy: (a) "Diarrhea? Drink!" (b) "Continue eating!" (c) "Take ORS solution." The phases were broadcast separately at three month intervals. The spots were broadcast on five radio stations, ten times a day, seven days a week.
- Radio spots for vitamin A capsules were broadcast for six weeks, mid-January through February, and mid-July through August. Again, the spots were broadcast on five radio stations, ten times a day, seven days a week.
- Three radio spots that were targeted towards increasing mothers' awareness of kader and posyandu were produced and broadcast for two months (April and May). The objective of the spots was to raise the status of kader in their villages with a resulting increase in kader job satisfaction and motivation.

### Monitoring/Evaluation Activities

All radio broadcasts were monitored by two mothers. Each mother had daily forms to complete, which were collected every month. This monitoring system was very low in cost. It revealed an 80-85 percent broadcast rate of contracted spots, which is very high in Indonesia.

All fliers, guides, banners, and radio spots were monitored for their impact. A separate report with those findings is in process.

A post-intervention KAP survey was conducted by Survey Research Indonesia with assistance from the Annenberg School in October (including 800 interviews). Key findings have been incorporated into future SOMAVITA activities planned for next year. One major issue is the insufficient number of posyandus. Low access makes it difficult for mothers to obtain vitamin A capsules. Alternative distribution/access points for vitamin A will be tested during the next year.

### Diffusion Activities

- The HEALTHCOM/USAID Communication for Child Survival manual was translated into Bahasa Indonesia. Six hundred copies were printed and distributed to all health education units throughout Indonesia and to numerous nongovernmental organizations, several universities, and indigenous primary health care institutes.
- The HEALTHCOM resident advisor assisted HKI and USAID/Indonesia with a major five-day social marketing workshop for over 25 NGOs throughout Indonesia. The resident advisor designed the curriculum and led many of the workshop sessions.
- The HEALTHCOM resident advisor designed and conducted a two-day workshop for the 35 regency heads of CDD in Central Java.
- The HEALTHCOM resident advisor, Judy McDivitt, John Elder, and Will Shaw gave presentations and lectures at the University of Diponegoro over the last year.
- The HEALTHCOM resident advisor assisted USAID/Indonesia with the social marketing/communication strategy for the mission's five-year child survival plan (FY 1991-96).
- The HEALTHCOM resident advisor gave a lecture on social marketing to 30 MBA students at the Central Java School of Business Administration.
- The resident advisor and John Elder completed a journal article on the kader behavior study.
- The resident advisor attended a five-day vitamin A conference for over ten African nations in Lusaka, Zambia, sponsored by USAID and HKI and presented "Social Marketing Concepts and Vitamin A Health Education."

### **INSTITUTIONALIZATION ACTIVITIES/PROGRESS**

HEALTHCOM Central Java is not making institutionalization a separate "piece of work" apart from program intervention activities. The institutionalization plan is built into intervention activities. Stress is laid on quality control and proper use by team members of the social marketing management process. The two influencing factors throughout this strategy are the strengths and weaknesses of the ROVITA management team and the limited but replicable budget within which the project is working. The goal is to prove the value of the various HEALTHCOM methodologies with better than

average program results, thereby insuring their continued use once HEALTHCOM technical assistance ends.

ROVITA Project field staff have been involved in the marketing process--planning, marketing research, strategy design, communication materials development, and monitoring--from early project days onward.

Specifically:

- Planning--The ROVITA team members are excellent planners. They have already learned that planning is critical, but that plans must be changed if monitoring results illustrate the need.
- Research--Familiarity with different research activities is solid. All team members now pretest all communication materials. Analysis of data remains only average. Behavioral observation techniques have also been introduced to some team members (via kader study) with some absorption.
- Communication materials development--Strategy development is still a weak link, with creative design seeing only marginal improvement. The steps from materials production onwards, however, are strong with this project team. In the last six months, almost all materials development has been managed by the Indonesian ROVITA team with only minimal technical assistance from HEALTHCOM.
- Monitoring--The ROVITA team has come a long way in this area over the last six months. All communication activities are now regularly monitored with accompanying periodic reports. This is a major step forward from early project times when monitoring was considered a "luxury" that could be dropped if funds or lack of time became issues.

## MAJOR ISSUES AND LESSONS LEARNED

The institutionalization of a project depends upon the complete involvement of field staff. A project structured like ROVITA, in which the members of each participating organization at both the national and provincial levels are involved in the management of field activities, promotes a sense of "ownership." This sense is derived from staff being included in the design, planning, budgeting, implementation and evaluation of the ROVITA Project from the beginning. The approach requires a greater investment of time and effort on the part of project team managers and technical consultants, but the results are well worth this investment.

A strong partnership between the public and private sectors is possible. Following a period of skepticism, experience has demonstrated to the ROVITA team that efficiency can be increased when appropriate work is assigned to the private sector.

### Vitamin A

Recent KAP survey information shows that where a distribution point (i.e., posyandu) exists, a fully integrated communication intervention for vitamin A capsules can increase consumption over one year. Where no posyandu, or a weak posyandu exists, no increase in coverage was noted. Two approaches to this problem are possible.

Increasing the number of posyandus (i.e., strengthening the overall rural health system) could be critical to obtaining higher levels of vitamin A capsule consumption. Additionally, alternative distribution points for vitamin A should be pursued over the next year in the SOMAVITA project.

## ORS

KAP survey results suggest that ROVITA's ORT messages had a positive impact over one year. The messages were geared towards increasing mothers' administration of fluids. After the communication intervention, over 40 percent of mothers reported giving extra fluids to their children during diarrhea.

The potential for commercial ORS distribution has been demonstrated by the project on a pilot level. The ROVITA Project has concluded that this activity is sufficiently complex and time consuming that it will require a separate long-term effort by the MOH, with possible technical assistance from donor organizations.

Complex ORT messages need to be phased or broken down into parts (phase 1: drink; phase 2: drink and eat; phase 3: give ORS). All of this information could not be communicated to the care givers at one time.

## Social Marketing

The use of private sector radio stations required monitoring and supervision. The project assigned two mothers in selected villages to listen to the radio and record the time and station on which the message was broadcast. The use of public radio stations on a no-fee basis was not dependable.

Production of high quality printed materials took longer than originally thought. This was the case with large size banners.

The Central Java Provincial Ministry of Health reproduced and distributed Kader vitamin A and ORT training manuals and broadcast vitamin A radio spots with local government funds. This illustrates the potential for long-term commitment/sustainability of modern health communication and social marketing techniques on the part of the government.

## Kader

The health post kader are key persons for reinforcing health education messages. Generally, kader are tied more strongly to the village heads who choose them than to health department personnel. Recent elections of village heads have meant particularly heavy losses of trained kader; 50 percent of ROVITA-trained kader have been replaced by new ones over the last 12 months.

This is a problem with implications beyond the ROVITA Project, which needs serious attention from the MOH. The project's behavioral motivation study may assist policy makers to plan solutions.

<b>5.     <u>LESOTHO</u></b>	<b><u>Period:</u></b> October 1, 1989 to September 30, 1990
Date of Letter of Agreement:	August 5, 1986
Project Start-up Date:	November 5, 1986
Project Completion Date:	September 30, 1990
Child Survival Activities Focus:	Oral rehydration therapy, immunization, nutrition/breastfeeding, child spacing
Collaborating A.I.D. Projects:	CCCD/Lesotho, Family Health Services (FHI-II), District Management Improvement (MEDEX), Basic and Non-Formal Education Systems Project (BANFES)
Collaborating Donor Agencies:	
USAID	Project funding, support for MOH CDD and EPI programs, health worker training, computer hardware and software and technical services for health information system
UNICEF	Health worker training, vaccines, UCI technical assistance
WHO	Health Education Division staff training
Rotary International and Save the Children Fund (UK)	Polio vaccine
The World Bank	Funding for qualitative research, production of health education materials, staff training
Primary Institution:	Ministry of Health, Health Education Division
Resident Advisor:	Edward F. Douglass
Date of Arrival:	November 1986
Date of Departure:	September 30, 1990
Collaborating Institutions:	
Health Education Division	Base of operations, counterparts, staff, facilities
Ministry of Health Government of Lesotho	Administrative and policy support

Private Health Association of Lesotho	Operates 50 percent of clinics and 60 percent of hospitals in Lesotho; essential role in health education
Lesotho Distance Teaching Center	Research on radio listening and newspaper readership, media availability, qualitative studies of peoples' knowledge and practices with respect to several diseases
National Curriculum Development Center	National curriculum on health, including new teaching modules on a variety of health topics, including the HEALTHCOM topics of ORT and immunization for use in primary and secondary schools
Radio Lesotho	Broadcast of health programs produced by Health Education Division, public service announcements
BANFES (AED)	Cooperative effort to design and produce teaching modules on health which have been introduced into the primary school system

Consultants:

Mark Rasmuson	March 12-30, 1986: Discussed HEALTHCOM involvement with staff of USAID, CCCD, and the Lesotho Ministry of Health; drafted and held preliminary reviews of the project letter of agreement; drafted and reviewed with CCCD and USAID a project budget.
Elayne Clift	January 6-9, 1987: Met with key officials within the Ministry of Health, USAID, CDC, WHO, and UNICEF to discuss launching of HEALTHCOM Project; participated in a major seminar on social marketing for the same audience.
Stan Yoder	March 27-April 7, 1987: Drew up a preliminary plan for the evaluation of HEALTHCOM activities in Lesotho after discussions with officials in the Ministry of Health and USAID.
Stan Yoder	September 28-November 13, 1987: Directed a baseline study of mothers' knowledge and practices with respect to diarrhea, oral rehydration therapy, and immunization; developed and refined questionnaire; selected and trained enumerators and field supervisors; oversaw data collection; and analyzed data.

Judith Graeff	September 21-27, 1988: Met with HED staff who work most closely with HEALTHCOM Project; met MOH and USAID officials; participated in project extension design and budget planning.
Linda Bruce Beth Crane	December 12-23, 1988: Trained HED staff in production of health education materials.
Donald P. Mullally	January 4-13, 1989: Trained HED staff in organizational development and management techniques.
Lisa Ware	March 12-31, 1989: Conducted behavioral research study of the amount of ORS given by mothers.
Ab Gratama	March 14-28, 1989: Trained HED staff in use of computers in graphic design.
Stan Yoder	November 5-12, 1989: Made preliminary plans for the HEALTHCOM Project evaluation.
Deborah Glik	November 26-December 8, 1989: Assisted Health Education Division staff in drafting a communication strategy during a planning workshop for the MOH Acute Respiratory Infection Control Program.
Lisa Ware	January 3-30, 1990: Directed a study of the quantity of ORS a sample of 214 mothers gave to their children in 24 hours following health education and treatment of their children in a clinic.
Judith Graeff	February 4-9, 1990: Discussed project progress with the Chief Health Educator and staff and with the National PHC Director, the EPI and CDD program managers, the technical officer of CCCD, and the A.I.D. Mission; reviewed work plans for the project's fourth year; observed implementation of communication strategies for the CDD and EPI programs; reviewed plans for the project evaluation.
Stan Yoder	February 15-April 6, 1990: Directed a summative evaluation of the HEALTHCOM Project (described below).

## PROJECT SUMMARY

On August 5, 1986, the Ministry of Health agreed with USAID to establish the HEALTHCOM Project under the CCCD Project. HEALTHCOM provided communication support to the existing priority health topics of the Family Health Division, including but not necessarily limited to those of the CCCD Project. HEALTHCOM provided a long-term resident advisor to supply technical assistance, training, and material support for health communication in oral rehydration therapy and diarrheal disease control, immunization, breastfeeding/nutrition, and child spacing. The resident advisor also assisted with the overall development of the Health Education Division. The advisor worked closely with the CCCD Project.

Lesotho is fortunate to be free of many of the tropical diseases of Africa, especially malaria. However, the population is not free from the substantial economic and social problems of the continent which result in poor health.

Lesotho does not produce enough food for its population and malnutrition is evident. A 1975 National Nutrition Survey of children under five indicated that about 23 percent of the children had stunted growth due to chronic protein-calorie malnutrition. A "hungry season" occurs in Lesotho between November and February which coincides with the diarrheal season. Diarrhea can exacerbate the problem of malnutrition in children in two ways. Some mothers believe that withholding food is appropriate when a child has diarrhea. It is also natural for the child with diarrhea to have a suppressed appetite. If diarrhea then leads to reduced food intake, the child becomes more malnourished and more susceptible to diarrhea and other diseases. A downward spiral in health status can set in.

The health education materials about oral rehydration therapy for mothers and health workers developed with HEALTHCOM's assistance not only have provided education and instruction about ORT but also have laid stress on the importance of continued breastfeeding and giving the child solid foods.

Lesotho has among the highest vaccination coverage rates of any sub-Saharan African country. Health education, staff training, cold chain maintenance, and supply of vaccine are carried out well. To increase the coverage rates, however, will require more sophisticated and extensive health education to motivate mothers to bring their children to be vaccinated and to bring them at the right ages and intervals. HEALTHCOM began its work first with the CDD Program because there appeared to be a greater need, but concerted attention has also been given to the immunization program in order to help it achieve higher levels of vaccination coverage against diseases such as measles. The HEALTHCOM/Lesotho Project closed its offices on September 30, 1990.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administrative/Management

During the reporting period the HEALTHCOM Project in Lesotho purchased a computer, printing equipment, and supplies. The software was used partly by the Ministry for on-site data entry and analysis. The resident advisor provided training in use of computers to division staff. In addition, the project conducted the following activities:

- provided training in public speaking skills to division staff;
- supported training of division illustrator;
- transferred responsibility of procuring commodities and technical services from the USAID mission to the Ministry of Health;
- provided technical assistance to researchers working on the topics of oral rehydration therapy, AIDS, and acute respiratory infections;
- assisted the division in the preparation of a long-range health plan;
- completed prescribed project close-down activities;
- participated in policy discussions concerning the adoption of a measles booster and hepatitis B immunizations to be added to immunization schedule.

### **Formative Research**

The project supported a study of the amounts of ORS a sample of mothers give their children. The study also examined why mothers give the amounts they do.

HEALTHCOM also assisted the EPI program in completing a situation analysis in order to identify the health communication priorities.

In addition, the resident advisor provided technical advice to an AED/BANFES study of radio listening habits and of Radio Lesotho's capacity to open a second radio program service dedicated to the promotion of economic and social development.

### **Intervention Activities**

#### **EPI**

HEALTHCOM assisted the EPI program in implementing a communication plan which was developed at CCCD's African Regional Health Education Center training course. The resident advisor advised in policy discussions leading to the adoption of a diphtheria-tetanus booster vaccination at 18 months of age and the adoption of a tetanus-toxoid series for mothers of child-bearing age.

The project participated in the development of several communication activities. The resident advisor assisted the Family Health Division in developing a new health record booklet for children. The booklet featured a more effective vaccination schedule display. The graphics section of the HED also designed a more effective vaccination schedule for mothers; incorporated the design into 1,000 A2 and 5,000 A4 sized posters, as well as the children's health record book.

#### **CDD**

The project incorporated ORS and SSS mixing instructions into new children's health record book referred to above.

Training focused on teaching health educators to conduct evaluations of health education techniques and offer on-the-spot training to clinic and hospital workers.

The resident advisor assisted the division in the development and implementation of a promotion campaign for ORS by a local advertising agency. The ORS was manufactured by the Lesotho Pharmaceutical Corporation and distributed by retail outlets throughout Lesotho. The promotion campaign includes 200,000 copies of a health education pamphlet for mothers with children under five years of age; 5,000 posters for retail stores; 300 copies each of four A2 sized posters for all clinic and hospital waiting rooms; 2,000 copies each of four A4 sized posters for public transport vehicles; 1,000 loose-leaf file folders with educational/technical information for health workers; and 10,000 stationery stickers for general promotion of the campaign.

Lastly, the project assisted the Lesotho Pharmaceutical Corporation in the selection of a semi-automatic packaging machine to package ORS in foil sachets.

### ARI

The resident advisor assisted with Dr. Deborah Glik in the development of the communication component of the Ministry's ARI Control Program.

### Monitoring/Evaluation Activities

Dr. P. Stanley Yoder of the Annenberg School for Communication conducted a summative evaluation of the HEALTHCOM Project in Lesotho. The evaluation findings were compared with a 1987 baseline study. The evaluation included: a national sample survey of 1,200 caretakers of children to estimate the current levels of knowledge and behavior related to diarrhea, oral rehydration therapy, infant feeding, and immunization; a series of community leader interviews about the social services available in their communities; interviews with 100 community health workers to determine their level of knowledge about ORT and their use of SSS and ORS; a collection of 30 narratives from women with young children recently ill with diarrhea; interviews with MOH, NGO, and mission staff for a narrative history of the HEALTHCOM Project; an examination of HED understanding of and ability to use the HEALTHCOM methodology in its regular functioning in order to assess the degree to which the HEALTHCOM methodology has been institutionalized in Lesotho; and monitoring the health programs produced and broadcast over Radio Lesotho by the HED radio producers.

The evaluation also included a study of the visual perception abilities of a sample of Basotho, conducted by Katherine Dusenbury, a graduate student at the Annenberg School for Communication.

Aside from the Annenberg evaluation, HEALTHCOM conducted regular monitoring activities, including:

- conducting 20 field site visits to observe utilization of health education materials developed with project resources;
- advising the CDD program coordinator on the development of two pilot studies to test the efficacy of using community health workers as sales agents for ORS sachets;

- assisting with the development of supervisory checklists for clinic visits to assess both the general management of the CDD program and the quality of health education activity.

### Diffusion Activities

The resident advisor contributed to the following diffusion activities:

- presented a description of the HEALTHCOM Project's role in CDD education and of the relevance of social marketing to the MOH CDD program at Lesotho's Child-to-Child Program;
- gave talks to high school students on careers in health education and social marketing at career guidance days at a local high school;
- recommended the use of a social marketing approach to the Lesotho Planned Parenthood Association in the development of their new research and evaluation department;
- facilitated a training workshop in radio production techniques, creating 25 radio spots for a vaccination campaign in Lubumbashi for the HEALTHCOM Project in Zaire.
- became chairman of the Maseru Rotary Club's PolioPlus Committee.

### INSTITUTIONALIZATION ACTIVITIES/ PROGRESS

A change in top management of the division has resulted in much less interest in the last year in most institutionalization goals. Staff training and the purchase of print production equipment are two areas that continue to be pursued at the HED. Division management showed little interest in such critical areas as organizational development, improved management, and the acquisition of radio production equipment. Without management dedication in these areas, the project has been unable to continue the assistance it had provided earlier in institutional development. Program coordination and output of health education materials--except activities supported by donor technical assistance--have deteriorated significantly.

When absent from the division, the resident advisor could measure the ability of his counterpart and the CDD program coordinator to pursue communication support for the commercial distribution of ORS. The results have been encouraging, indicating increasing ability to carry on project-initiated social marketing activities independently.

With project assistance, the division has been experimenting with the management of the design and production of health education materials by a local advertising agency. These materials otherwise would have been produced by division staff who are currently overloaded. Unfortunately, some division staff feel that they abrogate their responsibilities as health educators by giving their work to an outside organization. However, since this is their first experience managing work outside the division, it is premature to conclude that in the longer run they could not learn to take pride in such activities.

The design and production of camera-ready art work using computers and a laser printer appears to have taken hold in the division. The old techniques are no longer used with the result that more sophisticated, better quality materials can be developed in a shorter length of time. The project provided the computerized equipment and training in its use.

## MAJOR ISSUES AND LESSONS LEARNED

The Project evaluation shows that institutionalization of the HEALTHCOM methodology has taken place to an even greater extent outside the Health Education Division than in it. Ministry technical staff have grasped the essential elements of the methodology. They now wish to use health education as an integral component of their public health programs and have begun to pressure the division to provide this service. This is an important project achievement which indicates that demand for an improved communication method can be generated at the level of health program managers.

The relationship between counterparts and the resident advisor has been an important issue throughout the life of the project. The initial project document requires a counterpart, but the requirement is not specific. Consequently, for the first 18 months of the project, there was a counterpart for division development, but not one for the application of the HEALTHCOM methodology to health education materials, one of the main objectives of the project. Later, two junior staff were assigned part time to learn about and apply social marketing techniques to the promotion of oral rehydration therapy and immunization. The main benefit of these assignments was that there was an excellent opportunity for training the counterparts.

The negative side was that because of their "junior" status, the junior staff members could not make decisions or take full responsibility for project-supported activity. They did not have sufficient authority to recommend action effectively or be given budget responsibility over local funds. In addition, the counterparts have been given other responsibilities without sufficient consideration for the disruptive effect this has had on the implementation of project-supported activities or the training of the counterparts.

In the last year, a senior health educator was assigned as the counterpart. Decision making and proposals to the Chief Health Educator have been easier as a result of the counterpart's senior status. There remains, however, the problem of assigning additional work to the counterpart without consultation or consideration of the deleterious effects on project implementation.

The lack of specificity at the beginning of the project about the choice of counterpart and the relationship with the resident advisor has to some extent limited the effectiveness of the project in reaching its objectives. The lesson from the Lesotho experience is that the counterpart relationship and mutual expectations are very important to project success. They need to be defined clearly in order to create the strongest affiliation possible. The matter should be explored in detail with the host country at the project negotiation stage. The decisions agreed upon should be written into the project agreement.

**6. NIGERIA**

**Period: October 1, 1989 - September 30, 1990**

Project Start-up date:

May 1, 1987

Child Survival Activities Focus:

Immunization (EPI); Diarrheal Disease Control (ORT); Malaria; Birth Spacing.

Collaborating A.I.D. Projects:

CCCD/Nigeria; DMD; PRITECH

Collaborating Donor Agencies

UNICEF, WHO

Primary Institution:

Federal Health Education Division,  
Federal Ministry of Health

Resident Advisor:

Anthony Olu Agboola

Date of Arrival:

May 1, 1987

Collaborating Institutions:

Other Federal Ministry of Health (FMOH) Divisions--Project collaborates with a number of relevant divisions within FMOH: the Divisions of Epidemiology (where the national EPI and ORT programs are situated), Health Planning, and Primary Health Care.

State Ministries of Health--In those states where the project is carrying out intensive communication interventions, the State Ministries of Health (particularly the ORT and EPI programs and the Health Education Division) are the principal collaborating institutions.

Federal Radio Corporation of Nigeria (FRCN)--HEALTHCOM, UNICEF, and FHED are working together with FRCN to plan and produce prototype educational radio programs on child survival which can be disseminated at the national, regional, and state levels.

National Television Authority (NTA)--HEALTHCOM supports current FHED and UNICEF efforts to work with NTA on establishing an effective national program of child survival television programming.

Regional and State Broadcasting Authorities--In those regions and states where the project is conducting intensive communication activities, collaboration with the state television and radio organizations is essential.

Africa Regional Health Education Center (ARHEC)--This institution at the University of Ibadan is working with the School of Public Health from the University of North Carolina under a cooperative agreement with the CCCD Project to provide advanced training in health education planning and management to health educators in those countries where CCCD is working. HEALTHCOM and FHED are cooperating with ARHEC in planning this training program and extending it to Nigerian health educators with whom the project is working.

## Consultants:

Mark Rasmuson Carol Kazi	November 9-21, 1986: Finalized project scope of work and management; began recruitment for local staff.
Mark Rasmuson Carol Kazi Ab Gratama	March 2-18, 1987: Assessed training and equipment needs at FHED; finalized first-year work plan; hired local staff.
Tony Kamson Stanley Yoder Scott Geller Mark Rasmuson	April 28-May 5, 1987: Discussed project with Niger State Ministry of Health Officials and developed plans for behavior study and ethnographic research.
Ab Gratama Nancy Newton	June 7-19, 1987: Conducted materials development workshop; assisted in equipment specification.
Galen Lehman Stanley Yoder Adewale Oke	July 6-18, 1987: Assessed progress of behavior studies and began ethnomedical research work in Niger State.
Mark Rasmuson	August 1-5, 1987: Assisted in developing work plan for first focus state (Niger).
Lena Steckel	September 10-24, 1987: Assisted in the development of EPI training materials (flipchart) and handout for parents in Niger State.
Robert Clay (A.I.D./W)	September 28-30, 1987: Assessed HEALTHCOM progress. Met with senior staff at FMOH. Traveled to Niger State; met with Health Commissioner and Permanent Secretary.
E. Scott Geller Galen Lehman	October 3-11, 1987: Conducted training workshops on EPI health education for 43 health workers in two clinics in Niger State.
Ab Gratama	October 4-14, 1987: Assessed graphics equipment and materials supplied by UNICEF, and trained FHED in using them.
Carol Kazi	October 8-15, 1987: Worked with graphics staff of FHED in use of graphics materials.

Mark Rasmuson	November 2-15, 1987: Reviewed HEALTHCOM progress with CCCD evaluation team.
Danielle Schneider James Benjamin	November 15-24, 1987: Met with National Television Authority (NTA) and Federal Radio Corporation of Nigeria (FRCN) to review their child survival programming to date at national and regional levels. Identified NTA and FRCN technical assistance and training needs.
Stanley Yoder Douglas Ewbank	January 1-16, 1988: Designed instruments for summative evaluation baseline survey in Niger State.
Chris Koepke	January 1-March 3, 1988: Completed collection of baseline survey.
E. Scott Geller Galen Lehman	January 15-24, 1988: Led workshop in Niger State to introduce new EPI educational methodology and flipchart to participants from Niger State and other states in Zone C.
Judith Graeff	January 17-22, 1988: Assisted HEALTHCOM workshop on new approach to health education and EPI flipchart.
Ximena Sheehy Downey	January 17-22, 1988: Reviewed project accounting systems and trained new financial assistant.
Carol Kazi	February 1-2 and 13, 1988: Assisted resident advisor to develop work plan for next six months.
Ab Gratama	February 21-March 2, 1988: Installed computer graphics equipment and trained staff on their use.
Carl Allen	April 11-23, 1988: Designed the selection protocol and led the team which interviewed four prospective advertising agencies.
Mark Rasmuson Clarence Hall	April 25-May 20, 1988: Participated in zonal EPI workshops in Niger State; assisted in planning the Zone C Mass Media Workshop; and assisted with the development of the six-month HEALTHCOM implementation work plan.

Deborah Helitzer-Allen	May 2-21, 1988: Reviewed formative research reports on Niger State and prepared a creative brief. Drafted the advertising agency contract between St. George's Publicity Limited and USAID to provide services to HEALTHCOM.
Carol Kazi	May 4-6, 1988: Participated in advertising agency selection process and provided technical assistance for materials development, planning Zone C Mass Media Workshop, and developing the six-month HEALTHCOM implementation work plan.
Clarence Hall	June 25-July 23, 1988: Facilitated the Health Education and Management and Supervision Workshop in Niger State and participated in the Zone C Mass Media Workshop.
Stan Yoder Annie Voigt	July 1-10, 1988: Presented results of the Niger State baseline survey to health care personnel and participants in the Zone C Mass Media Workshop.
Carol Kazi Ibrahim Biu Abubaker	July 2-23, 1988: Provided technical assistance to a portion of the three-week Zone C Mass Media Workshop.
Clarence Hall	October 2-28, 1988: Supervised development of detailed communication strategy and implementation plan for HEALTHCOM activities in Niger and Bendel States; introduced consultant Chike Anyaegbunam to USAID affairs officer, CCCD project coordinator, FMOH, and other collaborating agencies; drafted a 1989 local budget for HEALTHCOM activities in participating zones.
Clarence Hall	January 16-February 16, 1989: Worked with HEALTHCOM staff and counterparts in conjunction with annual CCCD/Nigeria evaluation; finalized Niger State HEALTHCOM communication strategy; provided technical assistance for other activities.

Thomas Schmid	January 18-February 8, 1989: Designed and implemented a health practice study in Niger State to improve immunization completion rates through changes in clinic procedures and the health education message given on immunization days.
Clarence Hall	April 20-May 19, 1989: Facilitated follow-up workshop on Health Education Management and Supervision in Minna; provided technical assistance and management support.
Beth Crane	June 15-30, 1989: Planned Zone B follow-up Formative Research/IEC workshop. Checked installation of Macintosh software and hardware; trained HEALTHCOM graphics staff in use of equipment and software. Revised pretest and finalized two child survival materials for parents.
Thomas Schmid	June 22-July 10, 1989: Monitored behavioral study at three clinics in Niger State; worked with clinic personnel to design outreach intervention for mothers with children under five.
Clarence Hall Mark Rasmuson	August 6-24, 1989: Consulted with USAID Project Coordinator, FMOH, JHU/PCS, UNICEF, and other interested parties on health communication program, budget, and management issues.
Clarence Hall	October 3-27, 1989: Monitored project activities; finalized the 1989-90 work plan and provided routine administrative support.
Clarence Hall	January 28-March 1, 1990: Assisted with the design and planning of the PHC Health Communication Pilot Project for Rafi and Suleja Local Government Areas.
Clarence Hall	July 22-August 5, 1990: Monitored and provided technical support to the project; finalized the PHC project evaluation plan and participated in the annual ARHEC workshop on Health Education and Malaria.

Connie Carrino

September 16-19, 1990: Reviewed S&T/H/HSD assistance to Nigeria to determine future priorities in consultation with collaborating agencies.

## PROJECT SUMMARY

The health care delivery system in Nigeria prior to 1985 was characterized by:

- an undue emphasis on expensive hospital-based curative services;
- poor preventive health services;
- critical shortages of health care in rural areas;
- poor environmental health services;
- high fertility and rapid population growth;
- lack of a clear national health policy.

Nigeria's 1986-90 National Development Plan has attempted to address these problems. Current national health policy based on the concept of primary health care emphasizes the following:

- acceleration of promotive and preventative health measures that benefit the majority of people in the rural areas, as well as high risk groups such as mothers, children, and the aged;
- improved management, planning, and budgeting;
- an increase in both intergovernmental and nongovernmental cooperation, and community involvement.

In September 1985, HEALTHCOM participated with the original CCCD Nigeria Project assessment and design team. The goal of the CCCD Project is to strengthen Nigeria's institutional capability to decrease morbidity and mortality among children under the age of five. A means of achieving this goal is to help improve the management and technical skills of Nigerian health staff at the local, state, and federal levels. HEALTHCOM was designated as the party responsible for providing technical assistance in health communication and community mobilization. In essence, HEALTHCOM has become the communication component of a large A.I.D.-sponsored child survival program giving particular attention to immunization, diarrheal disease management, malaria control, and birth spacing. In December 1986, the CCCD Project agreement was signed between A.I.D. and the Government of Nigeria.

The HEALTHCOM communication specialists work in close consultation with CCCD and their Ministry of Health counterpart, the federal chief health educator. Both the office and the workrooms of HEALTHCOM/Nigeria are located in the Health Education Division. HEALTHCOM/Nigeria advises the Health Education Division on matters pertaining to educational materials for development and training.

The initial focus of the CCCD Project (including HEALTHCOM) was on strengthening communication capabilities at the Federal Ministry of Health and in a few selected states. In 1988, a shift in strategies took place from a national to a zonal approach and a new emphasis on integrating activities with the National Primary Health Care (PHC) Program. HEALTHCOM was urged to expand communication activities at the zonal and local government area levels and initiated a series of zonal communication training workshops in Zone B.

The Niger State PHC intervention described below was designed to comply with another shift in strategy in 1989, when USAID/Lagos directed the project to discontinue its activities in Zone B, and select two LGAs in Niger State in which to conduct communication interventions in support of primary health care.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administrative/Management

In accordance with the USAID directives to promote PHC in two local government areas (LGAs) of Niger State, HEALTHCOM consulted with the State Ministry. Two LGAs (Rafi and Suleja) were selected for PHC intervention. The two sites were chosen in part because of their differences: while Rafi is a rural area with a model PHC system, Suleja is an urban area with a normal PHC system.

Project preparation activities in these two LGAs had reached an advanced stage but had to be suspended at the end of September 1990, as funding committed by USAID/Lagos failed to materialize. Negotiations are underway among the USAID mission, S&T/Health, and HEALTHCOM for a funding package which will enable the project to implement the LGA/PHC intervention, finance an external assessment of HEALTHCOM I, and expand activities under HEALTHCOM II.

### Formative Research

The African Regional Health Education Centre (ARHEC) was awarded a contract to conduct KAP baseline studies in the two LGAs. ARHEC was assisted in its research by HEALTHCOM and the respective LGA staff. A preliminary report was submitted. The research studies conducted by the five states of Zone B were completed, and reports were submitted to CCCD.

The HEALTHCOM team conducted a careful study of the draft report of the baseline survey by ARHEC. Consultations were also made with authorities of both Niger State Ministry of Health and the two local governments of Rafi and Suleja. The following priorities were identified by each group:

HC/ARHEC	Niger State MOH	Rafi	Suleja
water supply	EPI	malaria	malaria
malaria	family planning	diarrhea	diarrhea
diarrhea	guinea worm	measles	measles
measles	malaria	skin diseases	malnutrition
guinea worm	school health	malnutrition	guinea worm
school health		school health	school health

The following were designated as shared priorities:

- malaria
- diarrhea
- measles
- school health
- guinea worm
- skin diseases
- malnutrition.

### Intervention Activities

Three PHC interventions were selected based on the results of the baseline report and the priorities of the Ministry of Health and local governments: measles; malaria; school health.

An educational campaign was designed to use radio broadcasts and community channels to increase measles vaccination coverage and prescriptive treatment of malaria with chloroquine. One of the community channels selected was school children.

Five primary schools in each of the two LGAs were selected to participate in the campaign and to conduct a broader health education component, including sanitation and personal hygiene, among their students.

The program has been a collaborative effort between UNICEF and HEALTHCOM. UNICEF provided plastic pots with taps, plastic wash-hand bowls and cups for the selected schools, while HEALTHCOM was responsible for training and production of training materials.

#### **Print Distribution and Radio Broadcasts**

During the reporting period the interventions were supported with numerous print and radio activities.

- HEALTHCOM produced Health Education Manuals for primary school teachers involved in the school health program.
- Modifications were completed on EPI and ORT educational materials. Twenty-two training pamphlets for health workers were designed and printed by the HEALTHCOM material development unit and distributed by the Federal Health Education Unit.
- HEALTHCOM helped to design and produce the child survival PHC pamphlets. The Federal Health Education Unit distributed the pamphlets.
- Radio jingles and programs awarded to St. Georges Advertising Agency were completed and broadcast on Radio Niger, Minna.

- The crown posters urging mothers to get their children immunized were produced in the three major languages. They were distributed by the State Health Education Unit.
- Billboards displaying the same EPI message in the three main languages were also completed by St. Georges Advertising Company. Two billboards have been erected in each of the ten LGAs in Niger State.

### **Training**

Training workshops to improve interpersonal communication skills were conducted in collaboration with the Niger State Ministry of Health for the following health workers:

- Eighty vaccinators and screeners;
- Forty-eight clinic health educators and health education assistants;
- Sixty NGO/VVHW/TBA;
- Twenty clinic supervisors;
- Sixty school teachers.

### **Diffusion Activities**

HEALTHCOM attended and presented papers at the Health Education Planning and Management Workshop on malaria control organized by ARHEC and CCCD.

### **INSTITUTIONALIZATION ACTIVITIES/PROGRESS**

- HEALTHCOM helped establish materials development units in both Federal and Niger State health education divisions. Graphic arts specialists trained by HEALTHCOM in health communication methods staffed the government-supported units.
- HEALTHCOM assisted in the development of a recording studio for the Federal Health Education division and video unit for the Niger State division.
- HEALTHCOM trained zonal health educators and clinic health supervisors as trainers for the future health programs.
- HEALTHCOM sponsored a joint training of health and media personnel in more effective health program production and encouraged a joint planning process.
- HEALTHCOM sponsored a workshop on formative research for members of the Nigeria health divisions taught by a HEALTHCOM consultant and Nigerian media, health, and university personnel.

- HEALTHCOM effected the establishment of local committees and clubs to run the affairs of health programs in Niger State. Such groups have included:
  - Health and community mobilization committee;
  - Health communication technical committee, made up of media and health personnel;
  - School health education committee;
  - School health clubs, comprised of selected pupils in grades 4 to 6, to encourage and promote child-to-child health activities in both the school and the community.
- HEALTHCOM assisted ARHEC to plan the fourth annual Health Education Management Workshop, which focused on malaria control. Two LGA representatives and HEALTHCOM made a joint presentation to the workshop participants on the Niger State experience in malaria control.
- HEALTHCOM involved both the local government and state personnel in the development of the LGA programs, from the needs assessment stage to program planning, implementation, and evaluation.
- HEALTHCOM transferred program management to state and local government authorities. For example, the Niger State Ministry of Health organized and supervised the annual training and planning for health education management in 1989, and the Local Government of Niger State planned the school health education program in August, 1990.
- HEALTHCOM helped create a budget for the FHED of FMOH for 1989.

## MAJOR ISSUES AND LESSONS LEARNED

### USAID

The sudden change of focus to primary health care in the two LGAs Rafi and Suleja, as directed by USAID, caused some problems. Most importantly, Nigerian MOH and media staff in the Zone B states where HEALTHCOM had begun working were disappointed at the lack of follow-through. On a positive note, it has given the project an opportunity to help the new federal government drive to make primary health care a local government affair. The people in the local government areas are very interested in their health program; working with concerned people is very beneficial, as they are cooperative and, with encouragement, take initiative in the program.

### FMOH

Securing a permanent counterpart was very difficult. Hence, HEALTHCOM relied more on the state and LGA counterparts, and both relationships were very successful.

HEALTHCOM's funding of federal counterparts' travels when on a project assignment should be reconsidered.

### Niger State MOH

The HEALTHCOM/Nigeria Project was fortunate that the State Commissioner and Director General for the Ministry of Health were health professionals. The officers were able to understand quickly the project's goals and the problems encountered in trying to achieve the goals. Because of the officers' related backgrounds as health personnel, HEALTHCOM had their full support and thus the support of the ministries at the state and LGA levels.

### Expansion Program—Zone B

The training of members of local health organizations in formative research studies demonstrated to the government of Nigeria and USAID that such tasks can be carried out by local personnel. However, the people trained in the five states have not followed up on the studies adequately. Some potential problems arising from this are:

- loss of enthusiasm for the project by those involved who expected to utilize the research results for further planning;
- loss of financial resources used for research and media equipment purchased for follow-up activities.

### Advertising Agency

St. George's Advertising Agency has not complied easily with HEALTHCOM's requests. Education materials were often delivered late. It would have been more effective and less expensive to have utilized the skills of the HEALTHCOM graphic and materials specialists, the resident advisor, and selected media personnel for production.

<b>7. <u>PAPUA NEW GUINEA</u></b>	<b><u>Period: June 22, 1988 - September 30, 1990</u></b>
Date of Letter of Agreement:	December 14, 1987
Project Start-up Date:	June 22, 1988
Project Close-down Date:	June 12, 1990
Child Survival Activities Focus:	Diarrheal disease control, nutrition, Expanded Program of Immunization (EPI)
Collaborating A.I.D. Projects:	
Radio Science	Technical assistance for broadcast materials
Collaborating Donor Agencies:	Asian Development Bank, WHO, UNICEF
Primary Institutions:	National Department of Health, the Provincial Health Office of the Central Province and the Health Office of the National Capital District
Collaborating Institutions:	
National Training Support Unit (NTSU)	Department within the National DOH responsible for production of print materials
First MarketSearch	Consumer research on CDD, nutrition, and measles
The Institute of Medical Research (IMR)	Technical assistance in medical anthropology
First Take Productions	Production of communication skills video
Resident Advisor:	Andrew B. Piller
Date of Arrival:	June 22, 1988
Consultants:	
Mary Debus	August 8-16, 1988: Assisted with development and design of communication strategy and implementation plan.
John Elder	January 16-29, 1989: Assisted with development and design of behavioral formative research and communication component study.

Cecilia Verzosa	May 21-27, 1989: Supervised ongoing communication and health education activities.
John Elder	June 18-26, 1989: Helped in the design of behavioral research models and the development of communication strategies.
Carol Jenkins	March 3-17, 1990: Monitored Madang Province Nutrition Project.
Susan Zimicki	May 22-June 4, 1990: Conducted a case study and summative evaluation of the HEALTHCOM Project in PNG.

## PROJECT SUMMARY

HEALTHCOM began its work in Papua New Guinea with the intention of introducing a systematic communication program that would strengthen PNG's health education system.

During the two year program, HEALTHCOM assisted the DOH in the planning, development, and evaluation of an interpersonal communications skills training component for health workers in Central Province and National Capital District (NCD). Aspects of this training were institutionalized nationwide. During the second year of the project, HEALTHCOM contracted with the Institute of Medical Research (IMR) to conduct a nutrition research/intervention project in two communities in Simbai District of Madang Province.

HEALTHCOM worked with local counterparts to demonstrate the efficacy of a systematic approach to public communication and education about preventive and treatment practices. Transferring this expertise to the health education staff helped prepare them to apply HEALTHCOM methodology to other health issues.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administration/Management

The HEALTHCOM staff prepared an implementation plan for 1988-1990. The plan presented the key communication strategies for the Control of Diarrheal Disease Program (CDD) and for the Expanded Program of Immunization (EPI) activities in Central Province and NCD.

### Formative Research

HEALTHCOM staff prepared and conducted a knowledge, attitude, and practice (KAP) survey in Central Province and NCD in order to develop appropriate communication strategies. The survey was conducted by a private company called MarketSearch and included 500 interviews (250 from five locations in Central Province and 250 from NCD). The survey also incorporated six focus group discussions--three in Central Province and three in NCD.

The survey indicated that mothers may not seek medical help when diarrhea is in its early stages because they do not consider it to be serious. However, when mothers do seek advice, health workers are their leading source of treatment and information. The research also indicated that there is widespread belief in spiritual causes of diarrhea, as well as for other diseases. Mothers were more willing to discuss these beliefs during focus groups than in one-on-one interviews.

Unfortunately, MarketSearch contracted with a local data processing company that went bankrupt before a complete analysis of the data was completed. During their close down the company destroyed the original questionnaires and the data on the computer. As a result, MarketSearch was able to provide only raw percentage data. As compensation, Chris Wiley, the director of MarketSearch, made his services available to HEALTHCOM on an informal but regular basis.

HEALTHCOM also designed a formative behavioral study of health workers and mothers. The research design included an evaluation of the workshops for health workers in each district from March through July. Pre- and post-workshop data were collected on a monthly basis. In four to five villages of each district in Central Province and NCD mothers and village health workers were interviewed. Mr. Rodney Wakei from the College of Allied Health Sciences worked with the resident advisor on supervising this activity.

## Intervention Activities

### CDD

HEALTHCOM produced a 15-minute video, "Making Things Clear." The object of the video was to teach interpersonal communication skills to health workers. It was shown at the district level workshops mentioned above. Mr. Megea Kivali from the DOH Health Education Unit assisted with this activity. "Making Things Clear" has been produced in English and Pidgin. Both versions underwent modifications based on recommendations from health workers in both provinces and from DOH and WHO officers. As of June 1990, over 60 copies had been distributed nationwide with brief user guidelines. Copies were also sent to WHO offices in Manila and Geneva.

A "mother's card" was developed in conjunction with the DOH and WHO to show mothers how to treat diarrhea at home. The original design of this card was based on an example found in the PRITECH manual, "Talking With Mothers About Diarrhea--A Workshop for Physicians." Pretesting led to the development of a less wordy version with more drawings. The size of the leaflet was increased slightly to match a series of leaflets being developed by the DOH. One hundred thousand leaflets were printed in three languages: 50,000 Pidgin, 40,000 English, and 10,000 Motu. Printing was carried out by NTSU and paid for by UNICEF. Shipping costs were also paid by UNICEF.

HEALTHCOM provided technical assistance in labeling and distribution to North Solomon Pharmacies. This is a private pharmaceutical company that expressed interest in producing ORS packets locally. Various factors such as financial and political complications slowed activities. As of June 1990, production had not begun.

Prior to the closing of HEALTHCOM in June 1990, work was begun on the development of a diarrhea poster. Up to that time, nothing had been produced locally. These posters would be for general distribution but are particularly needed for diarrhea treatment units being developed in a number of hospitals and health centers with funding from WHO.

Initial research to develop these posters led to the decision to use drawings instead of photographs. Drawings were found to be as easily interpreted as photos and less expensive to produce. Two posters were ready for distribution in August 1990. These posters are basically enlargements from the Treatment and Prevention of Diarrhea leaflets. There are tentative plans to develop a Dangers of Diarrhea poster.

## EPI

In response to a highly publicized outbreak of typhoid in early 1990, HEALTHCOM was asked to coordinate efforts to develop a quick mass media campaign about typhoid prevention and treatment. The pressure to create materials quickly prevented a more thorough development process, but poster and radio messages were produced. In addition, the first Public Service Announcement (PSA) produced by EM-TV dealt with typhoid. As of June 1990, the announcement was being broadcast one to two times daily. Although there were plans to produce a series of PSAs, EM-TV experienced financial difficulties and asked to postpone production until the second half of 1990. Costs for the production of these PSAs were completely covered by EM-TV.

## Nutrition

HEALTHCOM proposed and initiated a nutrition research and intervention project in Madang Province. The project involved two components. The first was to compare and test the use of arm circumference measurements for screening malnourished children, instead of the currently used measurement of weight for age. The second component was to develop a "buddy" system of support for mothers of malnourished children. Female relatives or other women in the community encouraged these mothers to feed their children more frequently and with a mixed diet of locally available foods. Preliminary results indicated that the use of the MUAC (measurement of upper arm circumference) tape to detect malnutrition was feasible in PNG.

## Monitoring/Evaluation Activities

HEALTHCOM attempted to monitor behavioral change of health workers and mothers resulting from the series of district level workshops on diarrheal disease (with a communication skills component). However, the study was unable to monitor these changes effectively for a number of reasons, including:

- cancelled or postponed workshops in two districts;
- a malaria infection that caused the resident advisor to miss one workshop;
- the fact that most mothers reported their children did not have diarrhea during the observation period and so did not visit the aid post for treatment. Thus, the health workers did not have an opportunity to demonstrate newly acquired skills. This study was modified in an attempt to demonstrate the effectiveness of the communication training video, "Making Things Clear."

To ascertain the effectiveness of the "Making Things Clear" video, a study was designed to observe health workers' interpersonal communication skills before and after they had watched the video. A small study contrasted the behaviors of 14 health workers who had received the communication skills training and had seen the video, with the

behaviors of 28 health workers who had not. Results indicated that even three months after training, health workers who viewed the video were more likely to conduct a more thorough assessment of the child and to ask the mother more questions than healthworkers who had not seen the video.

### Diffusion Activities

HEALTHCOM contributed to a WHO CDD Training of Trainers Workshop held from February 26-March 2, 1990, in Port Moresby, NCD. Thirty-five participants attended from throughout the country. HEALTHCOM was responsible for, among other things, presenting an overview of the social marketing approach and an introduction to focus group research methodology. Additionally, HEALTHCOM incorporated an interpersonal communication skills training component into the workshop. This included a brief introduction, a showing of the video "Making Things Clear," a follow-up discussion, some role-playing, and a short concluding discussion.

### INSTITUTIONALIZATION ACTIVITIES/PROGRESS

Institutionalization of the HEALTHCOM methodology has been a slow process in Papua New Guinea. During the two years of the HEALTHCOM Project, various officers and staff from the DOH had opportunities to learn about the HEALTHCOM methodology. However, DOH officials took a passively accepting approach to HEALTHCOM work. Still, HEALTHCOM activities were much appreciated. In particular, the interpersonal communication skills training within the DOH was recognized as a valuable component of HEALTHCOM activities.

Officials of the DOH were dismayed to learn that the HEALTHCOM Project was not going to be extended beyond its initially slated two years. Given more time (perhaps two to three years), it is reasonable to say that a more formalized, concrete institutionalization process would have taken place.

### MAJOR ISSUES AND LESSONS LEARNED

A number of constraints exist within PNG generally, and within the Central Province in particular, which complicated the challenge to implement the HEALTHCOM program. Among these are the following.

- **Decentralization:** In 1983, all health activities were decentralized to the provincial level. Management has been in a transitional state and management voids exist. The lack of qualified national personnel has opened the doors in all levels of public and private institutions to a large expatriate population.
- **Health Education:** The position of Provincial Health Educator has been completely phased out as a result of budget cuts beginning in 1985. When this occurred, health education duties were, in part, taken over by the Maternal and Child Health (MCH) Sisters. In late 1988, additional government funds to increase health education activities were authorized. Funding was cut back again in mid-1989, as part of a nationwide government budget reduction.

- **Transportation:** Additional budget cuts since 1985 affected the transportation system, with the result that almost all community outreach patrols by MCH Sisters were suspended for over one year.
- **CDD Management:** The PNG public health structure was established as a general system with no specific program for CDD. Hence, there has been no single person responsible for the program. The National Committee on CDD only met sporadically. There were a few meetings in 1989 to rewrite the national CDD policy. Without one person assigned to a leadership role, efforts at health education are diffuse and less effective.
- **Politics:** The political situation in Central Province, the initial project site for HEALTHCOM, was unstable. Consequently, policy planning was erratic. At the national level the closure of the Bougainville Copper Mine and associated unrest in North Solomons Province resulted in severe financial cutbacks for all government activities.
- **Institutions:** Many of the A.I.D. posts and sub-health centers in the Central Province were unstaffed, weakening a major link in the infrastructure.

Two years are not enough for an innovative program like HEALTHCOM to have much impact in a new project site. This is especially true when the program is small-scale with limited support from outside.

**8. PARAGUAY**

**Period: April 15, 1987 - September 30, 1990**

Date of Letter of Agreement:

October 21, 1986

Date of Project Start-up:

April 15, 1987

Date of Project Close-down:

July 31, 1990

Child Survival Activities Focus:

ORT, breastfeeding

Collaborating A.I.D. Projects:

PRITECH, SUPPORT

Collaborating Donor Agencies:

PAHO, UNICEF

Primary Institution:

Ministry of Health and Social Welfare

Collaborating Institutions:

Biederman Publicity Agency

Instituto de Comunicación y Arte

National School of Medicine

Liga Paraguaya de la Mujer

Local Radio Stations

Coca Cola

Resident Advisor:

José Maria Espinola

Date of Arrival:

April 15, 1987

Consultants:

Judy Brace

June 1986: Identified potential child survival communication activities.

Diane Urban and  
Mario Bravo

October 5-24, 1986: Made presentations about HEALTHCOM at three conferences in conjunction with an internationally renowned physician and nurse; developed a phased plan, budget and time frame for implementing child survival activities sponsored by HEALTHCOM and PRITECH in FY 1987.

Diane Urban

May 26-June 13, 1987: Formed a task force to review ad agency presentations and selected Biederman ad agency; began contract negotiations; spoke at a

	conference; reviewed ORS package design; visited research agency, assessed progress on physician study, and contracted with them to analyze results; held press conferences.
José Romero	November 1-15, 1987: Signed contract with ad agency; collaborated in writing the communication plan; assisted MOH personnel in publicity for educational project.
Diane Urban and Eduardo Contreras	February 18-March 1, 1988: Redesigned communication plan based on monitoring activities; designed the final evaluation plan of the program; monitored local production of ORS; prepared programs for future seminars.
Barbara Cook	April 1988: Set up campaign for marketing locally-produced ORS.
Diane Urban	November 1988: Spoke at two regional seminars on MOH breastfeeding campaign; debriefed with USAID representative in Uruguay.
Dennis Foote	March 6-16, 1989: Assessed HEALTHCOM ORT project activities as part of the HEALTHCOM evaluation.
Linda Bruce	April 19-23, 1989: Held creative workshop for development of educational and promotional materials for Ministry of Health staff.
Dr. José Francisco Zambroni	May 26-June 9, 1990: Researched breastfeeding practices in six maternity hospitals; lead a multi-sectoral workshop to define national norms and plan; drafted training manual.
Dr. Lisa Weld	June 24-June 30, 1989: Presented workshop on monitoring and supervision as applied to communication component of the national breastfeeding plan for MOH staff.
Linda Bruce	July 2-6, 1990: Conducted a materials development workshop to assist regional MOH staff to develop breastfeeding materials.

Diane Urban

July 23-August 3, 1990: Conducted a three-day workshop on interpersonal communication skills for MOH staff working on the breastfeeding project; made end of project visits to the Minister of Health, other MOH department heads, and USAID representatives; helped close office.

## PROJECT SUMMARY

The objective of Paraguay's national health policy is to reach the goal of "Health For All by the Year 2000," as stated by the World Health Organization. Since diarrhea is currently the principal health problem of children under five years of age in Paraguay, HEALTHCOM began its work there with the intention of introducing a systematic communication program to assist the Ministry of Health in reaching health workers and the public with well-designed messages about the control of diarrheal disease. Breastfeeding became the focus for the second campaign. Breastfeeding was identified as a major preventative measure that was not promoted adequately by the medical establishment and not practiced by urban mothers. National multidisciplinary task forces were created to guide program implementation for both interventions.

During the three-and-a-half-year program, HEALTHCOM assisted the Ministry of Health in the planning, development, monitoring, and evaluation of the interpersonal and mass media components of the national CDD and breastfeeding campaigns. Research included focus groups and a physicians' KAP survey for communication planning and message design. HEALTHCOM trained community leaders and health workers in content and communication skills. HEALTHCOM and its counterparts helped create and equip nine oral rehydration units (UROs) in regional health centers and at the National Medical School Hospital. Six TV spots, ten radio spots, and numerous posters, pamphlets, calendars, decals, and T-shirts were prepared for the two campaigns.

Training played an important role in the institutionalization process. HEALTHCOM trained the MOH staff in communication methodology, materials development, developing national plans and norms, monitoring, and interpersonal communication. MOH staff in turn gave presentations at three international health education congresses, amongst others, and applied the HEALTHCOM methodology to national EPI and AIDS programs.

The Health Education Department was reorganized after the new government was formed in 1989. Both MOH personnel and office space increased considerably.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administration/Management

As part of the close-down process, HEALTHCOM helped prepare an ORT program implementation plan and a national breastfeeding plan and norms. Task forces were formed for the national ORT and breastfeeding initiatives in order to coordinate the numerous tasks to be carried out by the MCH and Health Education Departments.

## Formative Research

### ORT

Five focus groups were conducted in 1987 with mothers of children under five in the Jopara language, which mixes Spanish and Guarani. Researchers learned the colloquial terminology for diarrheal diseases and determined which dialect to use for health messages. Mothers recognized five types of diarrhea. Rural mothers treated early diarrhea with teas and soups and sought advice from their mothers or herbalists. Mothers showed a tendency to withhold food. Distance from clinics and fear of physicians kept them from seeking medical help even when symptoms persisted. Neither dehydration nor ORS was a familiar concept to mothers.

Fifty physicians were interviewed about their knowledge, attitudes, and practices related to ORT. Seventy-five percent thought that ORS should be used as preventative medicine. Physicians in general felt that children do not reject the taste of ORS; that it is good to give teas, soups, and other liquids to children with diarrhea; and that mothers can be taught to mix ORS. Physicians also felt that mothers should continue to breastfeed during a diarrheal episode.

### Breastfeeding

Twelve focus groups were held with urban and periurban women to develop messages for breastfeeding materials. Several differences in practices were noted between the groups.

- Urban women were more likely to work and therefore introduce breast milk substitutes and other supplementary foods within two weeks after birth. These women claimed that they did not have enough milk to satisfy their infants and, upon seeking advice from their pediatricians, were encouraged to give formula. Some mothers had breast infections and were advised to discontinue breastfeeding because of the antibiotics they were given. By two months, the majority of urban women had weaned their infants. These women had not received prenatal information on breastfeeding and appeared eager to learn more about the topic. The mothers also equated their quantity of breast milk with the kinds of foods they ate during lactation. When interviewed about infant diarrhea, all of the mothers knew the importance of breastfeeding and oral rehydration therapy.
- Periurban women were inclined to breastfeed their infants for six to nine months, although they also introduced supplementary foods at two to three months of age. The main reasons for weaning the babies were insufficient milk supply and the belief that the baby no longer needed breast milk. Periurban mothers felt that eating certain foods would increase milk supply as well.

In 1990, five more focus group discussions held with 46 periurban women produced similar findings with regard to supplementation of breast milk with other foods and liquids, early discontinuance of breastfeeding, beliefs about the lack of importance of colostrum, about the deleterious effect of antibiotics, and about the role of food such as coconut and corn, rather than suckling to increase milk supply. Based on the focus group discussions, messages stressing the importance of breastfeeding frequently to increase milk supply were developed for a skit, for audio cassettes, and for four illustrations.

All of the mothers interviewed desired more information on breastfeeding. When asked what kinds of materials they would like, the mothers indicated a preference for brochures or booklets that were easy to read. Most of the women had at least a sixth-grade education and mentioned that they would also like to see articles on breastfeeding in the women's section of the daily newspapers. However, most preferred informative talks (personal communication) to print materials.

Materials for ORT and breastfeeding were pretested routinely as part of the development process.

### Intervention Activities

#### ORT

ORT materials were produced for the primary audience, caretakers of children under five, and the secondary audience, health care workers and community leaders. Several types of educational strategies were designed with consistent messages, themes, and activities.

**UROs and Health Institution Strategy:** Technical education personnel at UROs who had been trained in face-to-face communication skills provided information to caretakers of sick children. Educational activities included an introduction to the URO; mixing demonstrations; hands-on practice sessions; instruction in the concept of dehydration; recognition of the signs of dehydration; and ways of controlling and preventing diarrheal disease. Mothers who brought their children to health centers for ORS were given certificates.

**Mass Media Strategy:** Using research findings, the HED, the HEALTHCOM Project, cooperating advertising agencies, and technical health personnel worked together to prepare mass media messages for radio and television audiences. Four TV spots and eight radio spots were created in both Spanish and Guarani. Print materials in the form of news releases, flyers, brochures, posters, comic books, and decals were designed and distributed. Other local mass media techniques included the use of megaphones and loudspeakers--traditional means of communicating within communities.

**Ongoing Training of Health Workers and Community Leaders:** The Maternal/Child Health Department of the HED prepared educational sessions for the ongoing training of public health workers, including community leaders. The project began with a four-day regional training seminar for representatives from the nine initial health care center sites, the MCH Department and the HED, the Chairman of Pediatrics of the School of Medicine, and representatives of the private sector--research and advertising agencies and a local pharmaceutical company. The seminar covered public health policies in Paraguay, the social communication process, development of a communication plan, and implementation of the plan.

Seminar attendees were instructed to return to their respective communities and continue the training process among health workers, community leaders, and other community members. HEALTHCOM helped to implement a supervisory function into this "trickle-down" training process. HED staff made frequent visits to regional sites, ensuring adequate oversight from the central office of the HED. HEALTHCOM has encouraged institutionalization in this way.

HEALTHCOM sponsored a special training workshop for community leaders about the value and process of ORT; leaders were also taught how to teach ORS mixing skills to mothers and other community members.

### **Breastfeeding**

Breastfeeding materials were produced for the same primary and secondary audiences as for ORT. The following four program strategies reinforced one another.

**Health Institution Strategy:** Six maternity hospitals were visited to assess hospital breastfeeding policies and practices. Information was used to develop national norms and a national breastfeeding plan written by representatives of six departments in the Ministry of Health, the Medical School, the Pediatric Society, and the Red Cross. A task force has met regularly to coordinate activities. An illustrated manual of the norms was created. A flipchart and posters were designed for use in the clinic talks.

**Community-level Strategy:** The project held seminars in factories, department stores, and other places where women work to discuss breastfeeding information and practices.

**Mass Media Strategy:** HEALTHCOM, the HED, the ad agencies, and other cooperating organizations developed two broadcast ideas based on focus group results. These were disseminated over two TV channels and ten radio stations. In addition, a poster, a pamphlet, decal, and flipchart were prepared for the breastfeeding campaign.

**Ongoing Training of Health Workers:** Training activities consisted of the following:

- A PATH consultant conducted a three-day workshop in April 1989 to develop educational and promotional materials for the breastfeeding program. Participants included 20 Ministry of Health staff members, three advertising agency staff members, and one social marketing research agency staff member.
- Ministry of Health staff conducted three one-day seminars for 90 physicians and nurses and another seminar for 70 health workers and community leaders in four different cities in August and September 1989.
- A PATH consultant directed a workshop for 50 participants from different social sectors to define national breastfeeding norms and design a breastfeeding plan. A training manual generated from this workshop was drafted in May and June of 1990.
- A PATH consultant conducted a materials development workshop to assist regional Ministry of Health staff in developing breastfeeding materials in July 1990.
- The HEALTHCOM staff and HEALTHCOM counterparts conducted a three-day training workshop in July 1990 on interpersonal communication for trainers of regional workers.

## Monitoring and Evaluation Activities

The project and the HED drafted an implementation plan before beginning ORT program activities. HEALTHCOM and counterparts conducted periodic visits to regional health centers to monitor progress toward goals. Monthly programmatic and financial reports also documented project activities.

Harvard Institute for International Development staff held a workshop to apply monitoring, evaluation, and supervision principles to the breastfeeding project. The seminar included professionals from many different departments. The trainers and participants together developed sample project plans, flow charts, and checklists. Further training would help the Ministry of Health integrate the planning, monitoring, and evaluation processes.

In February 1989, a HEALTHCOM consultant advised that qualitative end-of-project interviews be conducted to evaluate the impact of the HEALTHCOM Project. He suggested that data be gathered from oral rehydration units. A local research company also prepared a list of topics for investigation and proposed various ways to obtain the data. This information was shared with the Annenberg School for Communication, which designed the final research plan for personnel involved in ORT programs in Asunción and four other cities.

## Diffusion Activities

- HEALTHCOM made a presentation on ORT to 50 mothers for the Wives of Rotarians in Concepción.
- The HEALTHCOM resident advisor and his counterparts from the Health Education Department and the Maternal/Child Health Department presented the HEALTHCOM ORT campaign at the HEALTHCOM Latin America Regional Workshop in January 1989.
- Eight representatives of the Health Education Department traveled to Rio to speak about HEALTHCOM methodology and the success of the breastfeeding program at the International Health Education Congress in July 1990.

## **INSTITUTIONALIZATION ACTIVITIES/PROGRESS**

One of the goals of the institutionalization plan was to involve key Ministry of Health decision makers--from the top levels in central offices to village-level health providers. In the planning and materials development stages and throughout implementation of the project, the HEALTHCOM resident advisor included key MOH and community leaders in decision making. They also participated in public relations events such as the donation of cribs and other equipment to UROs. USAID officials were also included to encourage communication among agencies and to acknowledge their support.

The Health Education Department expanded in 1989 when a new government was installed in Paraguay. Newly organized HED units, such as Research, Training, and Materials Production, reflect the steps in the HEALTHCOM health communication process. This was considered a sign that the MOH had adopted and would continue to utilize the HEALTHCOM methodology.

Tiered training activities involved the training of central-level health educators who in turn introduced the HEALTHCOM methodology to Paraguayan health educators during a week-long in-service training program. Shortly thereafter, participants trained community leaders from the nine URO areas so they could train their peers in other communities. To complete the cycle, central-level health educators supervised and monitored activities of the health workers they had trained. The Paraguayan training program has been highly integrated and has proved successful in institutionalizing a communication methodology.

One of the most successful ways of ensuring that ORT service would be provided continuously in the future was a training and supervising program conducted by renowned professors and leaders in the Paraguayan Pediatric Association for medical students and nurses serving as interns in teaching hospital UROs. The prestige of the program was highlighted by inviting internationally prominent physicians, nurses, and HEALTHCOM staff to address faculty, students, and private sector physicians at a three-day conference in Asunción. Spin-offs included one-day conferences for student nurses and physicians. The Medical School curriculum has been expanded to include ORT.

HEALTHCOM engaged various private sector firms to teach aspects of the HEALTHCOM methodology. The staff members of the local advertising agency were especially involved. They supported the program by contributing a speaker to training workshops; by frequently attending meetings at the Ministry of Health; and by organizing a workshop at the advertising agency to teach the Ministry staff how to plan media campaigns and produce materials. These activities have resulted in attractive materials with content which is consistent with MOH and WHO standards. Furthermore, the ad agency produced a documentary about the ORT program which has been shown internationally. They participated in writing a model contract with AED--the first such contract ever signed in Paraguay by an advertising agency.

Other efforts to extend the methodology to the private sector have included working with a Paraguayan pharmaceutical company that had a contract with Project SUPPORT to produce, package, and promote ORS. The package design and drawings were pretested, and the content was made consistent with Ministry norms. Arrangements were made to use the Ministry of Health logo for ORT and MOH pamphlets for point-of-purchase distribution. Pricing suggestions were offered to make ORS affordable for those most in need.

In the public sector, links with secondary schools were initiated. Students were taught to mix ORS and to teach the method to their families.

## **MAJOR ISSUES AND LESSONS LEARNED**

HEALTHCOM experienced some constraints, including:

- lack of hard survey data on which to base programs;
- limited funding, which affected the scope and quantity of HEALTHCOM activities in Paraguay;
- a change in government, which caused delays due to reorganization and staff changes.

Further training would be useful in the area of management skills, monitoring, evaluation, materials development and interpersonal communication.

A low-budget project can have the most impact if it is conducted in a country with a firm foundation of health education expertise upon which to build. Paraguay had a strong foundation--health educators were open to new ideas about communication, they adopted them, and they applied them to many health interventions.

**9. THE PHILIPPINES**

**Period: July 1987 - September 30, 1990**

Project Start-up Date:

July 1987

Project Close-down Date:

September 30, 1990

Broadcast Start-up Date:

February 1988 (Metro Manila Measles/EPI)  
August 1988 (CDD Pilot Program Regions 6,  
7, and 10)

Child Survival Activities:

EPI, CDD, ARI

Primary Institution:

Department of Health, Public Information  
and Health Education Service (PIHES)

Collaborating A.I.D. Projects:

PRITECH

Provided technical assistance to the DOH in  
the management and process evaluation of  
the CDD program.

REACH

Provided technical assistance to the DOH in  
the formulation of EPI program policies and  
operational guidelines for EPI programs,  
reviewing logistics requirements and supply.

Collaborating Institutions:

WHO

Provided technical support to the CDD  
program; collaborating in training of health  
workers on CDD, i.e., government physicians,  
nurses, and midwives, with priority given to  
regions 6, 7, and 10, where the  
communication test markets were launched  
August 18, 1988.

PAC/BBDO Worldwide

Ad agency for EPI campaign

Well Advertising

Ad agency for CDD campaign

IMS Pacific Ltd.

Drugstore audit and physician market  
research

Consumer Pulse Inc.

Market research on CDD

Trends, Inc.

Market research on EPI

Kabalikat ng Pamilyang  
Pilipino

Qualitative studies on CDD and ARI

Population Center  
Foundation

Management of consultative conferences on  
EPI

Resident Advisor:

José Rafael Hernández

Date of Arrival: January 1988

Senior Program Associate:

Eleanora de Guzman

Date of Arrival: November 1987

Consultant Visits:

Tom Reis and  
Cecilia Verzosa

February 6-21, 1987: Reviewed final HEALTHCOM budget with DOH and USAID/Manila; presented proposed resident advisor; assisted DOH with preparations for a national child survival communication plan formulation workshop; reviewed DOH pilot communication strategy for ORT promotion in Regions 6 and 7.

Cecilia C. Verzosa

February 28-March 4, 1987: Prepared job description and interviewed Filipino candidates for HEALTHCOM resident advisor position; finalized HEALTHCOM buy-in arrangements.

Cecilia C. Verzosa

July 22-August 14, 1987: Initiated and managed a communication plan formulation meeting held July 27-31, 1987.

Dr. Robert Hornik

July 26-August 1, 1987: Developed a research agenda for CDD and EPI programs; developed a work plan that would identify research activities, campaign preparations, and program evaluation; identified and set up the organization for the implementation of HEALTHCOM interventions in the Philippines; met with possible research subcontractors; undertook administrative tasks in relation to the establishment of the HEALTHCOM office.

Michael Ramah

September 27-October 11, 1987: Identified an advertising agency subcontractor for HEALTHCOM campaigns; conducted a creative brief for the measles vaccination campaign.

Susan Zimicki

September 10-October 10, 1987: Designed and supervised implementation of evaluation studies in preparation for HEALTHCOM activities.

Michael Ramah	September 27-October 11, 1987: Conducted an ad agency review, briefing, and selection. Conducted a review of market research companies in the Philippines.
Mary Debus	November 14-28, 1987: Worked with Caby Verzosa and HEALTHCOM's resident advisor in interpreting research data and incorporating that data into a creative brief for the ad agency on EPI and CDD programs. Ensured that the ad agency contract for the EPI program was in place. Began work on draft of Implementation Plan.
Cecilia Verzosa	November 14-28, 1987: Assisted in finalizing contract for subcontractor advertising agency; assisted in the preparation of a creative brief on EPI and CDD; held discussions with DOH and USAID Mission regarding potential future HEALTHCOM activities in ARI. Assisted in the preparation of an Implementation Plan for HEALTHCOM.
Robert Clay (A.I.D./W) and Mark Rasmuson	February 10-27, 1987: Project assessment visit. Assisted in the selection of an ad agency for the diarrheal disease communication program.
Cecilia Verzosa	April 9-16 and 24-30, 1988: Reviewed CDD test market plans for Regions 6, 7 and 10. With Hernández and de Guzman, briefed Dr. Michael Merson, WHO Global Program Head for CDD, on HEALTHCOM test market plans. Provided technical assistance during consultative visits of HEALTHCOM staff to Regions 6, 7, and 10; assisted in developing questionnaire for qualitative home fluids study; assisted in planning EPI nationwide campaign.
Susan Zimicki	April 10-May 20, 1988: Assisted in finalizing questionnaire for qualitative home fluids study, measles post-survey, and baseline KAP survey of physicians; assisted in planning nationwide baseline survey for EPI.

Mary Debus	July 7-August 6, 1988: Assisted in analysis of pre- post-measles/National Capital Region (NCR) survey results; assisted in finalizing questionnaires for visual look-test and radio and TV comprehension and recall for CDD; conducted training needs assessment of PIHES staff for communication; assisted in planning nationwide EPI campaign.
Cecilia Verzosa	January 3-28, 1989: Prepared IEC Child Survival Strategy paper for USAID Mission; assisted in launching ARI behavioral study; assisted in conceptualization of Research Dissemination Program for PIHES; assisted in finalization of PIHES institutionalization program; participated in planning session with PIHES Management Committee.
Renata Seidel	January 25-February 7, 1989: Assisted in finalization of two field notes and other documents; interviewed possible subcontractors for the Research Dissemination Program; acted as resource person during PIHES workshop on Clear and Effective Writing.
Beverly Graham	February 14-March 5, 1989: Met with subcontractors to discuss AED contracting procedures; assisted in preparation of budget for HEALTHCOM Project extension until 1990; initiated procurement procedures for HEALTHCOM and PIHES computers.
Douglas Porter	February 13-March 3, 1989: Trained interviewers for ARI behavioral study; pretested and finalized protocol; conducted orientation for PIHES and RITM.
Camille Saade	February 22-March 3, 1989: Interviewed preselected pharmaceutical companies on Oresol commercialization; assisted in clarification of guidelines for negotiations.
Chito Padilla	July 3-7, 1989: Interviewed subcontractors (Trends, Well, and CPI) and finalized their IQCs; discussed contracting arrangement with HEALTHCOM.
Susan Zimicki	June 11-July 14, 1989: Fielded national urban baseline mothers' survey; fielded national health center study; presented results of evaluation of Metro Manila campaign to HEALTHCOM, PIHES, MCHS, NCR staff, NIC, Executive Committee;

solicited comments on draft papers; held session on evaluation with PIHES, MCHS, HEALTHCOM; discussed monitoring with staff individually; prepared initial draft of CDD questionnaire.

Mary Debus

August 27-September 3, 1989: Consulted on market research for CDD; participated in planning and developed the workshop modules for the social marketing seminar for PIHES to be held in December 1989.

Camille Saade

September 13-22, 1989: Assisted in developing strategic options for the DOH regarding commercialization of Oresol and in plotting terms of reference for negotiations with pharmaceutical companies.

## PROJECT SUMMARY

HEALTHCOM began work in the Philippines under a new government which was eager to improve its capacity to provide its 57 million citizens with access to basic health care services.

HEALTHCOM's work in the Philippines has aimed to respond to these challenges. A participatory and collaborative approach has been used in the development and implementation of the HEALTHCOM program. A five-day Communication Planning Meeting held in July 1987 provided DOH counterpart staff from both central and regional offices with hands-on experience in addressing the question of what communication can contribute to health programs. It also provided them an opportunity to map out a research agenda, determine messages for communication materials, and identify resources for communication programs.

The HEALTHCOM Project has assisted the Department of Health (DOH) in developing a communication program to support the EPI program. Communication strategies piloted in Metro Manila were prepared for nationwide expansion. The Metro Manila measles vaccination campaign produced a significant improvement in measles vaccination coverage. Among 12 to 23-month-old children, measles vaccination increased from a pre-campaign level of 21 percent to a post-campaign level of 45 percent. Coverage for all other antigens also increased.

To support the control of diarrheal disease (CDD) program, the HEALTHCOM program developed a pilot project in three regions. Two basic communication modules were designed. The first module teaches the concept of dehydration. The second module promotes specific dehydration products such as increased fluids, cereal-based home fluids--specifically, rice or corn water (or am)--and oral rehydration solutions. The first module was launched in all three regions in 1989. In 1990, the am version of the second module was launched in Region 10 and the Oresol version readied for launch in Regions 6 and 7.

In addition, HEALTHCOM assisted the DOH in the planning of a communication component to support program activities for acute respiratory infection. An ARI behavioral study was conducted in 1989 to describe the signs and symptoms that bring

mothers to the health centers for ARI consultations and to examine health worker-mother interaction.

Although the project was scheduled to end in December of 1989, a no-cost extension continued activities through September 30, 1990. The resident advisor and most staff have transferred to the Philippines Child Survival Project. The Academy will assist communication activities under a subcontract to that project.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administration/Management

During the reporting period, HEALTHCOM/Philippines assisted the DOH in negotiating a number of contracts with private sector organizations. These included the following:

- the PAC/BBDO Worldwide, Inc.--for follow-on work for the mass media coverage of the nationwide measles immunization campaign;
- the Population Center Foundation (PCF)--to manage consultative and sales conferences with regional and city health office staff prior to media launch;
- TRENDS, Inc.--for the Pre/Post Campaign Mothers Survey;
- Kabalikat ng Pamilyang Pilipino--by the Annenberg School for Communication for the Pre/Post Campaign Health Center Study.

### Formative Research

During the last two weeks of December 1989, data gathering for the post-tracking study of the CDD test market Module A campaign (TV, radio) was completed. Topline results of Hydro P-A-P II, as the project was nicknamed, were presented by Consumer Pulse, Inc. on Feb. 26, 1990.

The research concluded that the Module A campaign was successful in cultivating knowledge about diarrheal dehydration among 600 mothers in Regions 6, 7, and 10. Overall awareness of the advertising campaign rose from 48 to 78 percent. HEALTHCOM presented these results to the DOH in April 1990.

The pretests for the Module B Region 10 materials--TV "Am," radio "Am," print ad "Am," radio "Signs of Dehydration," and the CDD print materials (comic series and pamphlet) were conducted in Cagayan de Oro from the last week of February to the second week of March 1990. The studies showed that the materials successfully communicated the intended messages.

The Module B Regions 6 and 7 "Oresol" materials were pretested in two batches. TV "Biktima," radio "Sa totoo lang," posters "Labanan" and "Panalo" were pretested in Iloilo City in April 1990. TV and radio "Oresol Mixing" ads were pretested in Iloilo City in July 1990. Pretest results for all the materials were extremely encouraging. Comprehension, copy, and situation recall were very high. Based on these results, the materials were finalized with slight revisions.

## Intervention Activities

### CDD Test Markets - Regions 6, 7, and 10

In September 1989, the TV commercial "Kasabwat" and print advertisement "Dehydration" were launched, followed by radio commercials ("Kasabwat" and "Did you Know"). The three-month campaign ended its TV airing on December 3, 1989, and its radio broadcast on December 16, 1989. Radio was the primary CDD campaign medium, due to its broad geographical coverage.

About 4,500 copies of the Dehydration-Rehydration poster, the last of the series of Module A posters, were distributed to the three regional health offices in March and April, 1990.

In September 1989, HEALTHCOM developed for mothers a short manual on diarrhea, dehydration, ORT, and preventive measures and a comic series communicating the same concepts as the CDD pamphlet. Each material was mass produced in three dialects: 75,000 in Pilipino, 150,000 in Cebuano, and 75,000 in Ilonggo.

In January 1990, PIHES/HEALTHCOM presented the communication campaign strategies for Module B to the CDD Program Management Team of the DOH. The objectives of the campaign are, for Region 10, to promote the home fluid am (rice water) for the prevention of dehydration; and in Regions 6 and 7, to promote Oresol for the treatment of dehydration. Secondary objectives include teaching the signs of dehydration and communicating messages of continued feeding and breastfeeding of children sick with diarrhea. Slogans for both campaigns were proposed:

"UNAHAN ANG DEHYDRATION. BIGYAN AGAD ANG BABY NG AM SA BAWAT PAGTAE." (Get ahead of dehydration. Immediately give am to your baby for every loose stool.)

"LABANAN ANG DEHYDRATION. BIGYAN AGAD ANG BABY NG ORESOL SA UNANG SINTOMAS PA LANG NG DEHYDRATION." (Fight dehydration. Immediately give Oresol to your baby at the first sign of dehydration.)

The Module B communication strategies were approved by the DOH.

Module B am materials included a poster, featuring the sequential visual of a baby dehydrating. In bold text, the headline reads, "Immediately give your child am." Text and visuals on preparation and dosage instructions accompany the main headline. This poster underwent a short pretest conducted by PIHES in March 1990. Respondent mothers perceived the messages clearly. The layout was finalized in August 1990. The materials were launched in September.

Broadcast materials on am that ready for pretesting by February 1990 included the following:

#### Television

- "Am" (30 second spot): advertisement in Cebuano dialect with am slogan and slice of life format showing sick baby being fed am;

- "Rider" (15 second spot): animation on continued breastfeeding, feeding, and giving more fluids;

#### Radio

- "Am" (60 second spot): radio adaptation of the TV "Am," along with messages on giving more fluids, continuing breastfeeding, and feeding;
- "Signs of Dehydration" (60 second spot): presentation of the signs of dehydration urging mothers to bring their children to the health center upon noticing even one of these signs. Broadcast in Ilonggo and Cebuano.

PIHES/HEALTHCOM conducted a sales conference in Cagayan de Oro for provincial, district, and city CDD coordinators and health educators of Region 10 on August 27, 1990. The objective was to orient participants in the "am" campaign.

The main message for the Module B Oresol campaign was encapsulated in the slogan: "Oresol brings back baby's strength and vitality lost in dehydration. Oresol works like a dextrose but better because it is taken orally. Oresol is proven by the World Health Organization as the most effective treatment against dehydration." From this slogan, the following materials were then developed by March 1990:

#### Television

- "Biktima" (victim) (45 second spot): animation and slice of life format showing how Oresol treats dehydration, in Ilonggo, Debuano, and Tagalog;
- "Oresol Mixing" (60 second spot): musical instructing proper mixing, in Tagalog;

#### Radio

- "Sa totoo lang" (In fact...) (60 second spot): promotion of Oresol;
- "Oresol Mixing" (60 second spot): A radio version of the TV commercial;

#### Poster/Print

- "Labanan" (Fight dehydration);
- "Panalo" (Win over dehydration).

These materials were pretested from April to July, 1990.

#### Oresol Commercialization

In September 1989, Camille Saade of PRITECH and HEALTHCOM visited the companies that had responded affirmatively to the invitation letters sent by the DOH dated May 7, 1989. The companies included: Astra Pharmaceuticals, United

Laboratories, Wyeth-Suaco, Pascual Laboratories, Procter & Gamble, and Abbott Laboratories.

By the end of September, the Guidelines for Commercialization were formulated. The DOH decided to open an Oresol franchise, provided interested companies commit to the objectives of continuous accessibility and affordability of Oresol. Pascual was the only company to apply for a franchise. The DOH approved their application, and the production of "Oresol Pascual" began in August.

### **EPI Nationwide Urban Communication Campaign**

HEALTHCOM assisted the DOH in preparing numerous broadcast and print materials and in conducting extensive interpersonal training in preparation for the nationwide EPI campaign. Television and radio spots consisted of two thematic and two tactical commercials in Pilipino. (The radio versions were translated into eight major dialects.) Thematic commercials warn of the dangers of measles. Tactical commercials remind mothers of immunization days at health centers. One tactical print ad was distributed in Pilipino, which included the reminder: "Wednesday is free immunization at your health center. Save your baby from measles. Have him/her immunized."

In addition, the project produced the following merchandising materials:

#### **For Health Centers:**

- thematic poster (18,100 pcs.) communicating same message as TV and radio ads, produced in Pilipino and eight major dialects;
- tactical poster (6,500 pcs.) produced in Pilipino and eight major dialects, conveying that every Wednesday is free measles immunization at the health center;
- welcome streamer for health centers reading: "Please come in. Free immunization against measles."
- buntings for health centers (3,000 sets);

#### **For Public Utility Vehicles:**

- jeepney tactical stickers (37,500 pcs.);
- tricycle tactical sticker (37,500 pcs.);

#### **For Health Center Staff:**

- DOH Immunization Team T-Shirt (12,000 pcs.);
- "EPI: A Mission for Life": 20-minute orientation/motivational slide-tape presentation for mayors.

Interpersonal training in preparation for the EPI campaign was extensive. In July and August, 1989, a number of EPI planning conferences were held for 185 regional immunization and health officers. In September 1989, Health Secretary Alfredo Bengzon and PIHES/HEALTHCOM met with selected mayors in Cebu City. Bengzon emphasized the crucial role of mayors in creating a successful immunization program. He gained the support of the 20 mayors present.

In addition, three master sales conferences were held in February 1990. About 188 health and immunization officers, amongst others, attended. Echo sales conferences for 2,398 health centers were conducted in March 1990 by those who attended the master sales conferences.

### Monitoring/Evaluation Activities

#### CDD

In November 1989, PIHES/HEALTHCOM visited TV stations, radio stations, and health centers to monitor implementation of the Module A media placements and display of the Module A print materials. The team conducted an informal survey of mothers' reactions to the media campaign.

Thirty-three health centers in the three target regions were visited. The ORS Calendar was present in 82 percent of the health centers; 64 percent displayed the Signs of Dehydration poster, and 49 percent displayed the Dehydration poster. Of the 53 mothers interviewed, 90 percent noticed the commercial, with 65 percent giving related recall. About 50 percent recalled the concept "dehydration."

#### EPI

The EPI nationwide campaign was monitored with weekly feedback forms. Forms were distributed to a random group of health centers, completed by them, and submitted to the city health officer each month. The forms helped track the number of vaccinations given by the health center on a daily basis. They also provided information in the problems encountered by health centers.

PIHES/HEALTHCOM staff also visited the health centers. In April 1990, PIHES assigned seven staff members to visit the health centers, which HEALTHCOM also monitored. By the end of September, 108 health centers had been visited.

Regional HEAs and PIOs monitored TV and radio EPI commercials at stations within their jurisdictions. Regional monitors, trained during the PIHES National Consultative Conference in March 1990, submitted monthly reports.

To examine the effect of the media campaign on EPI, a summative evaluation was implemented by the Annenberg School. Two studies were conducted. One was a nationwide baseline and post-KAP survey of 1,200 mothers, which aims to track changes in mothers' knowledge, attitudes, and perceptions regarding immunization. The other was a nationwide health center baseline and post-KAP survey, aimed at identifying changes in service delivery. Sixty health centers were surveyed during immunization days by Kabalikat ng Pamilyang Pilipino.

### Diffusion Activities

#### CDD

PIHES/HEALTHCOM presented the results of the post-tracking survey of mothers for Module A tri-media to DOH-MCHS and regional CDD coordinators at the biannual CDD National Consultative workshop in April, 1990.

## **EPI**

Diffusion activities in support of the EPI nationwide campaign included both pre- and post-campaign information and publicity efforts.

- Trends staff presented to PIHES/HEALTHCOM and MCHS the results of the 1989 baseline mothers' survey.
- PIHES and HEALTHCOM presented EPI campaign materials to the DOH Executive Committee in February 1990.
- A national press conference was held to officially announce the launch of the EPI campaign. DOH Secretary Bengzon presided, along with the directors of PIHES and MCHS and the HEALTHCOM resident advisor. Reporters from four TV networks, nine newspapers, and two radio stations, amongst others, attended. Press kits and campaign T-shirts were distributed during the press conference.
- As part of the public relations effort, PIHES and MCHS staff appeared in top-rating TV talk shows in April to discuss the campaign.
- Dr. M. Dayrit of PIHES updated 162 DOH central and regional officials on the status of the nationwide campaign during the National Staff Meeting in May, 1990.
- In August 1990, PIHES presented feedback gathered from health center visits and data collected from the weekly feedback forms to participants of the Inter-City Area Conference conducted by MCHS in Cagayan de Oro City.

## **INSTITUTIONALIZATION ACTIVITIES/PROGRESS**

In 1990, considerable gains were made by HEALTHCOM in institutionalization activities. HEALTHCOM was able to influence not only program areas in child survival, but also other health programs, notably TB control and schistosomiasis control.

A series of seminars was conducted by HEALTHCOM in order to provide PIHES and its network of regional health educators with the theoretical framework for social marketing and communication in EPI and CDD interventions, as well as other health areas such as TB prevention and schistosomiasis control. Participants rated the seminars very highly. They noted that it gave them a fresh perspective on their functions. They resolved to use social marketing as a tool in their work.

HEALTHCOM gave technical and planning assistance for the PIHES National Consultative Workshop in March 1990. HEALTHCOM also assisted in planning the second National Consultative Workshop in September 1990.

Although the HEALTHCOM Project has now ended in the Philippines, the HEALTHCOM resident advisor and much of his staff are still located at and assisting PIHES under the new Child Survival Project. This continuity will be a critical factor in promoting further institutionalization of public health communication approaches within the Department of Health.

## **MAJOR ISSUES AND LESSONS LEARNED**

A health communication intervention can be successful only through strong coordination with the service delivery network, from planning to implementation. In the Measles/NCR, EPI Nationwide, and CDD pilot interventions, the series of conferences with health center staff was an essential activity. Funds were allocated directly for this purpose. In the absence of these conferences, health center staff would not have valued their role in the campaigns or been enthusiastic about making them successful.

In a media-oriented country like the Philippines, use of mass media is very effective in promoting specific health practices. However, mass media can only create demand for a health practice. Because of time limitations, all pertinent messages cannot be communicated. In order to complement mass media messages, education materials must be available at health centers, and interpersonal communication skills of health workers must be developed.

It is important to distinguish between the roles of the communication manager and the program manager so that an effective working relationship is established between the groups. The program managers should decide on the health practices and key messages to be promoted. The communication team strategizes methods for promoting the health practices.

Moving from a pilot to a nationwide intervention is difficult and time consuming. In order to expedite the process, program managers need to meet regularly in order to achieve agreement on strategies for expansion.

Distribution of IEC materials is another activity which needs planning and allocation of funds. IEC materials are normally distributed throughout the DOH with medicines, with the latter given priority. Distribution of IEC materials from the DOH down to the health centers had to be incorporated into the CDD and EPI plans. A separate budget for distribution was established to ensure that materials reached the health centers in time. Had the materials followed the usual DOH distribution procedure, this would not have been the case. Health center staff also need to be oriented regarding IEC materials so that they can use them for educational purposes.

A major issue which arose during the HEALTHCOM Project was coordination/duplication of studies on CDD and EPI. HEALTHCOM conducted surveys of mothers as part of its formative and summative research. Other organizations, such as WHO and the University of North Carolina, were concurrently conducting studies on the same subjects but with different objectives and using different methodologies. It is important that a coordinating mechanism be established at the outset (perhaps to become a formal component of the program).

10. YEMEN ARAB REPUBLIC

Period: October 1, 1989 - September 30, 1990

Project Start-up Date:

September 1988

Child Survival Activities Focus:

Expanded Program of Immunization (EPI) and Control of Diarrheal Disease (CDD)

Collaborating A.I.D. Projects:

REACH

Overall management of A.I.D. Accelerated Cooperation for Child Survival Project that seeks to upgrade primary health care system in six governorates with special emphasis on improvement of MOH capacity to provide immunization and CDD services.

Collaborating Donor Agencies:

World Health Organization (WHO), UNICEF

Primary Institutions:

Ministry of Health, Directorate of Health, Education  
Local Community Development Councils

Collaborating Institution:

Center for Development Communication-Egypt

Resident Advisor:

Baher Ezzeldine Abaza

Date of Arrival: September 1988  
Date of Departure: March 1989

Syed Jahangeer Haider

Date of Arrival: July 12, 1990

Consultants:

Roger Pereira

November 18-December 22, 1985:  
Conducted survey of health communication in country.

Allan Bass

February 16-April 18, 1986: Conducted immunization needs assessment.

Roger Pereira

March 3-May 5, 1986: Conducted needs assessment.

Diaa M. Hammamy

June 9-23, 1987: Assisted REACH and USAID in assessment of governorates for inclusion in Yemen Child Survival Project; prepared budgets; arranged for placement of REACH long-term advisor.

Diane Urban	October 2-November 11, 1987: Met MOH counterparts, discussed health communication projects, drafted a Letter of Agreement for signature by USAID, MOH, and A.I.D./W.
Moncef Bouhafa	October 13-30, 1987: Participated in a workshop sponsored by Project REACH to plan child survival strategies.
Will Shaw	October 21-November 14, 1988: Helped develop initial work plan through discussion with MOH, governorate level health officials, and A.I.D.; reviewed activities in governorates; and assisted in setting up administrative project structure.
Joseph Rittman	October 21-November 14, 1988: Reviewed health education structure and equipment at national and local levels; helped prepare work, training, and equipment procurement plans.
Will Shaw	February 10-March 10, 1989: Reassessed needs with new MOH hierarchy; prepared new work plan and staff development plan; reviewed and revised HEALTHCOM administrative structure.
Darryl Kuhnle	May 10-August 12, 1989: Completed negotiations for project work plan; assessed equipment needs; procured and installed air conditioning; began initial research and materials development activities.
Anne Roberts	July 12-29, 1990: Met MOH counterparts; prepared new work plan and budget with resident advisor; assisted advisor in office set up.
Will Shaw	July 1990: Reviewed project history and helped develop future plans; presented HEALTHCOM terms of reference to MOH; officially delegated financial responsibility to resident advisor.

## PROJECT SUMMARY

Given the high infant mortality rates and low literacy rates prevalent in the Yemen Arab Republic, the Ministry of Health and USAID/Yemen launched a new project in 1987 designed to improve the public health care facilities in six of Yemen's twelve

governorates. The Accelerated Cooperation for Child Survival Project (ACCS) seeks to improve the health situation in Yemen by:

- supporting expansion of immunization services;
- expanding and improving primary health care;
- developing the capacity of central and regional health education units to use communication to increase community knowledge, understanding, and adoption of improved health practices;
- carrying out special studies/projects designed to improve the management and delivery of basic health services.

The A.I.D. REACH Project, implemented by John Snow, Inc., has been contracted by USAID/Yemen to provide overall management of the ACCS Project--particularly the first two and last goals. HEALTHCOM has joined the ACCS team to take overall responsibility for the development and management of the communication component of the project and assist in the development of health education capabilities in the governorates. HEALTHCOM will work with the Directorate General of Health Education (GDHE) of the Ministry of Health to use communication media to support the expansion of child survival services.

## PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD

### Administrative/Management

The HEALTHCOM Project was fortunate to find and field a resident advisor who not only has experience in program building, health education, and behavioral studies, but has three years experience in developing community health efforts in Yemen. Dr. Syed Jahangeer Haider spent two weeks in Washington for orientation at the Academy and then took his post in July, 1990. The resident advisor, with assistance from Anne Roberts and Will Shaw, revised the work plan and the in-country budget and created a staff development plan for the GDHE and local health workers.

Roberts and Shaw delivered a computer to the GDHE offices. Computer training for health education staff has been organized locally. Other administrative purchases include a typewriter, office equipment, and a project vehicle.

Vehicle and employment policies have been prepared and submitted to USAID for approval.

A roster of Arabic speaking consultants is being prepared.

Management responsibility for Yemen was transferred from Will Shaw to Anne Roberts, the new country manager and Senior Communication Advisor.

### Formative Research

Dr. Haider developed and submitted to the MOH and USAID the work plan and a preliminary review of data taken from visits to hospitals, clinics, and interviews.

## **Intervention Activities**

HEALTHCOM staff believe that agreement on a specific intervention is critical to the success of project activities and to institutionalization of the methodology. Baseline knowledge, attitudes, and practices (KAP) surveys will be conducted to determine the most critical health problem in the country and to design an appropriate intervention strategy. Some conflict exists between local health organizations. While the Primary Health Care Directorate has expressed the desire to expand the intervention to include more primary health care activities, GDHE has proposed that HEALTHCOM collaborate with UNICEF and the MOH's CDD program to collaborate on a pilot CDD campaign. A secondary health intervention strategy might be designed for breastfeeding. The final decision on intervention priorities will wait until the results of the KAP surveys, which will indicate the most critical needs of the community.

## **INSTITUTIONALIZATION ACTIVITIES/PROGRESS**

A program goal is to strengthen the GDHE's capacity to implement health communication programs successfully on its own. With this intent, plans have been developed during the past six months for training sessions in health education concepts, analysis, and application for members of all collaborating organizations.

## **MAJOR ISSUES AND LESSONS LEARNED**

Development efforts in Yemen, in which HEALTHCOM has had a major role, have effected great changes in attitude toward and knowledge of health education and communication within the GDHE. Much of this change can be attributed to the continuing efforts of several communication specialists who have stressed consistently that each phase of the methodology, from research to design to implementation and monitoring, must be carried out in order to achieve desired behavior changes. It is important now, as the second phase of the project gets underway, that HEALTHCOM support this new willingness to use research and pretesting techniques as the basis for project decisions.

<b>11. <u>ZAIRE</u></b>	<b><u>Period: August 1988 - September 30, 1990</u></b>
Project Start-up Date:	August 1988
Child Survival Activities Focus:	Diarrheal Disease, Immunization
Collaborating A.I.D. Projects:	Programme Elargi de Vaccinations (PEV) Santé Rural (SANRU) School of Public Health/Kinshasa PRICOR CCCD
Collaborating Donor Agencies:	
UNICEF	Providing training, equipment, honorariums, printing costs, transportation for front-line workers (social mobilization) who work with HEALTHCOM
Primary Institution: (FONAMES)	Fonds National Medico-Sanitaire
Collaborating Institutions:	
Programme Elargi de Vaccinations (PEV)	Providing assistance with policy issues
School of Public Health/ Kinshasa	Collaborating on major research activities and regional training activities
Resident Advisor:	Joan Schubert
Date of Arrival:	August 2, 1988
Consultants:	
Mark Rasmuson	May 8-12, 1987: Finalized Letter of Agreement.
Judith Graeff Susan Schneider	January 25-February, 1988: Planning of project start-up.
Judith Graeff	August 8-20, 1988: Assisted in project start-up.
Stanley Yoder	October 6-November 3, 1988: Set up baseline survey; developed questionnaire; conducted qualitative research including focus group and ethnomedical study.

Stanley Yoder	January 27-March 31, 1989: Set up and facilitated baseline survey for Lubumbashi; conducted observational studies of clinics in Ruashi/Katuba (Lubumbashi).
Stanley Yoder	April 1-5, 1989: Completed baseline survey assignment that started January 27; presented key frequencies and percentages to PEV/Kinshasa staff.
Kafam Toko Puku	April 26-June 17, 1989: Planned and conducted, in collaboration with resident advisor and local HEALTHCOM counterparts, a three-week training of trainers (TOT) workshop on IEC and interpersonal communication in Lubumbashi; compiled reference manual to facilitate future training.
Marion Clark	May 5-June 5, 1989: Planned and conducted a three-week TOT workshop on IEC and interpersonal communication in collaboration with resident advisor and local HEALTHCOM counterparts.
Mark Lediard	June 3-6, 1989: Developed a draft action plan for AIDS education activities in Lubumbashi in conjunction with resident advisor.
Lynne Cogswell Linda Morales	September 24-October 14: Worked with IEC team on message and materials development relevant to vaccinations, diarrheal disease and oral rehydration therapy.
Judy Graeff	October 2-16, 1989: Discussed proposed second resident advisor position with USAID/Kinshasa and extension of HEALTHCOM Project with collaborating agencies and institutions, monitored project activities and worked with Stanley Yoder to set up an observation study of the health talks in Ruashi.
Stanley Yoder	October 13-November 5, 1989: Collaborated on the observation study with Judy Graeff, presented the results of the community baseline survey in Lubumbashi and Kinshasa with the resident advisor and participated in a three-day planning session for a proposed workshop in IEC strategy design.

Mark Lediard	October 23-28, 1989: Participated in a three-day planning session for a proposed workshop on IEC strategy design and discussed the proposed extension of the HEALTHCOM Project in Zaire with USAID/Kinshasa.
Gilberte Vansintejan	February 1-March 2, 1990: Planned and facilitated a Training of Tutors (TOT) workshop on health communication and social mobilization for nursing instructors of the 16 Medical Technical Institutions in Shaba in collaboration with the resident advisor and in-country project collaborators; designed the workshop curriculum; helped to organize and initiate the <u>Maman Tengeneza</u> (Mothers for Improvement) program in Ruashi.
Gilberte Vansintejan	March 28-April 21, 1990: Co-facilitated second TOT workshop on health communication and social mobilization for nursing instructors of the 16 Medical Technical Institutions with resident advisor and in-country collaborators; provided technical assistance for training and monitoring of the <u>Maman Tengeneza</u> program in Ruashi, including developing a model training curriculum used by the Ruashi IEC team and assisting them with the initial <u>Maman Tengeneza</u> two-day workshop.
Edward F. Douglass	May 30-June 13, 1990: With the resident advisor, planned and conducted radio production workshop to develop and produce programs to support a vaccination campaign in Lubumbashi; teach specific recording and editing techniques, social marketing applications to radio spots; and expand range of formats and styles for use in health programs.

## PROJECT SUMMARY

The 1989 FONAMES (National Medical and Health Bureau, MOH) national information, education, and communication (IEC) strategy stresses decentralized health education efforts with particular emphasis on interpersonal communication. The thrust of the first phase of the HEALTHCOM Project in Zaire has been consistent with this plan. To help the MOH achieve its goals in IEC, HEALTHCOM has been working at various levels to demonstrate the value of research to gain in-depth knowledge about

different target populations' knowledge, attitudes, and practices (KAP). KAP surveys indicate influences on a populations' health-related behavior; This information is used to plan and implement appropriate and complementary IEC interventions and strategies, including interpersonal communication, community mobilization, folk media, print, radio, and training.

In 1981, the Government of Zaire (GOZ) formally adopted a decentralized primary health care system as the basis for the national health strategy. Although some health facilities are GOZ-funded, many are managed by an extensive private voluntary organization (PVO) network in Zaire, which relies primarily on health centers and village-level health workers. Basic elements of the Zairian health care strategy include essential curative care, vaccinations, improved drinking water and environmental sanitation, maternal and child health services, family planning, and referral. Health education is included as a key component of this strategy.

During the first two years of the project, immunization and diarrheal disease were priority concerns. These topics were selected by the chief medical officers of the two project pilot zones and approved by the medical inspector of Shaba. During the second project phase, other health care priorities for Zaire may be addressed, including nutrition, malaria, water and sanitation, family planning, and AIDS.

Because Zaire is such a large country with decentralized health care, two pilot zones in the Shaba region were selected as starting points for intensified project efforts. The pilot zones are Kabongo, a rural, SANRU-supported zone; and Ruashi, a semi-urban, UNICEF-supported zone associated with the University of Lubumbashi. Given the localized focus of this initial phase, the principal bureau for the HEALTHCOM Project at this time has been at the Regional Medical Inspection Building in Lubumbashi. During phase two, which begins in the fall of 1990, a major coordinating office will be opened at FONAMES in Kinshasa.

Two technical advisor positions have been approved for the Kinshasa office. The chief of party, who has been recruited, is a training and curriculum development specialist who will work to develop training capability and standards for health education at the national level. The second advisor, a specialist in materials development, will provide assistance with materials development for person-to-person communication and mass media, with an emphasis on radio messages. Recruitment for this position is continuing. HEALTHCOM expects that both advisors will be available to take part in a Washington orientation, followed by travel in-country, within one month of approval by the A.I.D. Contracts Office.

Principal collaborators for the project include FONAMES, PEV, SANRU, The School of Public Health, Kinshasa, the University of Lubumbashi, UNICEF, and Rotary International, in relation to vaccination acceleration activities. Other collaborating institutions during the second phase may include the PSND, the Bureau Regional de Coordination (BCC) and the MOH nutrition program, CEPLANUT.

## **PRINCIPAL ACTIVITIES CARRIED OUT THIS PERIOD**

### **Administrative/Management**

During the fiscal year 1990, the HEALTHCOM Project completed the following administrative activities:

- renovation of office space at the Medical Inspection Building in Shaba;
- hired, trained, and supervised administrative staff;
- purchased office equipment and new (replacement) project vehicle;
- managed IMPREST account;
- coordinated and supervised project activities in the field;
- prepared monthly reports and other written documents upon request.

### Formative Research

During the course of the project, HEALTHCOM carried out both quantitative and qualitative studies supporting formative research.

- The Lubumbashi Social Mobilization Team completed 15 focus group discussions. The results were used to develop the baseline knowledge, practices, and attitudes (KAP) survey and to prepare for the ethnomedical study. The KAP results demonstrated that mothers' knowledge of diarrheal disorders is complex and well-developed.
- Local IEC teams in Kabongo conducted twelve focus group discussions on diarrheal disease and vaccinations in preparation for project interventions.
- HEALTHCOM conducted eighteen focus group discussions on AIDS and condom use in the Katuba health zone of Lubumbashi in collaboration with the regional AIDS coordinating committee, the Bureau Regional de Coordination (BCC). Information gathered from the discussion used for message development and IEC strategy design.
- HEALTHCOM conducted an ethnomedical study on diarrheal disease in collaboration with researchers at the University of Lubumbashi. The study was used to formulate the baseline/community survey and to examine the consistency of mothers' diagnoses of the five illnesses characterized by diarrhea (which had been identified by the focus groups).
- In collaboration with students at the Medical School of the University of Lubumbashi, HEALTHCOM conducted a health services study in Ruashi. The study included an inventory of services offered and observations of ten health education sessions in ten health centers. The results helped in preparing the HEALTHCOM Project promotional plan.
- HEALTHCOM, in collaboration with a researcher at the University of Lubumbashi, carried out 24 in-depth interviews on common meeting places for women, to identify possibilities for additional channels of interpersonal communication.

- HEALTHCOM conducted a large-scale baseline/community survey of 1,125 mothers regarding diarrheal disease, ORT, the use of medical services, vaccinations, and access to mass media, in collaboration with the University of Lubumbashi and the School of Public Health, Kinshasa.

### Intervention Activities

As part of the its general health promotion plan, the HEALTHCOM Project initiated home visits by Maman Tengeneza, or neighborhood volunteers. The project also initiated approximately 40 health promotion sessions by primary school teachers in Kabongo. Materials developed included:

- seven large-scale wall murals of the new Ruashi health zone logo;
- 50 health zone logo T-shirts for Maman Tengeneza;
- approximately 250 certificates for workshop participation for to Maman Tengeneza, health educators, primary school teachers, health zone supervisors, chief medical directors, nursing school instructors, community health agents, and radio technicians, as appropriate;
- three training guides, including one for training of trainers in IEC at the level of the health zone, one for nursing school instructors, and another for training Maman Tengeneza.

### CDD

HEALTHCOM produced both posters and audiocassettes for health centers in support of diarrheal disease control. Two diarrheal disease/rehydration posters (175 copies each) were printed and distributed. Audio cassettes (50 copies) of six health education songs on diarrheal disease and dehydration were produced and distributed to health workers.

HEALTHCOM also sponsored about 1,000 home visits by Maman Tengeneza volunteers. In addition, approximately 100 health education demonstrations on oral rehydration therapy in health centers and in community health committee meetings.

### EPI

HEALTHCOM sponsored between 900 and 1,000 home visits regarding immunization by 38 Maman Tengeneza volunteers. In addition, the project sponsored about 150 health education sessions in health centers and during community health committee meetings regarding vaccinations and the vaccination calendar. Materials produced in support of EPI included:

- 27 radio spots;
- one theatre/comedy spot for radio;
- two television spots;

- one vaccination clapping song/game;
- 1,000 vaccination calendar posters;
- 175 copies each of four posters promoting vaccinations;
- four vaccination wall murals;
- 1,000 campaign T-shirts;
- 40 vaccination promotion blouses for health educators.

### **Interpersonal Training Activities**

HEALTHCOM/Zaire has focused on training activities since the beginning of the project. Selected activities include the following.

- a three-week training of 22 health workers from Ruashi, Kabongo, PEV, and the Lubumbashi Social Mobilization Team in planning, implementation, and management of appropriate IEC interventions at the level of the zone;
- two two-week trainings for 32 nursing instructors representing the 16 Medical Technical Schools for Shaba in primary health care and social mobilization;
- an 11-day training for nine participants in creative radio programming with Voice of Zaire staff and local nurses in support of the Lubumbashi vaccination campaign, during which 27 radio spots were prepared and pretested;
- two five-day trainings in health education for 27 nurses and social workers carried out by the Ruashi IEC team;
- a three-week hands-on workshop in materials development and pretesting carried out with the Ruashi IEC group and members of the Lubumbashi Social Mobilization Team in collaboration with PATH;
- a series of one- and two-day trainings for a total of five days of instruction for 37 Maman Tengeneza in social mobilization, vaccinations, diarrheal disease, and nutrition organized by the Ruashi IEC team;
- two ten-day trainings in primary health care and IEC for 28 nurses, carried out by the Kabongo IEC team;
- three five-day trainings for 60 community health workers in community mobilization and primary health care, organized by the Kabongo IEC team;
- two three-day trainings for approximately 30 primary school teachers on health education and primary health care, carried out by the Kabongo IEC team;

- a two-week practical training of 15 members of the Lubumbashi Social Mobilization Team on how to conduct focus group discussions about diarrheal disease;
- a five-day training of eight health workers and University graduates on how to conduct focus group discussions on AIDS

### Monitoring/Evaluation Activities

The Annenberg School for Communication conducted the evaluation of HEALTHCOM interventions in Lubumbashi in collaboration with researchers at the University of Lubumbashi and the School of Public Health at the University of Kinshasa, as appropriate. Evaluation activities included: a) a second round of data collection similar to that carried out during the baseline survey; b) observations of health education talks carried out in the Ruashi health zone to evaluate changes in interpersonal communication skills; c) exit interviews with mothers attending vaccination sessions and well baby clinics to assess effectiveness of health worker face-to-face communication; d) in-depth interviews with various people who have been involved with the project in Shaba, including medical leaders, health workers, mass media technicians at the Voix du Zaire, Maman Tengeneza, members of the Lubumbashi Social Mobilization Team, representatives of the University of Lubumbashi, nursing school instructors and their students, and so forth.

It is expected that the results of this research will prove very useful in preparing for the second project phase.

### Diffusion Activities:

- The HEALTHCOM Project staff presented the HEALTHCOM methodology at the 1989 SANRU National Conference.
- HEALTHCOM staff gave a presentation to Rotary International on HEALTHCOM/Zaire 1989 project activities.
- The HEALTHCOM video was televised twice on the culture and development program of the Voix du Zaire in Lubumbashi.
- HEALTHCOM staff made three presentations of the baseline KAP survey results in Lubumbashi and Kinshasa.
- HEALTHCOM distributed over 250 HEALTHCOM manuals to FONAMES, the School of Public Health (SPH)/Kinshasa, the University of Lubumbashi, SANRU, PEV/CCCD, the Department of Public Health, and participants from Guinée, Chad, Côte d'Ivoire, Togo, and Burundi, at the CCCD/SPH/Tulane University-sponsored Africa Regional Health Education (ARHEC) Planning and Management workshop in 1989.
- HEALTHCOM sponsored regular radio and television coverage of opening and closing ceremonies of project workshops in Lubumbashi.

- Three training manuals were completed during the first project phase, including one for the zonal training of trainers in IEC and community mobilization, a second for the training of nursing school instructors in primary health care and community mobilization, and a third for initiating the Maman Tengeneza program.
- A guide to setting up and implementing IEC activities at the level of the zone was developed, based on lessons learned from the initial pilot zone experience. This guide will be used as a tool in getting the second project phase underway. It is expected that over the next two years of the the project, at least twenty-five additional urban and rural health zones in five regions across the country will use this guide as a reference tool as they become involved in intensified project efforts.

### INSTITUTIONALIZATION ACTIVITIES/PROGRESS

Emphasis during the first project phase was placed on training medical leaders, health care delivery personnel, community health volunteers, mass media technicians, and nursing school instructors in formative research, materials development, pretesting, systematic planning, and health communication and training skills, as appropriate. The purpose of these efforts was to create a critical mass of people working in the two project pilot zones and the Shaba region who would be capable of disseminating the HEALTHCOM methodology and implementing appropriate communication interventions in the field.

Three training manuals were developed during the first project phase, based on training experiences in the field. The first manual sets up a training-of-trainers curriculum in IEC and childhood communicable diseases, which can be used by zones interested in developing their own health communication programs. The second manual proposes a curriculum for training nursing instructors in primary health care and innovative health education methods. The third is a guide for designing a Maman Tengeneza program, including a suggested curriculum and activities.

The HEALTHCOM staff wrote an IEC guide for health zones in Zaire based on experiences from the two project pilot zones. The guide will be distributed and used to set up the second project phase.

### MAJOR ISSUES AND LESSONS LEARNED

The health communication activities in Zaire took longer than expected to get off the ground. This was primarily due to the lack of zonal and regional IEC infrastructure, as well as extremely poor communication systems between the project office in Lubumbashi and both Kinshasa and Washington. Furthermore, a full-time government counterpart was never found to replace the one who left the project after two months. The HEALTHCOM counterpart at the regional level in Lubumbashi also has a full-time job as the regional medical coordinator for PEV. At the zonal level, the project has worked with the local medical directors who are likewise extremely busy with their regular jobs. Hence, although interest for the HEALTHCOM Project has been high, regular collaboration has been difficult.

Although it has been acknowledged that a second resident advisor to Zaire located in Kinshasa is a minimum requirement for meeting the high demand for technical assistance at the national level, USAID funds were not available during the first project phase to post such a person (or persons).

Despite certain difficulties, the project managed successfully to complete almost all of the activities which it had planned, including creation of a network of health technicians and communication specialists in the Shaba region capable of applying HEALTHCOM's communication methodology in the field. It is clear that the heavy emphasis during the first two project years on training of health workers and the close involvement of Zairian colleagues in all aspects of the project, including determining project goals and evaluation activities, has had a positive effect on institutionalization and has established a good foundation for future activities.

For example, the nurses and their chief medical directors in the Ruashi and Kabongo health zones worked together as teams to develop their own IEC action plans. From this, a sense of project ownership was created. The radio technicians at the Voix du Zaire also feel personally involved in ensuring the success of the vaccination acceleration campaign and are giving free and unlimited air time to promote activities. Plans are now being made by the Ruashi IEC team to expand the Maman Tengeneza program to 120 volunteers who will be supported by a soya flour cooperative. The expansion would include a nutrition information center to be run by the Ruashi health zone in collaboration with UNICEF. Nurses from the Lubumbashi Social Mobilization Team in Ruashi who were trained to lead focus group discussions on diarrheal disease are now implementing similar activities in other health zones on such topics as nutrition and community development with the University of Lubumbashi and other groups. Health workers who were trained by the project to be trainers are now regularly solicited to facilitate workshops by a variety of groups, including PEV, UNICEF, SANRU, and the BBC.

Another very important lesson learned during the first project phase was the power of women as community leaders. Women volunteers have a great influence on health education activities. It seems that the Maman Tengeneza volunteers have instilled a sense of confidence in the mothers during their home visits, as indicated by the fact that the mothers are more receptive and are asking more questions during the health education talks. On several occasions during the observation study, mothers were noted to question the health educator if the information presented during the talk was not completely accurate or if it needed to be simplified. As a result, the health workers seem to be taking the preparation of these talks more seriously, and their communication skills are improving constantly. Quality health education and community involvement seem to be joining hands as part of the Ruashi experience.

Institutionalization is often going to be slow if it is really going to take root. Results may not be seen for months if not years later, requiring at times some important shifts in evaluation strategies. Washington may not always be at ease with "invisible" activities such as training and helping counterparts develop self-confidence and management skills--skills which are critical for institutionalization purposes--because there is really nothing to count and no way to measure immediate results. It is very hard to work on institutionalization issues within a two-year framework when one is starting from rock bottom as was the case in the Shaba region in Zaire.

## B. PROJECTED NEW SITES

Activities are described below for two countries, Mali and Senegal, in which HEALTHCOM anticipates beginning new country programs during the next reporting period.

I. <u>MALI</u>	<u>Period: October 1, 1989-September 30, 1990</u>
Child Survival Focus:	Immunization, diarrheal disease control, nutrition, family planning
Collaborating A.I.D. Projects:	IFAHS (Integrated Family Health Services Project), PRITECH, Nutrition Communication Project
Collaborating Donor Agencies:	CARE, Africare, World Vision (for nutrition component)
Primary Institutions:	DSF (Division Santé Familiale) of the Ministry of Public Health
Resident Advisor:	Mr. Soulimane Baro from Burkina Faso has been selected and approved by the Ministry of Health and the USAID Mission. His contract will be signed when funding for the project has cleared A.I.D./Washington Contracts Office. Mr. Baro currently heads UNICEF's child survival communication program in Burkina Faso.
Consultants:	
Soulimane Baro	July 13-15, 1990: Interviewed by the Ministry of Health, USAID, and Chief of Party, IFAHS.

## PROJECT SUMMARY

The HEALTHCOM Project in Mali grew out of several years of short-term technical assistance to the Division Santé Familiale (DSF) in nutrition-related IEC provided by the A.I.D. Nutrition Communication Project, also managed by AED. Long-term technical assistance in communication was eventually judged better served through a more general child survival project. HEALTHCOM was therefore brought into these activities beginning in the spring of 1990.

HEALTHCOM in Mali will be the health communication component of a larger mission-ministry bilateral child survival project called IFAHS (Integrated Family Health Services Project). Through the work of a long-term resident advisor, the HEALTHCOM Project will collaborate with the Division of Family Health (DSF) in the Ministry of Public Health (MSP). Mr. Soulimane Baro of Burkina Faso and previously UNICEF officer

there, has been approved by all parties to become the resident advisor. Project goals in Mali will be to:

- provide technical assistance in IEC related to immunization, nutrition, oral rehydration, and family planning in the IFAHS Project zones and on a national level;
- assist the Division of Family Health (DSF) to conceive, plan, execute, and evaluate an IEC operations program for family health;
- assist the national supervisor for IEC/MCH and report regularly to the head of the DSF concerning program status, problems, and time constraints.

The budget for an 18-month HEALTHCOM Project was approved by the director of the DSF. The mission sent the PIO/T to A.I.D./Washington Contracts Office in August, 1990, for final approval.

## ACTIVITIES PLANNED

Anticipated project start-up is before the end of 1990, pending final approval by the Contracts Office of the submitted PIO/T. Principal activities during the next project period will be to:

- field resident advisor and set up HEALTHCOM office in Bamako;
- orient resident advisor in Washington;
- help to facilitate IEC workshop (specifically for nutrition) scheduled for December, 1990, in Bamako;
- collaborate with the Nutrition Communication Project on KAP and related formative research on infant feeding practices during diarrheal episodes.

## 2. SENEGAL

Period: October 1, 1989 - September 30, 1990

Child Survival Activities Focus:

Immunization, Diarrheal Disease Control, MCH/Family Planning

Collaborating A.I.D. Projects:

PRITECH, ISTI

Collaborating Donor Agencies:

UNICEF

Primary Institution:

Service d'Education Pour la Santé (SEPS) in the Ministère de la Santé Publique et Action Sociale

Collaborating Institutions:

ASBEF (Family Planning PVO), Peace Corps

## Consultants:

Mark Rasmuson  
Judy Graeff

June 11-22 1990: Conducted needs assessment; assisted project planning.

## PROJECT SUMMARY:

Contact with the Ministry of Public Health in Senegal began with a HEALTHCOM-conducted needs assessment in the spring of 1990. HEALTHCOM anticipates working with the Service d'Education Pour la Santé (SEPS) of the Ministère de la Santé Publique et Action Sociale (Ministry of Public Health). The PIO/T has been sent to the A.I.D./Washington Contracts Office. The following are the broad program components proposed by the HEALTHCOM team to strengthen the capacity of the Ministry of Public Health in IEC capacities over a two-year period:

### National Level

- development of a national health and family planning communication policy;
- development of a long-term (e.g., five-year) national health and family planning communication plan;
- training of national health communication personnel in key IEC skills (especially research and evaluation, planning, management);
- development of an IEC curriculum for health training institutions;
- development of communication materials, especially film and video, documenting successful public health communication services.

### Regional Level

- IEC training for health education personnel from ten regions;
- development of comprehensive regional IEC plans for four regions;
- development of IEC materials for four regions;
- support to the integration of health and family planning services in private sector institutions (both voluntary and commercial) in four regions;
- intensive technical support to the implementation and evaluation of at least one regional IEC program.

## PLANNED ACTIVITIES

Upon approval of funding from the A.I.D. Washington Contracts Office, a resident advisor will be finalized and fielded in Dakar. Early in the project, she or he will receive an orientation to HEALTHCOM/AED in Washington, DC.

## C. OTHER COUNTRY ACTIVITIES

### 1. Mexico

In March 1990 Dr. William A. Smith made an assessment trip to Mexico to analyze possibilities for HEALTHCOM II assistance. At that time, he found that the focus was shifting toward a rural strategy with an emphasis on ORS. He presented recommendations to the USAID mission, which included supporting the MOH rural strategy by creating materials and developing point-of-purchase support materials to strengthen the rural outlets of CONASUPO (government supermarkets).

Dr. Smith and Dr. Peter Spain (PRITECH) made a follow-up visit to Tabasco in July 1990 to design a rural communication component which would add to the PRITECH training and service-delivery intervention already planned. Smith and Spain observed Mexico's Cine Rural (Rural Cinema) and met with CICLOPE, a group that is already training rural health center staffs. Together, CICLOPE, PRITECH, and HEALTHCOM II have designed a rural strategy for training health workers throughout Mexico. A contract between the three groups is pending.

### 2. Peru

HEALTHCOM has been working in Peru since 1985; specifically, providing planning assistance to the government and the USAID mission to expand and improve the use of communication in their Child Survival Program. In early 1990, HEALTHCOM was requested by USAID/Peru to send a team of communication consultants to perform an assessment of the health communication opportunities under the CSAP (Child Survival Action Plan) with special focus on identifying opportunities in the private sector. William Smith, Susan Saunders, and Eduardo Contreras-Budge went in June 1990 and Contreras-Budge made a follow-up visit in August 1990 to participate in the project's midterm evaluation. HEALTHCOM is recommending further technical assistance in developing a health communication strategy and initiating a regional pilot project in Cusco.

## D. HEALTH PRACTICE STUDIES

During this reporting period, data collection for ongoing behavioral studies in Indonesia, Lesotho, Nigeria, Zaire, and the Philippines was completed. Each study is in some phase of data analysis or preparation of the final report. Reports of all the studies will be available by the end of the next reporting period. A brief description of study progress is given below.

### 1. INDONESIA

Central Java: This study addressed directly what conditions (reinforcements) would help keep kader active and effective volunteer health workers/educators in their community. Presently, the dropout rate of kader is very high (reported up to 50 percent in the first year in some regions), calling into question the viability of using a cadre of volunteers as the vehicle for primary health care in Indonesia.

Phase I: Four trained observers divided into two teams observed kader activities in health posts in 11 villages, recording their treatment, weighing, and educational activities. They also conducted interviews with 44 kader on the nature of their work and what would motivate them to remain on the job. Twenty village officials and four health supervisors were also asked similar questions.

The most surprising finding was that from among a range of reinforcements, the most meaningful intervention from the kader point of view was to receive some recognition of their work from village leaders and the community in general.

Phase II: Based on the findings from Phase I, the HEALTHCOM Project designed radio spots to bolster the image of kader in the village and to inform mothers of this resource. Radio spots were aired over a three-month period in eight villages. Eight other villages were selected as controls. Kader activities were observed and mothers interviewed both before and after the spots were aired. Village chiefs were also interviewed.

Preliminary results (analysis not yet completed) indicate that the spots were affecting the general level of recognition of kader in the intervention villages, and more kader were giving health education sessions at health posts in intervention villages than in the control areas. The final report is being prepared for journal publication.

West Java: As part of its work with a diarrheal disease control project in West Java, HEALTHCOM worked with provincial staff to improve the training and performance of kader. The program developed a set of counseling cards for kader to guide them through diagnosis, treatment, and training of mothers in diarrhea and oral rehydration therapy. The program also designed a participatory training curriculum for kader which emphasized role playing with the counseling cards. The new training and the cards constituted the intervention for the health practice study. Performance of a small group of kader receiving the intervention and the mothers they subsequently counseled were compared to a control group of kader receiving the standard MOH training (and no counseling cards) and the mothers they contacted.

Mothers exposed to the teachings of each group of kader reported that while 84 percent of the control kader explained diarrhea, 100 percent of the kader with counseling cards did. Thirty percent of kader in the control group correctly followed the diagnostic

protocol for diarrhea compared to 81 percent of the kader using counseling cards. Fifty-two percent of the control kader discussed breastfeeding during diarrhea versus 80 percent of the intervention kader.

When mixing Oralit for observers, mothers trained by the kader using counseling cards performed individual mixing skills (e.g., used correct glass, stirred with a spoon) significantly more often than mothers trained by traditionally trained kader. A detailed report of findings such as these has been written for publication.

## 2. LESOTHO

The study in Lesotho aimed to replicate, on a larger scale and in a different culture, the pilot study done in Mexico (described in Semiannual Reports No. 4 and 5) observing the quantity of oral rehydration solution (ORS) administered in the home by mothers.

From January to March 1990, 207 cases of diarrhea in children under three years old were followed up in the home after presenting at one of three hospitals in or near Maseru, the capital. Six trained observers interviewed mothers in the ORT corner of the hospital where the mother learned to mix ORS, and after rehydrating her child with diarrhea. Each mother was given a bottle of solution and instructions to give the entire bottle over the next 24 hours.

As in the Mexico study, an observer went to the home 24 hours later to interview the mother and to measure the amount of ORS remaining. Preliminary findings are that the volume given was fairly constant across age groups so that the amount per weight of child goes down with increasing age of the child. More solution however, was given to children considered moderately dehydrated than those mildly dehydrated. The direct measurement of solution also proved to be a viable and accurate method for assessing mothers' practices.

## 3. NIGERIA

### Study II:

A small-scale clinic-based study in Niger State attempted to explore whether personalized face-to-face health communication and improved clinic procedures can affect a mother's decision to complete the childhood immunization series during the first year of a child's life. In addition, six months into the study, mothers from one intervention clinic who had fallen behind in their visits were traced to their homes in an outreach effort by clinic personnel. Both they and their husbands were interviewed. Two intervention and one control clinic were selected where 20 mothers, each with a qualifying child, were followed for 12 months to see how many times they returned to the clinic to have the child immunized.

More specifically, the present hypothesis is that, in addition to general social determinants, the immediate consequences to having a child vaccinated once will also strongly influence whether a woman returns regularly with her child to complete all five vaccinations. The study is therefore aiming to alter consequences to seeking vaccinations, such as: clinic processing of patients on immunization days; clarity of communication on EPI facts; quality of health worker/mother interaction; and, a father's (husband's) knowledge of EPI and his role in whether or not his wife continues to go to the clinic.

In order to effect the changes in the clinic procedure, clinic staff were assisted through focus groups in designing new ways to handle patient flow and to use EPI brochures and flipcharts more effectively in health education. Staff motivation and supervision are also included in the study to support clinic personnel's new practices.

Statewide mass immunization days unexpectedly disrupted normal immunization procedures and interfered with reliable recording of vaccination visits as well as other study data, putting many results from the study into question. Nevertheless, the intervention clinics appear to have faithfully carried out the new procedures in patient flow and education, and the return rates recorded are higher than that of the control clinic. These process results will be incorporated into the report of the first behavioral study done in Niger State (described in Semiannual Reports No. 7 and 8) because they address many issues that the first study left unanswered.

#### 4. PHILIPPINES

Researchers completed data collection in the clinic-based observational study on acute respiratory infection (ARI) symptom recognition in June 1989. The study design and preliminary findings were described in Semiannual Reports No. 6 and 7, respectively. Currently, the U.S.-based consultant, the Manila-based collaborator (Kabilikat), and the HEALTHCOM staff are preparing a final report for publication and for the Ministry of Health's use.

#### 5. ZAIRE

The purpose of the study in Zaire was three-fold: to measure the impact of information, education, and communication (IEC) training on health workers' interpersonal communication skills; to measure the effectiveness of a TOT approach in interpersonal communication skills and planning on supervisors' ability to train health workers; and to demonstrate the use of observational data as a planning guide for trainers and as a viable feedback mechanism to both trainers and trainees.

In May, 1989, the HEALTHCOM Project in Zaire conducted a three-week comprehensive training of trainers (TOT) workshop for clinic supervisors in two health zones on IEC and interpersonal communication. The training included skills and practice in conducting effective interpersonal communication sessions as well as broader skills in conducting formative research, preparing and pretesting consumer-appropriate health messages, designing zonal-level action plans in health communication, and designing and conducting interpersonal communication workshops with clinic-level health workers.

Fifteen clinic workers and supervisors from a HEALTHCOM pilot health zone and three chief medical officers were among the participants in this training. In the zonal action plan for IEC activities that they developed as one of the workshop exercises, they included training in communication techniques for health educators under their supervision.

To help in this effort, researchers designed an observational instrument which included checklists of critical topics to cover in health talks on immunization and diarrheal disease control as well as what teaching techniques would foster maximum participation and learning among mothers. The instrument also included general questions on the health worker and under what conditions the talks were given. Three observers and a coordinator were trained to use the instrument to a high degree of reliability.

During the pre-training baseline period (October–November 1989) health worker talks on either immunization or diarrheal disease control were observed up to three times. The research coordinator compiled the data and shared the results with the zonal supervisors to aide in their planning of the upcoming training workshops. This feedback identified what health information each health worker gave correctly/incorrectly/not at all and what teaching methods he/she used or did not use. Health workers were trained in February 1990 in groups of 13 or 14 each during two, two-week sessions. Following training, observers again visited the health workers in their clinics up to three times (March–May) to record their performance during educational sessions using the same observational instrument as in baseline.

Data were compiled and presented in July to the clinic supervisors (the trainers). In general, scores from the checklist revealed little or no improvement in performance after training. Observers noted that while many health workers were initially enthusiastic after training in giving their talks, they became less so as the months went by, and some even avoided being observed.

At a diploma award ceremony given by the HEALTHCOM Project at the end of July, the health workers were given an individualized feedback form attached to their diploma. It listed their behaviors to be commended and those to be improved during health talks. The health workers were surprised and pleased to get the feedback, especially since it was individually tailored to their own performance.

It is hoped, in the second phase of HEALTHCOM in Zaire to begin in early 1991, that structured observations can continue as supervisors address issues affecting improvements in the communication performance of clinic level health workers.

## **E. APPLIED RESEARCH ACTIVITIES—HEALTHCOM II**

The HEALTHCOM II contract calls for a separate, centrally funded activity to address the more global, methodological issues across countries and to guide: the refinement of the communication methodology for application and adaptation; the institutionalization of communication methods within the public and private sectors; and the sustainability of behavior changes over time. This global research activity will comprise both further analysis of data collected under HEALTHCOM I and some new data collection.

The global research program is coordinated by the Senior Technical Director for Research, Dr. Alan Andreasen, and carried out under a subcontract with the Center for International, Health, and Development Communication at the Annenberg School for Communication, University of Pennsylvania.

In addition, HEALTHCOM shall continue to collect and analyze data from the communication activities in Honduras, including analysis of long-term behavior change. These activities are carried out under a subcontract with Applied Communication Technology.

Under the global research component of the project, HEALTHCOM will answer key questions that have particular relevance for the future of health communication programs, such as:

1. What do mothers know and why do they believe and act as they do regarding their children's health?
2. What influences and changes mothers' behaviors?
3. How do changes become recurrent--timely, correct, and habitual?
4. How do the community context and interpersonal health networks affect mothers' behavior to ensure adoption of desired health practices?
5. In what ways can the communication approach be refined so that it can be adapted by LDC institutions in an environment of scarce resources? What can reasonably be simplified within the communication methodology while still maintaining appropriate quality and impact standards? How best can the communication methodology apply across a range of child survival interventions in many different settings?
6. What is the optimum mix of communication channels (face-to-face, print, broadcast media, folk/traditional)?
7. What level of evaluation capability can be institutionalized within a country?
8. Can communication approaches be systematically applied to train health providers?
9. What incentives can be built into a program to motivate and sustain the active involvement of health communication staff?

10. What are the minimum essential elements of an effective formative research program?
11. How can the demand that is created by an effective communication program be met with an appropriate and sufficient supply?

## **1. Meetings of the Task Force on Research and Technical Advisory Group**

On December 18-19, 1989, HEALTHCOM held a Research Task Force meeting to discuss the current state of the evaluation program as well as questions developed for the new HEALTHCOM II research agenda. Participants included HEALTHCOM staff, including the new Senior Technical Director for Research, and representatives from A.I.D./Washington and other A.I.D. projects, the Annenberg School for Communication, Applied Communication Technology, Birch and Davis International, and Porter Novelli. The Task Force discussed the overall global research agenda, an overview of key findings to date, an overview of other projects' research, cost effectiveness issues, measuring of campaign effects, evaluation of health worker training, HEALTHCOM's formative research program, models of behavior change, and approaches to segmentation analysis. (Task Force Summary Report is included as Appendix A.)

On January 26, 1990, a combined HEALTHCOM I and HEALTHCOM II Technical Advisory Group met, focusing its attention on the project's global research agenda. Participants included representatives from A.I.D./Washington, other A.I.D. projects, HEALTHCOM collaborating organizations, and outside experts in the fields of health communication, evaluation research, anthropology, behavior analysis, and so forth. Major sessions included a review and discussion of the global research agenda prepared by the Research Task Force, process and impact studies, cost studies, formative research, and a review of technical/methodological issues (including targeting versus integration and institutionalization strategies.) (TAG Report Summary is included as Appendix B.)

## **2. Global Research Plan**

The Task Force on Research and the Technical Advisory Group Meeting provided input into a global research plan, drafted by Annenberg. The major substance of the plan is described below.

The focus of Annenberg's activities under HEALTHCOM II will be on making use of available data for cross-site generalization. Annenberg will prepare reports or articles on a number of areas which will address the specific "major questions" described in the beginning of this section. There will be at least one 25-50 page report in each area, or, alternatively, more than one focused report or published article. As work is initiated in a particular reporting area, Annenberg will develop a specific paper outline detailing the research questions that will be answered, the possible policy implications, the data sets that will be used, and the schedule for completion. This outline will be reviewed with the Senior Technical Director for Research and others at AED; suggestions for additions or modifications will be given full consideration. The areas to be investigated (followed by numbers corresponding to each of the above questions they are designed to address) are:

- What is the success of alternative ways of doing communication for diarrheal disease control? For at least six sites (Ecuador, Swaziland, Lesotho, West Java, Central Java, Guatemala) we have, or will have, data about the effects of communication interventions as well as narrative descriptions of the interventions. By contrasting contexts, strategies, and effects, we should be able to enrich our understanding of how best to do communication for diarrheal disease control. This report will deal with such basic questions as: should one do communication at all; what can one expect it to accomplish? (Questions 1, 2, 5, 6, 8, and 10.)
- What is the success of alternative ways of doing communication for EPI? For five sites, (Ecuador, Peru, Lesotho, Guatemala, Philippines) we have, or will have, data about the effects of one or more EPI communication programs as well as narratives about the nature of the interventions. Insofar as the programs represent different strategies (intense pulses, multiple vaccination days, routine service, social mobilization campaigns), we will be able to compare both short-term and long-term outcomes and make some judgments as to the most promising directions for incorporating communication into EPI programs. This report will deal with such basic questions as: should one do communication at all? (Questions 1, 2, 5, 6, 8, and 10.)
- What is the nature of ORT behavior after communication interventions? ORT programs advocate a range of specific behaviors--home fluids, feeding, ORS use--each of which has sometimes been studied as a "yes" or "no" behavior. Yet clearly each is a complex behavior if it is to be performed adequately, including such elements as the nature of preparation and administration as well as quantities of ORS given, which home fluids are added, and which reduced or eliminated, the details of eating behavior, and so forth. If new behaviors are adopted, some other behaviors may be replaced (for good or bad). Some new behavior may persist for individuals and spread to others in a community. Other behavior may be given a single trial, or be used only sporadically. Many of our studies incorporate measures of the details of CDD behaviors. This report would ask how successful programs are in achieving not just increased tendency to do a new behavior, but increased probability of doing it productively, across sites. (Questions 1, 2, and 3.)
- Who responds to diarrheal disease control communication programs? Before the launch of communication programs, appropriate behavior is not equally likely among all segments of the population. There may be different rates of use related to socioeconomic circumstance, distance from health facilities, family structure, educational background, perception of child's illness, and other characteristics of individuals and their communities. To what extent is there a consistent pattern of reduction or exacerbation of such differences as a function of communication programs, across sites? Does the approach of the communication program produce different gap opening or closing effects? (Questions 1, 2, and 4.)

- Who responds to EPI programs? Before the launch of communication programs, appropriate behavior is not equally likely among all segments of the population. There may be inequalities related to socioeconomic circumstance, distance from health facilities, family structure, educational background, and other characteristics of individuals and their communities. To what extent is there a consistent pattern of reduction or exacerbation of such inequalities as a function of communication programs, across sites? Does the approach of the communication program produce different gap opening or closing effects? (Questions 1, 2, and 4.)
- What is the power of social context and individual explanations for CDD behavior before and after communication program? How can we best explain diarrheal disease control behaviors? There are many typical models which theorists (and implicitly, practitioners) use to try and influence behavior. While available data are stronger for some explanatory models than others, the report will contrast models as possible across sites and, in particular, compare their predictive power before and after communication interventions. Extra attention will be given to models which argue that behavior is largely a function of social expectations versus those that focus on individual cognitions. The report seeks to describe what assumptions about how behavior change occurs can be best used to construct communication programs. (Questions 2 and 4.)
- What is the power of social context and individual explanations for EPI behavior before and after communication programs? How can we best explain EPI behaviors? There are many typical models which theorists (and implicitly, practitioners) use to try and influence behavior. While data available is stronger for some explanatory models than others, the report will contrast models as possible across sites and, in particular, compare their predictive power before and after communication interventions. Extra attention will be given to models which argue that behavior is largely a function of social expectations versus those that focus on individual cognitions. The report seeks to describe what assumptions about how behavior change occurs can be best used to construct communication programs. (Questions 1, 2, and 4.)
- What are the independent and complementary roles of alternative channels in communication programs? Different channels may reach different numbers of people; they may be more or less difficult to organize at first and then maintain over time; they may influence individual and community behavior to a greater or lesser extent; they may have different costs. While none of the HEALTHCOM programs undertook controlled variation in their use of channels so as to gauge their relative utility, the evaluations do provide some descriptive and correlational evidence about this issue. Cross-site comparisons must be careful not to confuse the specifics of how a channel was used in a given context with an overall generalization about a channel. Nonetheless, there is likely to be much of practical relevance for the design of future campaigns from such a cross-site comparison. (Question 6.)

- Which message approaches work best? Some of the evaluations provide data about various types of knowledge and beliefs and their association with particular behaviors (both in CDD and EPI). This report area will examine changing associations between cognitions and behaviors before and after the introduction of communication interventions which focus on particular beliefs as the key to changed behavior. For example, it would ask how programs which emphasized one or another cue (like dehydration) to increase ORS use were able to realize both an increasing recognition of the symptom and a tendency to rely on that cue for changing treatment choice. Another issue would be the advantage or disadvantage of incorporating multiple themes in a particular program. (Questions 1 and 2.)
- How does one institutionalize health communication? This reporting area will make use of the narrative histories created for each project. Under what conditions does serious health communication become part of what the MOH does? How has it been organized? What organizational model promises to serve the short- and long-term needs of doing communication as part of a public health program? What skills are most essential to initiating a program and to maintaining it: communication design, management, research? How much research is feasible and where should it be directed? What is the cost of doing it and who pays for it? (Questions 5, 7, 9, and 10.)
- What have we learned about doing research and evaluation in health communication programs? Making use of cross-site data, individual reports, and articles, we will address such issues as: measurement of CDD and EPI behavior, sample design effects, approaches to separating community and individual influences on behavior, approaches to sorting out channel effects, and qualitative and quantitative research strategies for communication program design. (Question 10.)
- What have we learned about affecting the behavior of health personnel (paid and volunteer)? In Indonesia, Lesotho, and the Philippines, we have or will have data from surveys and/or observations of health personnel. In Indonesia and the Philippines, the health worker data are matched to the caretakers' surveys. In all sites we have data from caretakers describing the actions taken by the health system. These data will permit us to see how healthworker or local health volunteer behavior has changed in response to training efforts and how those changes are related to changes in practices among caretakers. These analyses will allow us to describe the complementarity between changes in the health delivery system and direct them to audience communication efforts. (Questions 4, 6, and 8.)
- What do we know about the maintenance of behavior change? This issue has two elements. One asks about how often first trial (of ORS, for example) becomes continuing behavior. A separate issue is what happens to behavior after the major communication efforts are stopped, either after a short campaign or after an extended program. The existing Annenberg data sets mostly involve two waves to data collection with the second wave collected soon after the end

of the campaign. They are not useful for examining extended effects. One exception is the Philippines where four rounds of data from Manila about immunization practice were collected. Between the second and third rounds of data collection there was a period of more than one year without intensive communication efforts, which will permit the estimation of a no-campaign fall-off. (Question 3.)

## C. DIFFUSION ACTIVITIES

### I. Communication Seminars

**HEALTHCOM II Kick-Off Meeting:** On October 13, 1989, HEALTHCOM organized a kick-off meeting for the HEALTHCOM II Project, bringing together officers from S&T/Health, the regional bureaus, other A.I.D. offices, the program's subcontractors, and staff from other A.I.D. child survival programs. The participants reviewed A.I.D.'s support for health communication, the HEALTHCOM II scope of work, and the staff pattern for the new program. Some of the findings and issues identified by HEALTHCOM I research were briefly discussed. HEALTHCOM I research has also identified several methodological approaches which improve data collection and reliability.

A discussion on future challenges for health communicators identified the need to develop a standardized and affordable set of minimal research protocols with modules for each major child survival intervention. This would enhance the sustainability of the research component with limited MOH resources. Interpersonal channels need to be rejuvenated by more participatory training techniques, increased use of traditional media, creative incentive systems for health volunteers, and more community-controlled service delivery activities. More attention also has to be given to market segmentation, especially to the non-adopters, and to private sector participation. The importance of coordinating service delivery with demand creation and post-launch pulsing to sustain compliance at a lower cost was also noted.

Group discussion also took place on strategies for integrating A.I.D.'s health communication efforts with other child survival projects and linking community efforts with mass media interventions.

**A.I.D. Communication Cluster:** On September 14, 1990, Mark Rasmuson and William Smith met with the Communication Cluster Group within the Bureau for Science and Technology and presented major lessons learned from HEALTHCOM's experiences. The presentations focused on the evolution of health communication methodology towards the present concept of integrated marketing communication, and on opportunities and constraints vis-a-vis integration of health messages and institutionalization of communication methods.

**A.I.D. Workshop:** On July 9-11, 1990, Caby Verzosa gave a presentation at A.I.D.'s workshop on "Rapid, Low-Cost Data Collection Methods." The presentation described the use of focus groups to develop feeding messages in Nigeria.

### 2. Faculty Workshop

**Faculty Workshop:** HEALTHCOM held a three-day Faculty Strategy Session at the Academy for Educational Development in Washington, DC, on June 25-27, 1990. The purpose of the strategy session was to discuss curriculum needs in health communication and ways to strengthen resources, curricula, teaching, and related practical experience in the teaching of future health and communication practitioners. The meeting also served as a work group for developing follow-up ideas with participants.

HEALTHCOM's Strategy Session followed a three-week seminar at The Johns Hopkins University, Population Communication Services, entitled "Advances in Family Health Communication." The JHU event was attended by a select group of high-level

decision makers and program managers from a number of countries who explored essential elements of successful communication programs in family planning and health.

HEALTHCOM sponsored two participants to the Baltimore seminar--Ms. Magda Fischer of INCAP/Guatemala, and Dr. Florence Tadiar of the University of the Philippines, School of Public Health. Mr. Bill Brieger, representing ARHEC/Nigeria, joined these participants in attending the HEALTHCOM meeting. INCAP, UP, and ARHEC are viewed by HEALTHCOM as potential partners in the development of regional training programs, with the assistance of JHU, which is working under subcontract to AED. Also joining the group were Dr. Alberta Jacoby of Yale University School of Public Health, and Dr. Royal Colle, Professor and Chair of Communications, Cornell University. Dr. Phyllis Piotrow and Dr. Ben Lozare represented JHU at the HEALTHCOM workshop.

### 3. LDC Workshops

**Indonesia:** HEALTHCOM/Indonesia staff and counterparts from the Community Health Education Department organized and ran a three-day workshop on "Improving Communications Research and Strategy Design for Child Survival," as an addition to a national conference of epidemiologists hosted by the Indonesian Epidemiological Network (JEN) and the Ford Foundation in Semarang, Indonesia, from November 16-18, 1989. The workshop focused on ways of combining epidemiological research data with consumer research data to design a richer communication intervention. The majority of the 27 participants were physicians, including at least one representative from each of the 12 national JEN centers. They were joined by the Health Department counterparts. The participants actively engaged in small- and large-group discussions related to topics such as social marketing theory, the marketing cycle, types of research needed by communicators, and the role of epidemiological data in communication planning. In the process, the participants developed a draft communication research strategy for a breastfeeding intervention.

**Nigeria:** In March, 1990, 20 vaccinators and 20 screeners from each Local Government Area attended a one-week workshop designed to update vaccination techniques and strengthen communication skills. Effective interpersonal communication skills were taught through role playing and supervised field work. The HEALTHCOM resident advisor was the leader of the training team.

**Nigeria:** In May, HEALTHCOM completed a series of workshops in Rafi and Suleja Local Government Areas, Niger State, to prepare MOH staff, community leaders, and school teachers to participate in a PHC health communication intervention. Measles and malaria campaigns will be simultaneously conducted in the two LGAs. A variety of communication channels (including mass media) will be used to deliver and reinforce consistent messages to caregivers.

**Philippines:** In the Philippines, HEALTHCOM sponsored a series of seminars on social marketing with the Department of Health. The first was held January 22-26, 1990, and assisted by Mary Debus of Porter/Novelli. Health educators from the 13 administrative regions of the Philippines participated in the seminar, which provided participants with an understanding of social marketing and its applications to public health issues. A second workshop was held May 15-21, with resident advisor Hernandez as main resource person and with assistance in several sessions from HEALTHCOM, PIHES, and Well Advertising Agency staff. A third workshop was held in July, 1990.

**Philippines:** From March 19-23, 1990, a workshop on face-to-face communication was held at health centers in Zamboanga City. All health education advisors and public information officers participated. A HEALTHCOM team assisted as facilitators and resource persons. Workshop goals were to: provide participants with a sense of the history of health education in the DOH; describe the current status of interpersonal communication at health centers; explain principles and processes of interpersonal communication; and describe goals, roles, and tasks of various levels of health education personnel in support of effective interpersonal communication at health centers. The HEALTHCOM team provided technical assistance in producing films to be used as learning aids, developed a workshop evaluation instrument, and identified and briefed outside resource people.

**Zaire:** HEALTHCOM consultant Gilberte Vansintejan assisted in designing and carrying out nursing instructors' workshops for participants from the 16 medical technical schools for Shaba on communication skills and curriculum development, particularly on how to conduct health communication and how to design courses/curricula around health communication. The first two of the two-week workshops were held in late February and early April. Vansintejan worked with one nursing faculty member and one representative from SANRU to plan and co-facilitate the workshops. Extensive post-training observations were conducted of the Ruashi health workers.

**Zaire:** In April of 1990 the first group of Maman Tengeneza, or village volunteer health workers, received training in such topics as nutrition, vaccinations, and diarrheal disease control. They also began doing home visits which proved to be especially helpful in providing nutrition advice to mothers and in getting children vaccinated when mothers were unable to bring a child to the health center. The success of the program led to interest from many groups such as the Salvation Army, the University of Lubumbashi, and UNICEF/Kinshasa. Voix du Zaire aired three radio and one television show during July focusing on the volunteers. By the end of that month, 40 Maman Tengeneza in Ruashi health zone had received five days of basic training in PHC subjects and outreach work. The IEC team expressed interest in expanding the program to 120 women over the next year and also considered financing the effort by setting up a sort of soya flour cooperative and nutrition/health education center to be run by the Maman Tengeneza with aid from UNICEF/Kinshasa.

**Zaire:** HEALTHCOM conducted a workshop the first two weeks of June in Lubumbashi to develop broadcast media support for the vaccination acceleration campaign scheduled for late July, August, and September. The workshop was conducted with assistance from HEALTHCOM's resident advisor from Lesotho, Ed Douglass. More than ten Voix de Zaire and television personnel and Ruashi Health Zone supervisors participated. Recording equipment to accomplish field work during the workshop was hand-carried from Washington, DC. The workshop participants also had full access to the Voix de Zaire radio studio. During the two weeks, participants developed approximately 25 EPI messages--based on formative research conducted by HEALTHCOM--to support the immunization acceleration campaign. Mothers in Ruashi wrote a song about immunization that recited the immunization calendar. Workshop participants recorded the song in several different versions for use as stand-alone radio spots and as background music for radio spots and television programs.

#### 4. Publications and Reports

**Semiannual Report:** "HEALTHCOM Semiannual Report No. 8: April 1, 1989 - September 30, 1989" was completed, submitted to A.I.D., and approved for distribution.

**Work Plan:** "HEALTHCOM II Year I Work Plan" was submitted to A.I.D. and approved.

**Meeting Reports:** Summary reports of the HEALTHCOM Task Force on Research, held December 18-19, 1989, and of the HEALTHCOM Technical Advisory Group Meeting, held January 26, 1990, were submitted to A.I.D. for review and approved for distribution.

**Implementation Plan:** The Zaire Implementation Plan was finalized and approved.

**Special Reports:** Managing a Communication Program on Immunization: A Decision-Making Guide, was prepared jointly by the HEALTHCOM Project and the Department of Health, Republic of the Philippines. Authors include Cecilia Cabañero-Verzosa, Marietta G. Bernaje, Eleanora M. De Guzman, José Rafael S. Hernandez, Carmencita N. Reodica, and Mario M. Taguiwalo. The special report was published in December of 1989.

William Smith, Senior Technical Director for Research, wrote a special report entitled, Consumer Demand and Satisfaction: The Hidden Key to Successful Privatization.

In addition, Communication for Child Survival, previously translated into French and Spanish, has also been translated and reproduced in Bahasa Indonesia. The English version was used in a USAID-sponsored workshop for staff members and local NGOs in Jakarta, Indonesia, in September 1989. The NGO participants strongly recommended that the manual be translated into Indonesia's national language and that a social marketing association be developed. Several participants and training staff subsequently joined together to form the Centre for Social Marketing and to voluntarily contribute their time to translate the HEALTHCOM manual.

**Health Practice Studies:** Several health practice studies have been drafted or published during the reporting period. These include:

- "How Much ORS Solution is Actually Administered During Home Based Therapy?" Paul E. Touchette, John Elder, Moises Naigel. Journal of Tropical Medicine and Hygiene. London. 1990. 93, 28-34.
- "Immunization Education in Nigeria: Evaluation and Improvement of a Clinic Program." E. Scott Geller, Gelen R. Lehman, Judith A. Graeff, Mark R. Rasmuson. (Submitted for publication.)
- "A Behavior Analysis Approach to Acute Respiratory Infection (ARI) in Honduras." John Elder, Peter Boddy, Patricio Barriga, Ana Lucila Aguilar, Hector Espinal. (Submitted for publication.)

**Field Notes:** HEALTHCOM staff, subcontractors, consultants, and others are drafting, or have already submitted, a number of field notes. Among these are:

- "The First Step in Sustainability: Participatory Project Management," by Joan Schubert.

- "Strategy in Focus: Development of a New ORS Product Identity for Mexico," by Mary Debus, et al.
- "The Medium and the Message: Culturally Appropriate Channels for Health Communication," by Elayne Clift.
- "Lessons in Creating a Communications Training Video for Health Workers," by Andrew Piller.
- "Launching a Social Marketing Project for Immunization in Metro Manila." Eleanora De Guzman, et al.
- "Breastfeeding Knowledge and Practices in Jordan: A Summary Report of the Results of the HEALTHCOM Baseline Survey," by Abulaban, McDivitt, Wilkins, Dusenbury, and Goksen-Erelcin.

**Articles and Papers:** HEALTHCOM staff, subcontractors, consultants, and others are drafting, or have already submitted, a number of papers and articles. Among these are:

- "Issues in Communication for Diarrheal Disease Control," by Hornik, Smith, and Rasmuson, prepared for The Johns Hopkins/UNICEF/WHO Conference on Home Management of Diarrheal Disease, April 15, 1990.
- "Using Focus Groups to Develop a Produce and Its Communication Program," by Caby Verzosa, Cecile Johnston, and Bode Kayode, prepared for the A.I.D. workshop on Rapid, Low-cost Data Collection Methods. July 1990.
- An article in French on research strategies and ethnomedical diagnosis of diarrheal disorders in Lubumbashi, by P. Stanley Yoder. (Accepted for publication in Ecologie humaine.)
- "Understanding Mothers' Knowledge and Behavior Related to the Treatment of Diarrhea in Young Children in West Java, Indonesia: Recommendations for Health Communication," by McDivitt and McDowell.
- "Child Spacing Knowledge and Practices in Jordan: A Summary of Report of the Results of the HEALTHCOM baseline survey," by McDivitt, Wilkins, and Abulaban.
- A report for the HEALTHCOM Kick-off Meeting: "What are we Learning from the Evaluation of the Communication for Child Survival Project?" by Robert Hornik.
- "Measuring the Success of Oral Rehydration Programs: Evidence from HEALTHCOM Surveys," by Zimicki, Koepke, and Hornik. (Submitted for publication.)

## 5. Conferences and Presentations:

Other HEALTHCOM conferences and presentations have included the following:

- October, 1989 HEALTHCOM staff and consultants participated in the annual American Public Health Association conference in Chicago. Mark Rasmuson made a presentation on communication to sustain health behaviors, Judy McDivitt and Chris Wilkins (Annenberg) presented data from HEALTHCOM/Jordan, and Renata Seidel and Elayne Clift presented a poster session.
- November, 1989 Patricio Barriga, resident advisor in Honduras, attended the PAHO Regional Conference on social participation, held in Barbados.
- November, 1989 P. Stanley Yoder (Annenberg) presented the results of the baseline survey done in Lubumbashi, Zaire, to a group of physicians and researchers in Kinshasa and Lubumbashi.
- November, 1989 P. Stanley Yoder presented "Ethnomedical Diagnosis of Diarrheal Disorders and Choice of Treatment in Lubumbashi, Zaire" at the Annual Meeting of the American Anthropological Association in Washington, DC.
- November, 1989 Tom Reis, resident advisor in Central Java, Indonesia, was the keynote speaker at the Indonesian Epidemiology Network (JEN) social marketing workshop.
- December, 1989 Patricio Barriga, resident advisor in Honduras, presented ARI ethnographic research and multiple baseline findings to 120 participants at the Third International Congress on Traditional Medicine, organized by PAHO, the MOH, EDUCSA (local PVO), and the School of Medicine.
- January, 1990 William A. Smith gave a presentation at the meeting on "Eliminating Neonatal Tetanus: Issues and Future Directions," sponsored by USAID through REACH and MotherCare. Susan Zimicki (Annenberg) provided additional analyses of Philippines data to William Smith for his presentation
- January, 1990 Susan Zimicki gave a presentation at the Harvard School of Public Health about the vaccination campaign in the Philippines.
- February 8, 1990 Robert Hornik (Annenberg) gave a talk to the staff of the REACH Project on evaluation methods and results from immunization campaign evaluations.

- February 22-23, 1990 Elayne Clift gave a lecture on the HEALTHCOM methodology to graduate students at the Yale University School of Epidemiology and Public Health.
- March, 1990 Judith McDivitt (Annenberg) gave a lecture at the University of Diponegoro, Central Java, Indonesia, on evaluation methodology.
- March 7, 1990 Judith McDivitt made a presentation on "Current Methodological Issues in the Evaluation of Child Survival Programs" at the University of Diponegoro School of Medicine in Semarang, Central Java. Approximately thirty faculty members attended the lecture.
- April 2-6, 1990 Joan Schubert, resident advisor in Zaire, Edward Douglass, resident advisor in Lesotho, and Mark Rasmuson, project director, attended the Fifth Consultative Meeting of Africa Child Survival Initiative Combatting Childhood Communicable Diseases, held in Swaziland.
- April 15, 1990 Robert Hornik gave a presentation on "Issues in Communication for Diarrheal Disease Control" at The Johns Hopkins/UNICEF/WHO Conference on Home Management of Diarrheal Disease.
- April 24, 1990 Robert Hornik (Annenberg) spoke on "Communication and Child Survival" during Grand Rounds of the Pediatrics Department of the Albert Einstein Medical Center.
- April 25, 1990 Judy Graeff described HEALTHCOM's work on a radio health talk show on station WPFW/FM in Washington, DC. The topic was health behavior change issues in developing countries.
- May, 1990 Robert Hornik spoke on the subject, "What are we learning from the evaluation of the Communication for Child Survival Project?" at the International Communication Association Conference in Dublin.
- May 11, 1990 Judy Graeff made a presentation on "Health Communication in Developing Countries" at the Harvard School of Public Health's course on the use of mass media in health communication. Fifteen students attended the lecture.
- May 17, 1990 Robert Hornik (Annenberg) gave a presentation, "Fighting Disease Through Communication," at the University of Pennsylvania's 250th anniversary celebration.

- May 17, 1990 Mark Rasmuson made a presentation on "Health Communication Methodology" at a program for young African leaders sponsored by the U.S. Information Agency entitled "Public Health in the United States." The 17 participants included African physicians, nurses, and health care professionals; national and regional administrators; public health practitioners; and professors or community health educators.
- May, 1990 Ernie Hernandez, resident advisor in the Philippines, presented a session on "Social Marketing as a Strategy for Health Advocacy" at the WHO Western Pacific Regional Workshop on Advocacy for Health. Participants included physicians, health educators, and information officers from 19 countries.
- May 30-31, 1990 Mark Rasmuson gave a presentation on "What We Know About the Behavior Change Process" at the A.I.D. Cooperating Agencies Meeting in Arlington, VA.
- June, 1990 Ernie Hernandez, resident advisor in the Philippines, conducted a session on Advertising Campaign Creative Strategies at a training course on communication campaign planning organized by the UNDP in Metro Manila.
- August, 1990 Diane Urban gave a workshop in interpersonal communication at the International Health Education Symposium in Rio de Janeiro. The Director of the Health Education Department, MOH, Paraguay, spoke about the HEALTHCOM methodology and the development of breastfeeding materials for working mothers.
- August 3, 1990 Clarence S. Hall, Tony Agboola, and Idris Nagia made a presentation on "HEALTHCOM Methodology and the Niger State Malaria Control Campaign" at the Fourth Annual ARHEC/CCCD Workshop on Health Education Planning and Management in Oyo. The 40 participants included health education personnel from The Gambia, Swaziland, Zaire, and four states in Nigeria.

## 6. Videos

In PNG, Andrew Piller, resident advisor, worked with FirstTake, a private film-making company, to develop a 20-minute health communication training video entitled "Making Things Clear." Versions have been produced in English, Pidgin, and Tok Pisin. The video was first presented as part of a two-week WHO-sponsored CDD workshop for 35 health officers. HEALTHCOM was responsible for the communication skills component. Participants viewed the video and engaged in extended discussion about how health officers can use the video with the health workers they supervise in the provinces. Six hundred copies of the video have been produced for use throughout PNG. In addition, the video has been actively reproduced by the WHO regional office in Manila. It has been used in Laos, China, and Vietnam. In Laos, officials are dubbing on a

Laotian soundtrack and plan to produce a completely Lao version in the future.

## 7. Other

**In-Service Workshop:** In December of 1989 and January of 1990, HEALTHCOM conducted a series of in-service technical training meetings for staff members. Presentations/seminars were conducted on the subjects of diarrheal disease control, ARI, immunizations, malaria control, breastfeeding and child spacing, maternal health, waterborne diseases, and vector borne diseases. Numerous A.I.D. projects sent representatives to these meetings to provide state-of-the-art information and to exchange ideas with HEALTHCOM staff. The sessions were followed in March by a meeting for core staff and subcontractor personnel on administrative matters.

**Media Awards:** A number of HEALTHCOM media materials won prestigious awards during this reporting period.

In May of 1990, the Annual Indonesian Advertising Awards recognized the integrated child survival CDD campaign, assisted by HEALTHCOM, with a gold award for best use of Indonesian culture in an advertising campaign, and a bronze award in the best multi-media campaign category. The campaign--which includes training of community volunteers with specially designed and tested counseling cards, banners, bill boards, press, posters, leaflets, intensive radio messages and mobile films--uses imaginative local symbols and themes to support community involvement in diarrheal disease control. This is the first time a public sector campaign competed with leading commercial product advertisers in the competition.

In addition, several central office materials won recognition during this period. The HEALTHCOM Project received a second prize from the Academy for Health Services Marketing, a division of the American Marketing Association, in its "Flashes of Brilliance" competition, external publications category, for its manual, Communication for Child Survival, and an honorable mention for its video, "Partnership for Child Survival." The HEALTHCOM video also won awards in the John Muir Medical Film Festival and the Houston International Film Festival.

**Promotional slide/script:** Elayne Clift and Anne Roberts developed a comprehensive slide/script and overhead presentation on the HEALTHCOM methodology, to be used for introducing audiences to health communication theory and practice.

**Information:** The project continued to distribute a large number of reports which are in high demand, in particular the HEALTHCOM manual, the EPI manual, and French and Spanish versions of the special report on focus group research, by Mary Debus. During this reporting period requests for videos, in particular the HEALTHCOM methodology video, and "Making Things Clear," (developed in PNG) were also high. The project responds to daily requests for information from health professionals around the world.

**Regular Reporting:** Monthly reports have been prepared for subcontractors and collaborating institutions as well as for the AED report.

## **G. SUBCONTRACTOR ACTIVITIES**

### **I. The Annenberg School for Communication, University of Pennsylvania**

The Annenberg School for Communication remains a subcontractor to the Academy under the HEALTHCOM II Project, with a new scope of work. These activities described under the Section, APPLIED RESEARCH ACTIVITIES. Work under the HEALTHCOM I contract is described below.

During this reporting period data collection was completed for the final evaluations in Central Java, West Java, Jordan, and Lesotho. The preliminary results of those surveys were sent to Central Java, West Java, and Lesotho. Interviews for case study evaluations were completed for Papua New Guinea and the interviews for the institutionalization sections of the final evaluation reports were completed for Central Java, Jordan, and Lesotho. Analysis for the final evaluation is in process for six sites (Central Java, West Java, Ecuador, Papua New Guinea, and Lesotho). A number of papers, baseline reports, and presentations were completed during this time. In addition, CIHDC staff members attended two meetings for HEALTHCOM II. The purpose of one meeting was to discuss the research agenda, and the other was to clarify new administrative procedures.

**Ecuador:** Robert Hornik, Christopher Koepke, and Nancy Morris continued writing the final report of the PREMI evaluation. Data analysis for the final report continues, and will focus both on the evidence for behavior change and the evidence that the communication component was a substantial influence on that change.

**Guatemala:** Hornik spent a week in country in February to make plans for a follow-up survey. A revised evaluation plan was developed and a new survey instrument and sampling plan were defined. Agreement with INCAP to carry out the survey was signed, and Eduardo Contreras visited Guatemala to supervise the implementation of the survey. Training was completed and the field work was about to begin when USAID/Guatemala determined that, because of tension between USAID and the MOH, it should not proceed. Eventually the survey was cancelled. A subsequent decision to do a limited, narrative case study was also cancelled, when the Mission determined that further visits to Guatemala to do interviews were inappropriate.

#### **Indonesia:**

**Central Java:** The major activities in Central Java during this reporting period were carrying out the follow-up survey of knowledge and practices related to vitamin A and diarrhea and analyzing the data for preliminary reports and the final evaluation report. Data collection was carried out by Survey Research Indonesia in October. The data from this survey were received in Philadelphia in December, and Judith McDivitt began analysis immediately. McDivitt and Fatos Goksen-Erelcin continued analysis and reporting of results throughout this reporting period. In January, a report of preliminary results on vitamin A coverage was prepared at the request of Helen Keller International (HKI). Cleaned computer system files were sent to HEALTHCOM in Central Java in February. Final frequency distributions were sent to AED and to HEALTHCOM/Central Java in March. McDivitt was in country in March reviewing evaluation findings with project staff, giving a guest lecture on evaluation methodology at the University of Diponegoro, and completing interviews for the narrative history of the project. In August, she sent early drafts of sections of the final report to Indonesia at the request of HKI. Data analysis for the final report continues.

**West Java:** During this reporting period the follow-up survey was completed on knowledge and practices related to the treatment of diarrhea by mothers, health workers, health volunteers, and retailers. In March, drafts of the revised questionnaires were sent to Indonesia for review by government and project staff. McDivitt was in country in February and March to organize activities for the data collection which was carried out by Survey Research Indonesia from March 5 to mid-April. McDivitt and Goksen-Erelcin began analyzing the data from the follow-up survey in May, and McDivitt sent preliminary results from the West Java evaluation to HEALTHCOM/West Java. Further tables and text were sent to Indonesia in August for use during a government planning meeting. Cleaning and analysis of the data for the final evaluation report continues.

**Jordan:** The primary activity in Jordan during this reporting period has been the development and implementation of the follow-up survey on breastfeeding knowledge and practices. Planning for the survey began in March. In June, McDivitt sent a draft questionnaire to Jordan for comment and translation. She traveled to Jordan in July to provide technical assistance in questionnaire design, sampling, and interviewer training. During that trip, she also completed the interviews for the narrative history of the project. Data collection was completed in August, and Ayman Abulaban analyzed and reported on the data during September.

**Lesotho:** P. Stanley Yoder spent one week in country in November discussing the summative evaluation plan with personnel from the Ministry of Health and collecting materials diffused through HEALTHCOM messages. In January, Yoder completed the questionnaire to be used in the follow-up survey and remained in country in March to supervise survey activities. During that trip Yoder completed interviews to measure institutionalization of the program in Lesotho. In April Yoder, Dusenbury, and Zhong Zheng began preliminary analysis of the data from the follow-up survey. They completed a draft report of the analysis in May and sent copies of the report to AED and to HEALTHCOM officials in country. Yoder and Dusenbury also analyzed the results of a village health worker survey and sent a report of these findings to AED. They then began analysis for the final evaluation of the Lesotho project. The analysis continues to date.

**Nigeria:** In May Yoder wrote a work plan for the data collection to be done in Niger State by Dr. A. Oke.

**Papua New Guinea:** Susan Zimicki traveled to Papua New Guinea in May to gather information for the case study evaluation. She began writing the case study evaluation in June.

**Philippines:** In October Zimicki reviewed a manual on developing communication programs written by Caby Verzosa. Zimicki provided a series of short technical notes to HEALTHCOM/Philippines personnel on 1) the sample design for the proposed national diarrhea baseline survey; 2) the questionnaire for that survey; 3) methodologic issues of using 24-hour or longer recall periods when asking about treatment of diarrhea. She also provided detailed explanations for the analyses underlying the figures and tables included in the draft report "Result of the Manila Vaccination Campaign: Evidence from Surveys of Mothers." Zimicki finalized plans for the follow-up national mothers' survey and for the health center study and summative evaluation interviews while she was in country in June. (The health center study began in July.) In September, Zimicki spent four days in country interviewing persons from the government, USAID, and current and former HEALTHCOM project staff for the institutionalization section of the final report.

**Zaire:** Yoder was in country in October to discuss evaluation strategies with health care professionals there. In November Yoder presented the results of the baseline survey done in Lubumbashi to a group of physicians and researchers in Lubumbashi and another in Kinshasa. He also revised a series of questionnaires to be used by the SANRU Project in a study of community participation in ten health zones of Zaire. Yoder spent a week in country in February to observe health education talks in health centers in the Ruashi health zone.

### **World Health Organization Collaboration**

Annenberg continued its support of the social science research component of the WHO/CDD program in Geneva through an arrangement with the HEALTHCOM contract. During this period, Susan Zimicki consulted on breastfeeding activities in Ethiopia, Guatemala and Pakistan for the WHO Control of Diarrheal Disease Program (CDD) and worked with the Research Institute for Tropical Medicine (RITM) on evaluating the acceptability of different types of oral rehydration solutions in the Philippines.

**Ethiopia:** Zimicki was in country from November 26 to December 5, 1989, assisting MOH and MCH officials to develop a proposal for a situation analysis of breastfeeding in Ethiopia.

**Guatemala:** Zimicki met with staff of the Comision Nacional de Promocion de la Lactancia Maternal in Guatemala from February 5 to 14, 1990, to discuss breastfeeding research. Topics on the agenda included the feasibility of doing a case study of the national breastfeeding program, and the logistics involved in doing a data collection to evaluate certain aspects of the program.

**Pakistan:** Zimicki travelled to Islamabad from February 24 to March 10, 1990, to advise government officials on possible CDD breastfeeding activities and review available data sources on breastfeeding patterns and their determinants in Pakistan. She then traveled to Geneva from March 12 to 13, 1990, for a debriefing.

**The Philippines:** Zimicki worked with staff from the RITM in Manila during May 1990 and again for a week in August 1990 in developing and implementing a study to test the acceptability of different varieties of oral rehydration solutions, particularly a rice-based solution.

**Dissemination:** During this period, the ASC staff made a number of presentations of evaluation findings from specific countries and completed a number of papers. These are listed under the DIFFUSION Section of the report. Works in progress include:

- an article using data from both Lesotho surveys on the link between different types of knowledge of diarrhea and ORT and the use of ORT (Yoder and Zheng)
- a paper describing the levels of cluster effects observed in HEALTHCOM diarrhea and immunization surveys and examining some of their correlates (Ewbank)
- a special report on issues in evaluation (CIHDC staff)
- final evaluation reports for Central Java, West Java, Jordan, Lesotho, Ecuador, Papua New Guinea, and the Philippines (CIHDC staff)

## **2. Applied Communication Technology**

Applied Communication Technology remains a subcontractor to the Academy under the HEALTHCOM II contract. During this period ACT's President, Dr. Dennis Foote, participated in HEALTHCOM's Research Task Force and Technical Advisory Group meetings and played an important role in helping to define the project's global research agenda. Dr. Foote traveled to Honduras in May to present data from HEALTHCOM's 1987 resurvey of ORT practices and discuss interest in and timing of the follow-up surveys in Honduras proposed in the HEALTHCOM II contract. As HEALTHCOM's central funding was extremely tight during FY 1990, however, no further ACT evaluation activities took place in Honduras this year.

ACT also completed a number of research deliverables for HEALTHCOM during the year, including resurvey reports from Honduras and The Gambia, institutionalization studies from both countries, and a case study evaluation from Paraguay.

## **3. Birch and Davis International, Inc.**

Birch and Davis International, Inc., is a new subcontractor under the HEALTHCOM II Project. Birch and Davis participated in a series of meetings at the start of HEALTHCOM II to define the project's global research agenda, culminating in the December Task Force Meeting on Research. At these meetings, Birch and Davis staff (John Raleigh and Veronica Elliott) played the role of helping HEALTHCOM to think through the different types of cost studies the project might carry out and the complexity and political value of each. Potential cost studies range from comparatively simple accounting studies of the actual costs incurred in conducting a communication intervention to more complex studies which weigh costs against impact or benefits realized.

Subsequent to these initial meetings, Birch and Davis met further with HEALTHCOM staff to define concrete next steps on the cost studies. It was agreed that a series of meetings with staff from the different regional bureaus in A.I.D./Washington would be useful to assess bureau interest and priorities vis-a-vis communication cost studies, and that the best opportunities for cost studies in HEALTHCOM's current countries existed in Indonesia, Honduras, and Lesotho. Due to HEALTHCOM's central funding shortfall during FY 1990, however, implementation of these next steps had to be postponed indefinitely.

## **4. The Futures Group**

The Futures Group is a new subcontractor to the HEALTHCOM II Project. In addition to participating at project start-up and research planning meetings, the principal activity carried out by the Futures Group under HEALTHCOM II was the preparation of a concept paper on computer modeling of health communication cost effectiveness. The paper, prepared by Katrina Galway and other senior Futures Group staff, presents an approach for developing 1) a global model/presentation about health communication for child survival as an educational and promotional tool; and 2) a RAPID-type computer model of the costeffectiveness of health communication to be applied to individual countries.

## 5. The Johns Hopkins University

The Johns Hopkins University Center for Communication Programs (JHU/CCP) is a new subcontractor to the HEALTHCOM II Project, focusing primarily upon development of a health communication curriculum. During FY 1990 JHU/CCP has carried out the following activities.

**Recruitment:** The importance of a full-time employee to fulfill the objectives of the JHU subcontract were recognized from the beginning. JHU/CCP recruited for a Senior Health Communication Curriculum Advisor to strengthen the institutional capabilities of developing-country health and related training institutions in teaching, providing field support for, and evaluating health communication in population-based child survival programs. JHU/CCP ran advertisements for the position in the APHA journal, The Nation's Health, and reviewed many resumes for this position. The backgrounds represented by these individuals included work in Guatemala, Iran, Ghana, Nigeria, Thailand, and the Philippines, as well as the United States. Four candidates were brought to Baltimore and Washington for interviews with AED staff and Robert Clay at A.I.D. They were: Patricia O'Connor, Zohreh Zarnegar, Benjamin Lozare, and Kathleen Cash. Ultimately, insufficient core funding necessitated postponing filling this position until further notice, possibly within one year.

**Meetings:** On October 13, 1989, Phyllis Piotrow attended the HEALTHCOM II Kick-off Meeting at AED. On March 22, 1990, Phyllis Piotrow, Paul Bankerd, and Elizabeth DuVerlie attended the "In-service Education" meeting AED on management issues and on qualitative and quantitative research. In addition, on March 28, 1990, Phyllis Piotrow and Larry Kincaid attended the JHU Health Communication Curriculum Committee meeting to discuss expanded programs at The Johns Hopkins University.

**Workshops:** The JHU/CCP annual workshop, "Advances in Family Health Communication," held in Baltimore June 4-24, 1990, included two registrants nominated by the HEALTHCOM Project: Magda Fisher of INCAP/Guatemala and Florence Tadiar of the University of the Philippines School of Public Health. A third individual, Will Brieger from ARHEC/Nigeria, was unable to attend. Following the workshop, Phyllis Piotrow and Benjamin Lozare and Ms. Fischer, Dr. Tadiar, and Mr. Brieger participated in the three-day "HEALTHCOM Faculty Strategy Session" held at AED in Washington, June 25-27. Dr. Piotrow led a segment on "Institutional Perspectives on Curriculum Development." Plans were discussed to encourage a larger role for communication in the curriculum of schools of public health and other training institutions.

## 6. PATH

In Paraguay, PATH staff member Linda Bruce visited Paraguay to conduct an information, education, and communication (IEC) materials development workshop for staff of the regional Ministry of Health, Health Education Department (MOH/HED). This workshop was held as part of HEALTHCOM's breastfeeding support activities. The 21 workshop participants conducted focus group discussions with rural mothers to investigate knowledge and practice of breastfeeding. A drama, an audio cassette, and illustrations were developed and pretested with mothers in market places, clinic waiting rooms, mother's clubs, and bus terminals. The drama, in particular, was well received by mothers, which underscores the appropriateness of this traditional medium for the target area. The participants also formulated strategies to replicate these activities in their regions using local resources.

In addition, Path staff participated in the following HEALTHCOM related activities:

- PATH staff facilitated ongoing collaboration between Project SUPPORT and HEALTHCOM.
- PATH staff submitted a trip report to HEALTHCOM.
- PATH staff read trip reports, monthly status reports, memoranda, and other documents prepared by HEALTHCOM staff, consultants, and other subcontractors and provided feedback to HEALTHCOM.
- PATH staff submitted semiannual narrative and monthly financial reports to HEALTHCOM.

#### 7. Porter/Novelli (P/N)

Porter/Novelli remains a subcontractor to the Academy under the HEALTHCOM II Project. During this period, Porter/Novelli recruited and hired a market research specialist, Dr. Cecile Johnston, to become the Formative Research Coordinator for HEALTHCOM II. Dr. Johnston, who joined the HEALTHCOM team in October, 1989, participated in HEALTHCOM's December Task Force Meeting on Research, in which she presented a strategy for the new directions the project could take in formative research, including streamlining and counterpart training. She traveled to Indonesia that same month to assess the research being conducted at HEALTHCOM's sites in West and Central Java, and assist the West Java program in designing several pre-media campaign research efforts.

Dr. Johnston also coordinated the monthly meetings of HEALTHCOM's internal research group, which reviewed current research issues the project faced, and invited guest presentations from outside research professionals. She participated as well in the project's training group and produced a draft training module on formative research.

Due to a central funding shortfall which required HEALTHCOM to scale back a number of activities, the project requested Porter/Novelli to shift Dr. Johnston off HEALTHCOM activities and funding. This change took place in June 1990.

In addition to Cecile Johnston's participation, several other senior Porter/Novelli staff made significant contributions to HEALTHCOM. Mary Debus traveled to the Philippines in January to conduct a five-day workshop on social marketing and integrated marketing communications for senior PIHES staff, and Michael Ramah assisted HEALTHCOM in designing the next phase of the project's activities in Mexico.

## H. COLLABORATION WITH OTHER PROJECTS AND INSTITUTIONS

HEALTHCOM continues to work collaboratively with a wide variety of institutions--other A.I.D. projects, donors, and nongovernmental organizations. Highlights of these collaborative efforts during this reporting period include:

### I. Other A.I.D. Projects

HEALTHCOM invited representatives from a number of partner A.I.D. health projects to its Research Task Force Meeting in December and asked them to share their research objectives and activities. Representatives from the following projects sent representatives: REACH, MotherCare, PRICOR, PRITECH, and Financing and Sustainability. Subsequent to this meeting, follow-up meetings were held between HEALTHCOM's new Senior Technical Director for Research and representatives of the REACH and PRICOR projects to discuss research approaches in a more in-depth manner.

Following a presentation at PRITECH of the results of HEALTHCOM's behavioral studies, HEALTHCOM has begun a serious dialogue with PRITECH and PRICOR about collaboration in strengthening training programs for health personnel in diarrhea case management. The three projects are discussing possibilities for pooling their respective experience to bolster upcoming PRITECH training initiatives in several African countries, with a particular emphasis on reinforcing and maintaining new health worker skills gained through training programs. Several of HEALTHCOM's behavioral studies in the past have focused on this particular issue, studying potential health worker incentives and approaches to improving supervision.

HEALTHCOM's resident advisors continued to support the CCCD programs in Nigeria, Lesotho, and Zaire; while HEALTHCOM completed its work at the end of September in Lesotho, the Project is awaiting buy-ins to continue activity in Nigeria and Zaire under HEALTHCOM II. The HEALTHCOM director and resident advisors from Zaire and Lesotho attended the annual CCCD consultative meeting in Swaziland in April and held joint review meetings with host country and CCCD counterparts.

HEALTHCOM participated in the Technical Advisory Group meetings of the REACH, MotherCare, and Financing and Sustainability projects.

HEALTHCOM collaborated with the REACH Project in preparing a set of papers on sustainability for the 1990 meeting of the Global Advisory Group of the WHO Expanded Programme on Immunization. HEALTHCOM's paper addressed the role of communication in sustaining immunization programs.

HEALTHCOM collaborated with a number of projects working under S&T/Health to assist the office to prepare a strategy paper on acute respiratory infections. HEALTHCOM produced a draft section on communication for the strategy paper based on its ARI behavioral research in Honduras and the Philippines.

### 2. WHO

HEALTHCOM began a major collaborative effort with the WHO/EPI Program in June 1990. Two HEALTHCOM staff members traveled to Geneva to begin plans for the development of a training module on improving the face-to-face communication skills of immunization workers. The module is scheduled for completion in early 1991 and may

lead to additional collaboration on materials development. WHO/EPI also invited HEALTHCOM to produce a communication concept paper for its annual Global Advisory Group meeting in Cairo in October.

HEALTHCOM continued its support of the social science research component of the WHO/CDD program in Geneva through its subcontractor, the Annenberg School for Communication. During this reporting period Annenberg staff carried out WHO research assignments in Ethiopia, Guatemala, Pakistan, and the Philippines. Work focused on studies regarding breastfeeding in all of these countries, except in the Philippines where the study evaluated the acceptability of different types of ORS, particularly a rice-based solution.

### 3. Private Sector

HEALTHCOM continued to work with the private pharmaceutical sector to help launch new ORS products in Honduras, Lesotho, and the Philippines. In the Philippines, following joint HEALTHCOM/PRITECH visits to six interested pharmaceutical companies, the Department of Health decided to open an ORESOL (the government ORS product) franchise, provided interested companies commit to the objectives of continuous accessibility and affordability. In August, the DOH approved the application of Pascual Laboratories for a franchise, and the production of "ORESOL-Pascual" began.

HEALTHCOM continued to collaborate with Helen Keller International under the ROVITA Project in Central Java and helped HKI secure funding from the FVA Bureau for at least another year of activity. HEALTHCOM also met with the representatives of several other PVOs, including CARE, World Vision, Project Hope, and Rotary International, to discuss possible collaboration. There was a great deal of interest expressed from these groups in receiving technical assistance from HEALTHCOM in social marketing and communication planning, and HEALTHCOM is moving ahead in the development of a package of communication training modules specifically targeted at field staff of PVOs.

HEALTHCOM began the first steps of collaborative activity in curriculum development and training with universities or research institutions in several countries during the year. Representatives from the University of the Philippines, University of Ibadan (Nigeria), and INCAP (Guatemala) attended a Faculty Strategy Session at HEALTHCOM/Washington in June to share experiences and perceived needs in health communication curriculum development. In May, HEALTHCOM met with faculty members from three universities in Indonesia--University of Indonesia, Diponegoro University, and Gajah Madah University--to explore mutual interests in improving teaching capacity in health communication and social marketing. HEALTHCOM also met with the School of Public Health in Kinshasa (Zaire) to develop plans for collaboration in teaching and research.

HEALTHCOM also took a number of steps during the year to identify opportunities for the project to offer assistance in expanding the marketing and promotion of child survival services in the private sector. The project made contact with a number of USAID missions, including those in Kenya, Zaire, Egypt, Honduras, Jamaica, and El Salvador to determine mission and host government assistance in this area. HEALTHCOM has been requested and is preparing to carry out an assignment in Jamaica to assist the Jamaican Family Planning Association market an integrated child survival/family planning service to private employers in Jamaica.

## SECTION III

### MAJOR ISSUES AND LESSONS LEARNED

#### A. TECHNICAL ISSUES

##### I. Institutionalization

The experiences of the HEALTHCOM Project, and previously MMHP, in striving to achieve long-term impact upon public health education and communication infrastructures have given the project valuable insights into the depth of this challenge. During the last year, HEALTHCOM has continued to explore different models for institutionalization and to examine recurring challenges.

HEALTHCOM/Honduras, the longest running site, demonstrates that institutionalization is an ongoing long-term process rather than a "goal" which can be "achieved" at one point in time. The success that HEALTHCOM has had--in training various professionals and in increasing the budget and commitment of the MOH to communication efforts--has created its own problems. Many professionals have become so well-trained and highly valued that they have been hired away by international donors or private commercial organizations. Training must be viewed as a never ceasing process. Honduras also illustrates the precariousness of government-based programs. Even a program as seemingly secure as health education in Honduras is subject to the powerful politics of individuals who are constantly being rotated in and out of ministries. Although the LAC region has generally been viewed as more conducive to institutionalization than, for example, the Africa region, HEALTHCOM's experiences this year in Honduras, Guatemala, and Paraguay demonstrate that the struggle for policy maker support and understanding must be a continuous one.

On the positive side, HEALTHCOM has increasing experience with different models of institutionalization and with the advantages of working with a broad range of players, particularly in the private commercial realm. The project has now collaborated extensively with private market research organizations, advertising agencies, universities, pharmaceutical companies and so forth, often introducing ministries to the the complex processes of cooperation and contracting. Activities have focused on both demand creation and service delivery. HEALTHCOM has encouraged numerous ministries of health to hire local research companies and advertising agencies, and has worked in Honduras, the Philippines, and Lesotho to bring about private sector production of ORS. Collaboration, however, is never a simple process and is often frustrating and seemingly unsuccessful in the short term. Experiences in Guatemala and Nigeria, for example, have demonstrated the importance of educating the private sector in the use of research as a basis for planning. Reliance upon collaborators and contractors must be highly geared to local realities.

Other "rules" of institutionalization are becoming clear. These include:

- the importance of a committed full-time counterpart, identified in the project negotiation phase, whose relationship with the resident advisor is clearly laid out;

- the importance of consensus-building at the national, regional, and community levels, beginning with the planning stage of the project;
- the importance of concomitant efforts to improve service delivery, as demand creation activities intensify;
- the importance of training a cadre of trainers in selected health communication fields;
- the importance of stable and committed leadership at the policy levels.

HEALTHCOM's overall experience in the area of institutionalization has demonstrated increasingly that institutionalization must be a long-term goal, approached in increments appropriate to a given country, and viewed over a period of ten to twenty years.

## 2. Behavior Maintenance

HEALTHCOM's many research components (the case study evaluations, the longitudinal studies in Honduras and The Gambia, and the health practices studies, among others) continue to provide valuable insights into the complexity of promoting new health practices among large populations. One of the enduring realities is the importance of a strong and accessible service delivery network as the foundation of any communication effort. Recent data from the Central Java vitamin A intervention illustrate this. KAP survey information showed that where a distribution point (i.e., posyandu, or health post) existed, a fully integrated communication intervention for vitamin A capsules could increase consumption over one year. Where no posyandu, or a weak posyandu existed, no increase in coverage was noted. Two approaches to this problem are possible. Increasing the number of posyandus (i.e., strengthening the overall rural health system) could be critical to obtaining higher levels of vitamin A capsule consumption. Additionally, alternative distribution points for vitamin A could be pursued over the next year. Although HEALTHCOM is not a service delivery project, it often highlights weaknesses in this area and can help identify the most cost effective solutions.

A number of countries have focused on coordination with health delivery personnel to increase the effectiveness of a single visit to the health center. The Philippines Metro Manila and nationwide measles campaigns demonstrated that a vaccination "hook," such as measles, can increase overall vaccination coverage. From a pre-campaign level of 77 percent, missed opportunities decreased to 54 percent and 44 percent afterward. Card verified measles vaccination coverage doubled. Card-verified data also showed an increase in coverage particularly for polio and the third dose of DPT. On the other hand, a study of the EPI program in Honduras revealed that over half of the infants visiting MOH facilities were not given needed vaccinations. HEALTHCOM is assisting the ministry in devising communication strategies which foster a collaborative relationship between consumers and health workers to solve this problem.

Several of the HEALTHCOM health practice studies have observed and designed interventions to strengthen health worker interactions with mothers. Many HEALTHCOM countries have undertaken large-scale, tiered, trainers-of-trainers programs for health workers, often followed up by observations to evaluate the training. Recently HEALTHCOM staff have engaged in several collaborative efforts with other

A.I.D. projects, in particularly PRITECH and PRICOR, to address health worker motivation and supervision issues. As HEALTHCOM II gets underway, curriculum development will be an increasing part of this effort.

HEALTHCOM continues to gain a better understanding of the importance of face-to-face communication and the role which can be played by neighbors and volunteers in affecting care givers' practices. A training program for Maman Tengeneza in Zaire has been highly successful, whereas studies of the kader system in Indonesia point out the difficulties of motivating and even retaining a group which is largely selected by local political chiefs.

Evaluation data from Annenberg suggest that health practices must be seen as belonging to the community as well as to individuals. Caretakers with knowledge about a given practice are much more likely to engage in that practice if they live in a community in which adoption is high. Similarly, support within a community--from opinion leaders, close family members, neighbors, and others--is one of the most powerful determinants of health-related behavior. Studies of community behavior and influencers are perhaps the most promising directions for new discoveries about behavior maintenance.

### 3. Technologies and Behaviors

Child survival communication programs neither develop technologies nor set national health intervention policies--yet they must be based upon agreements among others regarding both of these. HEALTHCOM's experiences have shown that the "position" of a communication program in regard to approved technologies as well as national policies is complex.

To date, the absence of international and national policies regarding control of acute respiratory infections, for example, has meant that communication programs cannot develop consistent, useful messages for mothers. Communication programs must in essence wait for protocols to be agreed upon by the medical community. On the other hand, ARI is a major, if not the chief cause of mortality in many developing countries and ministries of health consider this area a high priority. HEALTHCOM has been active in conducting research about what mothers presently do to treat respiratory infections among their children, and what local terms they use to discriminate among different conditions. HEALTHCOM has carried out ethnographic studies and focus groups in Honduras, as well as simple pilot interventions to motivate awareness. Studies in both Honduras and the Philippines have assisted WHO in developing policies regarding control of lower respiratory infections.

Experiences in Zaire, Lesotho, and other countries have shown that communication programs can help influence adoption of appropriate technologies when national policies are in a state of change. Since the arrival of resident advisors in both Zaire and Lesotho, national policies have shifted from promoting sugar-salt solutions to home-based gruels (in Zaire) and packaged ORS (in Lesotho). Communication managers must help make such transitions as clear as possible to consumers. HEALTHCOM has also been able to assist in examining mothers' ORS administration behaviors (in both Mexico and Lesotho), which will give medical professionals insight into which aspects of the practice are difficult or misunderstood by mothers. Although ORT is one of the most advanced child survival technologies, investigations into "super-ORS" are ongoing and the technology will continue to be refined.

#### **4. Integration of Themes and Within Overall PHC**

The logic, particularly from the consumer's point of view, of combining child survival messages in an integrated primary health care approach is obvious. However, the vertical structures of most ministries of health can make the cooperation necessary to reach such goals difficult. And the dangers of confusing the public with overloaded promotional efforts should be weighed against the advantages of simple, consistent messages.

Integration can mean many things. One or more themes (ORT, ARI, EPI) can be linked logistically--delivered together as a single administrative package. Themes might be linked conceptually through an umbrella concept, promoted to the consumer as a "package." Or themes could be linked behaviorally--urging mothers to breastfeed and give ORS during the same time period, for example. No matter what the approach, integration has two elements: management and consumer acceptance. From a management point of view, integration may be useful if it permits governments to take advantage of a single delivery system for several interventions, but harmful if combining topics weakens each of the integrated themes. Where consumers are concerned, is there an ethnographic linkage--are the diseases linked in the mind of the mother in terms of timing or causality?

In Ecuador, the government, under the PREMI Project, decided to distribute ORS packages during national immunization jornadas. The results of research suggest that integrating ORS distribution and promotion with immunization had mixed results. About 40 percent of the population surveyed recalled vaccination as the primary PREMI theme, while only 8 percent associated PREMI with diarrhea. Reported trial use of ORS nearly doubled early in the campaign, but was not translated into increased use of ORS for the most recent case of diarrhea. If a separate campaign had been run, more attention might have been paid to developing a permanent infrastructure for packet distribution in the Ministry of Health.

#### **B. MANAGEMENT ISSUES**

The overriding management issue for HEALTHCOM, as with the other major "centrally-funded" A.I.D. health projects, is one of financial management under the current system of buy-ins.

The HEALTHCOM II contract ceiling is predicated on a projection of 67 percent buy-ins from USAID missions, with core (S&T/Health) funds making up the other 33 percent. Two things are wrong with this projection: 1) Many projects like HEALTHCOM are now competing for ever-higher percentages of mission buy-ins. 2) In some countries, such as the Philippines, HEALTHCOM I succeeded to the extent that the mission decided to put a health communication component into its new bilateral child survival project; in these countries, then, HEALTHCOM is no longer needed as a source of long-term technical assistance.

Relying on mission buy-ins for major portions of program budgets had made HEALTHCOM's longstanding research-and-development mandate ever more difficult to serve, since USAID mission staff are often little interested in research and evaluation issues. It has made financial planning much more difficult. In the case of HEALTHCOM's program in Nigeria, for example, HEALTHCOM over a period of more than a year had both verbal and cable commitments from the USAID mission of a final

increment of mission funds to complete HEALTHCOM's activities. During this period, HEALTHCOM advanced central funds--more than \$120,000--to sustain program activities. Ultimately, however, the mission did not deliver the planned-for funds, and HEALTHCOM was forced to absorb a \$120,000 loss, at a substantial cost to other project activities.

Even as the competition for mission funds has grown keener, the process of moving them from mission budgets into central project contracts has become more highly regulated and thus much more time and labor consuming. It now often takes from three to six months after a PIO/T from a mission has arrived in the A.I.D./Washington contracts office before it is negotiated with the contractor and funds actually obligated. In one recent HEALTHCOM case, a PIO/T from the USAID mission in Honduras remained in the A.I.D./Washington contracts office over eight months before being obligated to the HEALTHCOM contract.

Recognizing the major issues that this financial context poses for the successful implementation of HEALTHCOM II, the project's management has agreed with its CTO in S&T/Health to meet early in the new fiscal year to determine whether any major changes may be required in the project's scope of work and/or funding. Major issues to be addressed will be the ratio of core versus buy-in funding, and whether the project might be better advised to seek fewer country sites with long-term technical assistance packages and use a greater percentage of core funding for development of innovative global communication strategies and materials.

## SECTION IV

### ADMINISTRATIVE REPORT

Fiscal year 1990 posed complicated and difficult management issues for HEALTHCOM. The year entailed both completion of many HEALTHCOM I deliverables and close-down of a number of HEALTHCOM I sites (Philippines, Guatemala, Paraguay, Papua New Guinea, Lesotho, and West Java) and the launch of HEALTHCOM II, with its many new initiatives. This already complex task was made even more problematic by the discovery early in the year that a shortfall in funding from S&T/Health and several USAID missions buying in to HEALTHCOM was going to prevent the completion of some scheduled activities.

Project management was forced during the year to take a series of extreme cost-cutting measures, including the following:

- reducing the home office staff, including the positions of Training Coordinator, Project Management Associate, Editorial/Training Assistant, and Logistics Specialist;
- requiring senior professional staff to reduce their billable days on the project by 15-20 percent and seek coverage of their time from other AED or outside project sources;
- postponing all new initiatives by project subcontractors (including curriculum development by The Johns Hopkins University, cost studies by Birch and Davis, computer modeling by The Futures Group, follow-up research in Honduras by ACT, and formative research coordination by Porter/Novelli);
- postponing procurement of computer equipment in the home office;
- denying requests for centrally-funded project extensions in PNG, Philippines, Zaire, and Guatemala.
- curtailing the development of promotional material and travel for new project development travel;
- reducing the scope of HEALTHCOM I evaluations in Zaire, the Philippines, and Indonesia;
- postponing planning and implementation of certain HEALTHCOM II deliverables, including the second Task Force and TAG meetings.

Having taken these austerity measures, HEALTHCOM completed FY 1990 in a fiscally sound position but entirely reactive posture; the project has been unable to explore and promote new initiatives which will serve the project's health in the long run. Thus, project management's first priority in FY 1991, when full funding is expected, will be to turn HEALTHCOM's now streamlined home office team to the task of actively marketing the project's considerable experience and expertise in new areas of identified need, including curriculum development, communication training, and marketing and promotion of health services in the private sector.

In September, HEALTHCOM I received a no-cost extension from A.I.D. to complete certain project tasks, principally the analysis and reporting of Annenberg evaluations of HEALTHCOM's major sites.

## APPENDICES

**APPENDIX A**

**RESEARCH TASK FORCE SUMMARY**

**SUMMARY REPORT**  
**HEALTHCOM PROJECT TASK FORCE ON RESEARCH**

**December 18-19, 1989**

**Academy for Educational Development**

**Prepared by the Annenberg School for Communication  
University of Pennsylvania**

The following is a summary report of the Task Force Meeting on Research for the HEALTHCOM Project, which was held at the Academy for Educational Development on December 18-19, 1989. The purpose of the meeting was to formulate and discuss a research agenda for the remainder of HEALTHCOM I and for HEALTHCOM II.

**I. INTRODUCTION**

**Mr. Robert Clay**  
**Chief, Health Services Division**  
**Office of Health**  
**Bureau for S&T**

Mr. Clay discussed the history of HEALTHCOM I and where he envisioned the project to be going under HEALTHCOM II. He noted that the concept of using communication in child survival programs started ten years ago under the Mass Media and Health Practices Project (MMHP). Since then, the project has expanded into other countries. He recommended that the research team use the data collected under MMHP and HEALTHCOM I to define the future directions of the project. The research to date has been used to identify child survival interventions that should be undertaken and to apply the results to countries in an attempt to leave programs that will continue. Mr. Clay recommended that, in the next five years, the project must be concerned with sustainability. He suggested that new directions to follow under HEALTHCOM II should include attempts to influence policy concerns in countries in which the project works.

**II. HEALTHCOM'S GLOBAL RESEARCH PROGRAM**

**Dr. Alan Andreasen**  
**Senior Technical Director**  
**HEALTHCOM Project**

Dr. Andreasen set the goal of the global research component of HEALTHCOM II to address the question of legacy. What can the project leave behind to be a legacy to people working in the field (such as in-country policy makers, program implementors, the scholarly community, and the broader public)? He suggested that research undertaken for HEALTHCOM II should focus on sustainability and institutionalization. HEALTHCOM II research should look at what works to change the behavior of the target audiences--mothers, children, caretakers, and health workers--and policy makers who fund the projects, give the approvals, or, especially, not give the approvals. Other USAID programs (i.e., PRITECH, REACH, and others) can play a significant role in assisting HEALTHCOM to institutionalize its work. HEALTHCOM II should explore further the role of the private sector in carrying through the projects begun by donor agencies.

### III. OVERVIEW OF KEY FINDINGS TO DATE AND DEVELOPMENT OF A RESEARCH AGENDA

Dr. Robert Hornik  
Annenberg School for  
Communication, University of  
Pennsylvania

Dr. Hornik proposed a research agenda for the rest of HEALTHCOM I and for HEALTHCOM II. He illustrated the current state of the evaluation program (Supplement 3), and then discussed questions developed for the new research agenda (Supplement 4). Dr. Hornik proposed that the following evaluation questions be addressed for each site for the remainder of the HEALTHCOM I analysis:

- What was the program? (narrative history)
- What were the program's effects on the public health practices of interest?
- If there were effects, how did they come about? If there were no effects, why not (evidence about the process and constraints--awareness, knowledge, attitude change; limits associated with individual or community characteristics; limits associated with the particular way the program operated or with the nature of the practice being diffused)?
- How equitably were the effects realized (differences between the poor and the less poor, the urban and the rural, the better educated and the less well educated, those with better and worse access to health services)?
- What level of program activities can be sustained as HEALTHCOM withdraws?

The following are cross-site questions about the overall strategy and particular elements of its implementation suggested by Dr. Hornik as part of the global research program of HEALTHCOM II:

#### Process of behavior change questions (in overlapping categories):

- What types of knowledge--logistic and skill-focused versus underlying conceptual knowledge--affect behavior?
- How do perceived symptoms and severity affect treatment choices for CDD?
- Under what conditions--social influences, community structural influences, individual skills, material conditions, predisposing attitudes--do mothers turn knowledge into behavior?
- Is the new behavior performed adequately? How do new behaviors fit with old behaviors, i.e., do new "good" behaviors c.ive out old "good" behaviors?

- How well do social psychological theories of behavior change (i.e., Health Belief Model, Self Efficacy Model, Theory of Reasoned Action Models) serve to explain behavior and provide useful message approaches?
- What factors affect persistence of behavior in individuals and spread of behavior to others?
- What differentiation among segments locates practice differences and differences in responses to programs: lifestyle segments, household structure segments, type of community, perceived benefits, perceived case type, education?

#### Communication and health system questions:

- Channel questions: What is the reach and effectiveness of various channels? How many channels should be used? How central is mass media? When can mass media teach a complex skill in the absence of interpersonal channels?
- Message questions: Which message strategies produce short-term changes? Persistent changes? How many different themes can be incorporated in a single program?
- How do communication programs interact with health system changes? For example, will demand creation in the absence of adequate institutional supply enhance supply?
- Topic questions: Which behaviors are reasonable targets for particular public health communication programs (product categories)? How much change can you expect from a primary health care program in how much time?

#### Institutionalization questions:

- Under what conditions does serious health communication become part of what the ministry of health does?
- What skills--communication design, management, research--are most central in initiating and maintaining a program?
- What is the cost of doing health communication? Who pays for it?

#### Methodological questions:

- How can CDD and EPI behavior be measured?
- Can the effects of a particular sample design be measured in practice?
- How do researchers separate social/community influences from individual influences?
- How do researchers sort out channel effects?

- Can the project create qualitative and quantitative research strategies for developing programs?

Finally, Dr. Hornik outlined the topics that would be discussed in more detail during the rest of the meeting. Examples of types of questions that were to be addressed included:

- Persistence of effects in EPI programs: alternative implementations and alternative possible outcomes.
- Estimating the effects of health worker training programs.
- Testing the Health Belief Model, Theory of Reasoned Action Model, and Self-efficacy Model in an ORT packet promotion program.
- Examining the power of alternative segmentation dimensions in predicting responses to interventions.

#### IV. OVERVIEW OF OTHER PROJECTS' RESEARCH

##### Project Representatives

Representatives from other projects were asked to present their research activities.

REACH and MotherCare: REACH is involved in ongoing research, especially evaluation of EPI programs and field testing of a solo shot syringe developed by PATH. Communication research is being done on an Indonesian urban EPI program. Research is being set up under this project to define urban populations and subpopulations to feed into urban areas in Jakarta and Surabaya. Mr. Michael Favin said that they found in Indonesia that qualitative research on immunization was difficult to do because the project is implementation rather than research oriented.

Health Financing and Sustainability Project (HFS): Dr. Martin Makinen said that there are nine major research projects occurring under this program, and 30 minor ones. He stressed the importance of consumer demand and other consumer considerations in the program, as well as the importance of working closely with HEALTHCOM. HFS is looking into issues such as cost recovery, social financing, public/private collaboration in financing, cost, and product financing.

WASH: Mr. Phil Rourke defined three research themes for the WASH Project: (1) sustainability, or looking at variables that will allow the systems to be maintained and operated in the long-term, as well as looking at cost recovery; (2) sanitation; and (3) environment--looking at such factors as hazardous waste, pesticides, garbage disposal, and the general village environment.

The Johns Hopkins University: Dr. Annemarie Wouters was interested in research on cost, integrated demand and supply, and cost recovery. She maintained that this problem reaches beyond the interests of economists; indeed, it is an interdisciplinary problem that involves anthropologists, epidemiologists, and others.

**PRICOR:** Mr. Stewart Blumenfeld described the PRICOR research that focuses on primary health care workers and the services they provide. The PRICOR Thesaurus and its systems analysis model were developed to document what health workers do and what kinds of support they receive, and to show the variance in how health workers perform. General areas of similarities across countries include poor supervision and poor provision of face-to-face communication by health workers.

**PRITECH:** Dr. Martita Marx summarized four important issues in CDD which are the result of 60 small studies on program implementation issues planned by PRITECH. One issue deals with mothers' behavior: can mothers sustain the use of appropriate fluid? Another issue focuses on the effective use of fluids by practitioners. A third issue addresses the problem of how to integrate preventive activities in a curative environment. Finally, PRITECH researchers are looking at the problem of persistent diarrhea and how to define what actions a health worker can take.

### Discussion

A discussion followed on the appropriate role for research in child survival projects. Participants stressed the importance of implementing what was learned from the research, looking at the research other projects have done, choosing the messages necessary for sustainability, and taking into account which research government officials want in order to encourage institutionalization. This last point stimulated further discussion about the importance of guiding government officials in using and interpreting data. Dr. William Smith (AED) pointed out that because countries do not often have money to do research, the focus of research should be on questions HEALTHCOM can answer. Dr. Hornik summed up this discussion by outlining the three types of research on the agenda: (1) that which serves the immediate program needs of the countries; (2) that which serves the policy needs of the countries; and (3) that which attempts to make a global statement about the HEALTHCOM approach.

## V. COST EFFECTIVENESS

Ms. Veronica Elliott  
Mr. John Raleigh  
Birch and Davis International,  
Inc. (BDI)

Ms. Elliott opened the cost effectiveness presentation by discussing cost as an implementation and management issue. If the goal is the sustainability and institutionalization of the HEALTHCOM methodology, then ministries of health must know about the cost of the project when they make their program choices. Furthermore, to make a systematic attempt to gather information on cost, Ms. Elliott recognized that BDI must work closely with the Annenberg School and AED. Mr. Raleigh of BDI then went on to outline:

### **The options for methodologies in costing and other financial studies:**

- Financial feasibility
- Financial/economic analysis
  - break even analysis
  - net-present value analysis
  - return on investment
  - cost-benefit analysis

- cost effectiveness analysis
- resource/output analysis
- Financial planning

**And the tradeoffs in the methodological options:**

- Financial feasibility (compares sources and timing of fund flows with amount and timing of funds requirements)
  - risk and uncertainty in evaluation
  - go/no go decisions
  - consider range of options
- Financial or economic analysis (compare timing and amounts of inputs to the outputs)
  - prospective (provide scenarios, future-oriented) or retrospective (backward looking)
  - monetized or non-monetized
  - adjusted or unadjusted data
- Financial planning (compare sources and timing of fund flows with amount and timing of funds required)
  - assumes a "go" decision
  - risk management plan incorporated
  - uncertainties may still exist, but are minimized

**Discussion**

A question was raised about how the research agenda for HEALTHCOM II affects costs. Mr. Clay explained that components of HEALTHCOM II are to orient policy makers in making decisions and using resources after HEALTHCOM leaves. A discussion followed on what aspects of other child survival projects to consider. Cost-benefit analysis fits into decisions on allocating resources within a country and in a global debate. Dr. Hornik suggested that because HEALTHCOM is not the only actor in the equation, sorting out the HEALTHCOM effects seems problematic. A recent REACH cost report attempted to identify general costs (i.e., what is the cost of a fully immunized child?). The report looked at the type of program and what percent of GNP was needed to sustain a particular level of immunization. It examined such questions as: What is affordable? What are the implications for donor countries? REACH did not try to sort out individual efforts, but rather looked at immunization levels overall. Mr. Raleigh suggested that researchers must agree on a focus and on who the audience is, what their span of control is, and how they can be helped.

**Summary Comments**

Mr. Clay stated that the amount of effort put into research is striking. There was a fear that after ten years of project activities, old age would set in. However, HEALTHCOM has been successful because there has been a push to maintain the state-of-the-art in research activities. A tremendous amount of work remains to be done, and it will take a great deal of effort to make a difference.

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## VI. MEASURING CAMPAIGN EFFECTS

Dr. Susan Zimicki  
Annenberg School for  
Communication, University of  
Pennsylvania

Dr. Zimicki presented a framework for considering the effects of different communication strategies on the vaccination campaign results. This framework is outlined in Supplement 5. There are four possible patterns of effects: (1) a simple stimulus-response pattern in which increased vaccination persists only as long as the stimulus does and then coverage level returns to baseline; (2) a rebound pattern in which increased vaccination persists as long as the stimulus does but after the stimulus stops coverage dips below baseline before returning to baseline; (3) a pattern of delayed return to baseline in which increased vaccination persists after the stimulus stops but coverage eventually returns to baseline; (4) a pattern of delayed return to a level of coverage that is higher than baseline. Five HEALTHCOM projects have focused on vaccination. These projects vary in use of the two major mechanisms through which effects can occur--demand creation through use of media and improvement of health worker practice through training and motivation. For example, the Metro Manila project used a high intensity of media (relative to other country projects) for three months, with a one-time strong motivation of health workers (through "sales conferences"). The Lesotho project, on the other hand, used only a moderate amount of media at fairly low frequency, but provided frequent health worker training. Through examining the patterns of effect across different projects and relating them to the type of program that was used, Annenberg hopes to be able to answer the question of how to design media campaigns to achieve the highest and most persistent levels of vaccination coverage.

### Discussion

A discussion followed focusing on specific issues in the measurement of vaccination campaign effects including the question of missed opportunities (i.e., a child not receiving all the vaccinations for which he/she was eligible, place of vaccinations, vaccination cards, and so forth). Dr. Hornik reiterated the two models of vaccination effects: one model is a demand creation effort, and the other uses trained health workers who follow the correct procedures and give mothers correct information. Some programs use more of one method than the other, and the Annenberg School tries to sort out the effects. The discussion touched on topics relating to training health workers and how to measure those effects.

## VII. EVALUATING HEALTH WORKER TRAINING

Dr. P. Stanley Yoder  
Annenberg School for  
Communication, University  
of Pennsylvania

Dr. Yoder addressed two main questions in discussing a method for evaluating health worker training: what information do we need to judge how effective the training was? How do we judge if the training was appropriate? He pointed out that if the various stages of a training program are identified and isolated, the limits of its reach can be seen more easily. Supplement 6 illustrates stages in the training program in Zaire.

### Discussion

Dr. Smith commented on the difficulty of measuring the effectiveness of a training program, because a training study must show not only that a person was trained but also how long it takes to apply the training. For example, if a health worker does not use the training for two or three months, then the effect of the training may be lost. Dr. Hornik confirmed these concerns and questioned whether this is a place where research money should be invested. Dr. Yoder further questioned whether training was an appropriate strategy for the Zaire project. The group then discussed issues surrounding the Zaire health worker training project.

## VIII. HEALTHCOM'S FORMATIVE RESEARCH PROGRAM

Dr. Cecile Johnston  
Porter/Novelli

Dr. Johnston provided an overview of the formative research agenda for HEALTHCOM II, using Honduras, Nigeria, and the Philippines as case studies. Supplement 7 is a copy of that presentation.

### Discussion

Discussion focused on the use of formative research by in-country officials. Dr. Andreasen questioned whether HEALTHCOM might be overloading these people. Dr. Yoder replied that presenting the research in country can pose problems because many of these officials do not have experience with using research results about their own countries. Dr. Johnston asserted that training in research techniques is going to be a part of HEALTHCOM II. Dr. Zimicki summed up the problem by explaining that the missing link in an effective campaign is the transformation of the problem into ideas for research. Another problem discussed was that of training people in country to do the research themselves. Is research that will produce good results preferable to having people in country be able to do the research themselves? The latter choice produces other problems, such as who will decide what people in country really need to know, who will decide in which issues to train researchers, how to pretest data to make effective changes, and so forth.

Dr. Johnston suggested producing an "expert system," or a simple program offering guidance on what kind of research to do. Dr. Hornik questioned the efficiency of a standard formative research tool for use by in country officials. He reasoned that there are two different uses for formative research: one is for basic planning activities and the other is for all other activities conducted during the intervention. The methods used are different. On the other hand, Dr. Willard Shaw (HEALTHCOM) maintained that the overall strategy is to develop the research capability in country. Money is often not available for research, so he stressed the importance of using research for the maximum potential. The problem, according to Dr. Hornik, is not getting the research done, but getting it to affect the project.

## IX. HEALTH BELIEF MODEL

Dr. Judith McDivitt  
Annenberg School for  
Communication, University of  
Pennsylvania

Health education programs generally have been based on cognitive models. These models were developed and tested extensively in the United States. Should they also be used to study health education programs in developing countries? The models under discussion--the Health Belief Model, the Theory of Reasoned Action, and Social Learning Theory--are illustrated in Supplement 8, along with examples of how they might be used to study ORS behavior change in Indonesia.

### Discussion

Dr. McDivitt's primary question was how to test these models based on HEALTHCOM data. She suggested using appropriate pieces of each of the models and not necessarily using them the way they were designed. Dr. Smith proposed hiring someone familiar with the models to work out a scheme for HEALTHCOM evaluations. Dr. Yoder suggested hiring an in-country anthropologist to develop a cultural equivalent of the models. Dr. Hornik summed up the problem in three issues: (1) it is unclear if these models can be used effectively for HEALTHCOM II purposes; (2) HEALTHCOM programs have not used the Health Belief variables in the approach, so the project cannot be evaluated based on these models; and (3) HEALTHCOM's models have no heavy internal cognitive component, but are rather more social in character. Distance to clinic and availability of ORS packets are also important factors to the HEALTHCOM model. The problem is a practical one--what should be included in questionnaires? Discussion moved on to consider those variables that should be examined--community influence, rewards for correct behavior, self-reported activities, and so forth.

## X. COST EFFECTIVENESS

Birch and Davis  
International, Inc.

In this round of discussions on cost effectiveness studies, Dr. Smith set the objective for BDI to do studies on as many HEALTHCOM I countries as possible and to target the information to the public health community interested in child survival. He also proposed that costs of launching a program be compared with costs of sustaining one, and costs of a media program be compared with programs with no media. After some questions on what will be measured, Mr. Raleigh defined cost as: (1) cost of program compared to alternate choices; and (2) extra cost of communication campaigns. Dr. Smith raised the concern that once public health officials find out the cost, they may not want to do the program. From this, a discussion arose about the benefits and difficulties of doing financial analyses versus economic analyses. Dr. Smith stressed the importance of looking at cost issues from an economic perspective. Dr. Hornik warned that the numbers chosen to work with must be closely justified. Another concern raised was that decision makers could misinterpret numbers and need to be taught how to use the numbers in planning their communication strategies.

Mr. Raleigh proposed some initial questions to consider in planning the studies. What does it cost to invest in the media? Is there a way to show benefit? Do clients have skills to interpret the information? Are they motivated to interpret the information? Are the decisions within the realm of the client's environment that allows them to make the investment? Supplement 9 outlines issues to consider for cost effectiveness analyses including design, implementation, and interpretation issues, and options for costing and other financing studies.

## XI. APPROACH TO SEGMENTATION ANALYSIS

Dr. Robert Hornik

Dr. Hornik discussed two purposes for segmentation analyses. One--which is most commonly used by the HEALTHCOM team at the Annenberg School--is the evaluation purpose. That is, who responds to an intervention? The second--on which it may be desirable to spend more time--is the communication design purpose, or matching segments with differential response to communication research. There are many ways to organize segment classifications. The following structure is used to guide the search for relevant segments:

- community structural differences
- community social differences
- individual, structural differences
- individual, learned skills and experience differences
- individual, enduring characteristic differences

Supplement 10 is an outline of one way to view segmentation effects.

### Discussion

The discussion began with considerations on how community influences behavior (as found in the Annenberg studies). Dr. Andreasen recommended putting more resources into the study of community social differences to find out why this appears to affect behavior. Dr. Dennis Foote (ACT) was concerned with making the results of the research accessible to program implementors for use in strategic planning. AED representatives generally agreed that it is important to make the findings from the global research agenda easy for program planners to use. Mr. Mark Rasmuson (HEALTHCOM) raised questions on how to link the research questions with the strategic planning component of HEALTHCOM. He questioned to what extent the institutionalization mandate of HEALTHCOM is being served by the research mandate. Should it be more so? Dr. Andreasen suggested that the priorities for the global research program should be: (1) cross-site analyses to be used in country; and (2) research to be used on the long run. He said that the program should leave behind a research legacy, i.e., questions to be asked, and so forth. He then questioned how the research activities will be coordinated with other HEALTHCOM activities. He asked that resident advisors have input on their informational needs. Dr. Hornik said that all the research questions on the list can be addressed by HEALTHCOM I data, and if other information is needed, Annenberg should be notified before more surveys are conducted.

**APPENDIX B**

**TECHNICAL ADVISORY GROUP SUMMARY**

**Technical Advisory Group Meeting:  
Setting HEALTHCOM II's Global Research Agenda**

**HEALTHCOM Project**

**January 26, 1990**

**Academy for Educational Development**

**Washington, DC**

**SUMMARY REPORT**

**INTRODUCTION**

The fourth annual Technical Advisory Group Meeting of the HEALTHCOM Project was held on January 26, 1990, at the Academy for Educational Development (AED) in Washington, DC. The meeting served as a combined TAG for both the HEALTHCOM I Project and the HEALTHCOM II Project, which was awarded to AED on August 31, 1989. HEALTHCOM II represents the third phase of A.I.D.'s support for health communication and marketing. The five-year project (FY 1989-1994) will continue HEALTHCOM I's goal of bringing about key changes in health practices at the community, family, and individual levels by applying innovative, systematic, communication knowledge and technology. Increasingly, this third phase of the Agency's health communication program will focus on sustainability of behavior changes and institutionalization of effective health communication strategies.

As a lead-in to the TAG Meeting, HEALTHCOM held a Task Force Meeting on Global Research at AED on December 18-19, 1989. The main purpose of this meeting was to set an agenda for HEALTHCOM II's global research component. The group reviewed research questions in areas such as communication systems, institutionalization, methodology, and the process of behavior change, and prepared a draft research agenda to present to the TAG. The TAG was charged with reviewing this agenda as well as providing guidance to HEALTHCOM in terms of its global research component, targeting versus integrating interventions, and institutionalization.

**MORNING**

**I. INTRODUCTORY REMARKS**

**Dr. Ann Van Dusen  
Acting Director  
Office of Health  
Bureau for Science & Technology**

**Mr. Robert Clay  
Chief  
Health Services Division  
Office of Health  
Bureau for Science &  
Technology**

Dr. Van Dusen opened the TAG meeting by focusing on the child survival community's activities over the last five years and the issues that A.I.D. and A.I.D.'s child survival programs will be facing in the future. Over the last five years the community has seen incredible growth in political and financial support for health programs. Budgetary increases have meant that A.I.D. has increased the number of

countries in which it works, the number of projects, and, more importantly, the number of institutions in both the United States and LDCs that are engaged in child survival activities. Strategies focusing on a select number of key countries, based on their health indicators, and on indicators and targets for achieving them, have all served to keep the A.I.D. child survival program focused and to keep the interest of others focused over the last five years.

A.I.D. now faces tensions within the child survival strategy about whether to continue to focus primarily on the "twin engine" interventions of EPI and ORT or to expand its programs into some of the other essential child survival areas such as nutrition and maternal health issues. The child survival community feels that these newer issues must be addressed. However, if the focus is diffused, the danger is that the interest may be diffused. The ongoing strategic debate deals with the issue of whether the focus should remain on child health or whether it should shift to some of the adult health issues that will be increasingly salient for health systems in developing countries in the years ahead. Populations are getting older and becoming increasingly urban: modern adult diseases and accidents will begin to make many demands on LDCs; yet A.I.D.'s strategy has focused on children and tends to be national or rural in scope.

The child survival community debated hotly over health research in the 1980s. Between 15 and 20 percent of the health budget went into health research. There was concern that in A.I.D.'s focus on health technology research, they have underfunded or at least overlooked behavioral and operational research areas, where, in fact, A.I.D. and its programs have a much better comparative advantage. The issue of the role health research plays in an overall health assistance program is one that A.I.D. will be looking at very closely in the 1990s.

A.I.D. is becoming increasingly decentralized, with increasing authority for problems, diagnosis, and project selection taking place at the mission level. A.I.D. thus needs to re-examine how centrally-funded projects work. This is particularly necessary as a number of centrally-funded projects have grown increasingly dependent on larger shares of mission buy-ins.

Mr. Robert Clay reviewed A.I.D.'s vision for HEALTHCOM II. This vision is a result of over a year of activity which involved an external evaluation of HEALTHCOM I, inputs from three regional workshops with communication advisors and host country counterparts, and a broad agency project committee that developed HEALTHCOM II. The challenges that face HEALTHCOM in the next phase of the project follow from its past achievements. Phase I, the Mass Media and Health Practices Project, focused in two countries on the development of an effective health communication method and its application to diarrheal disease; Phase II, HEALTHCOM I, applied the method to other child survival interventions in 15 countries. HEALTHCOM I focused a great deal of time convincing ministries of health, donors, PVOs, and the private sector that communication can work in changing awareness, knowledge, and practices of mothers and caretakers. HEALTHCOM II will focus on the sustainability of behavior changes and the institutionalization of communication programs. HEALTHCOM II will emphasize the behavior of the audience and the behavior of the institution as a way to ensure that its efforts can be passed on to others to continue in countries long after the project ends its assistance. HEALTHCOM II hopes to increase the involvement of the private sector, including commercial organizations, PVOs, and private practitioners; facilitate government and donor commitment to the role of communication; introduce communication programs to schools and universities which train health professionals; look at the health providers, as well as the caretakers, to improve the way that they are communicating with patients; review the wealth of data which has been generated during the project; and summarize the key lessons for the international community.

HEALTHCOM II begins its term with a solid foundation of ten years of experience, a good track record of representing the state of the art, a healthy respect for the importance of data and appropriate research, and a dynamic, talented, and creative team.

## II. RESEARCH PRIORITIES

### Statement of Issue

Does the research agenda developed by HEALTHCOM's Research Task Force comprehensively address the interests and priorities of the international health community? What are the basic decisions the project will make regarding communication which research can help inform?

What should be the highest research priorities for HEALTHCOM II? What is the appropriate allocation of effort and resources among the applied, basic, and methodological research areas?

### Introduction

Dr. Alan Andreasen  
Senior Technical Advisor for  
Research  
HEALTHCOM Project

Dr. Andreasen reviewed the results of the Global Research Task Force Meeting held in December 1989 and differentiated the HEALTHCOM II global research component from the research approach of HEALTHCOM I, which has focused primarily on evaluating individual country programs. HEALTHCOM II's research will be concerned with the "legacy issue"--what will be left behind as a research platform for future projects. All research that will serve as a platform should ultimately serve the decisions of those who wish to influence behavior and child survival. Thus, HEALTHCOM will increasingly encourage "backward research design," which begins by asking what key decisions the users of the research need to make. The focus of the early stage of the global research project will be to talk to and get the perspective of various users, including key decision makers in both host country MOHs and at A.I.D., so that the project will have a better focus on what the users want or how they may try to influence the project.

Dr. Robert Hornik (Annenberg School for Communication) outlined four suggested research areas for discussion by the TAG: the effects of short-term campaigns on long-term vaccination rates; the extent to which projects are dealing with a demand creation function, or trying to increase mothers' demands for health services and understanding of what they are supposed to do to obtain these services; whether health communication programs equally benefit all groups in society; and whether, as supported by the "social norms model," most health-related behavior is not individual, but social--belonging to the group or community.

Dr. Dennis Foote (Applied Communication Technology) added several key research areas for consideration. HEALTHCOM II hopes to return to Honduras to track the longitudinal study of the impact of the original MMHP and subsequent HEALTHCOM I efforts in the country, primarily in ORT introduction. During HEALTHCOM I, the project found that there has been continued growth in awareness and use of ORT in Honduras, even though the national ORT program itself has atrophied over time. Another aspect of the longitudinal work in Honduras is to look at institutionalization of the HEALTHCOM methodology within the Ministry of Health. The research work HEALTHCOM has done in Honduras has begun to attempt to relate project inputs to

project outcomes, but has not developed precise methodological tools for relating inputs to outputs. HEALTHCOM needs to develop method questions to track inputs (specific child survival interventions), and their relationship to effects (long-term cumulative changes), which will make a contribution to program design. Dr. Foote also suggested that HEALTHCOM look more closely at the process issues of how mothers come to change, and how they think about it; and some of the methodological issues of how to conceptualize and measure impact and persistence, and how to connect those to audience and program factors.

How should HEALTHCOM think about institutionalization in terms of research agenda priorities? HEALTHCOM has not accomplished having the target institutions assimilate or self-generate the entire set of behaviors without continued outside inputs. The research agenda needs to address this issue. Finally, HEALTHCOM needs to institutionalize research in the programs with which the project works overseas.

### Discussion

Dr. Robert Northrup (Brown University) endorsed the idea of "backward research design" because ultimately HEALTHCOM must deal with issues over which decision makers have some control. A discussion followed on the kind of research HEALTHCOM should conduct. From a practical implementer's point of view, very specific choices or strategic decisions need to be made, such as how useful is a pamphlet on diarrheal disease control given to a mother at the time that she sees a health worker. Another major decision that country planners need to make is whether to emphasize the training of health workers or to communicate directly with mothers. Training can be remarkably ineffective, and, in many situations, appears to have been substantially less effective than communication efforts aimed directly at mothers, with providers as a secondary audience. Not much research deals with the effectiveness of training and how to make it effective, and particularly that compares it to money spent on communication in different situations.

Dr. Abraham Horwitz (PAHO) noted that while ideally in public health planning one bases decisions on data, decision makers at the highest levels often seem indifferent to data and even to the very basic issues in health and nutrition. HEALTHCOM might address the factors that interfere with decision makers being convinced by data. In addition to its new research agenda, HEALTHCOM should continue to conduct basic research on decision makers, mothers, and others who participate in health interventions.

Dr. Carl Kendall (JHU) stated that in all the above cases--determining whether a particular piece of print material is sine qua non of a diarrheal disease control program, whether a program needs health workers as a vehicle for delivering the service, or looking at executive decision making--the research would be looking at very complex issues, would generate uncertain results, and would be very expensive. He suggested that HEALTHCOM's research requires the application of new methods to better understand **processes** of change. Therefore, HEALTHCOM needs to strengthen its qualitative research component.

Mr. Gary Gleason (UNICEF) noted that if some well-packaged research methods as well as results were networked better in HEALTHCOM II, it would be a great help to UNICEF offices and their work with governments around the world. Mr. Gleason remarked that the trend in the future will be to advocate much more strongly for essential, country-specific health research, both from a contribution to global issues and a focusing standpoint. Projects like HEALTHCOM and PRITECH and other contractors and organizations like UNICEF should make a longer-term investment in capacity

building to ensure that what they are doing stays on the ground. To develop the modeling capacity and to increase the respect for research and researchers inside the countries where these projects are working has not been a high enough priority. To this end, HEALTHCOM should look at developing a more tool-oriented, practical, and adaptable research foundation.

With regard to research on institutionalization, Dr. Anthony Meyer (A.I.D./Office of Education) pointed out that the ability for the child survival community to think about and ask good research questions is only in its infancy. In thinking about what other "hooks" there are to ask about institutionalization research, another element of the HEALTHCOM II research agenda fits in as a segue or a bridge between individual behavior change and institutionalization: the potential synergy across subareas within child survival--immunization, oral rehydration therapy, and so forth. Dr. Meyer, noting that the difficulties raised by the AIDS issue have not yet been fully faced, argued that the connection between perinatal transmission and infants with AIDS is evident and makes it necessary to consider the introduction of AIDS prevention and control into child survival.

Dr. Clifford Block (A.I.D./Office of Education) added that the "silver lining" is that in terms of HEALTHCOM's narrow objectives, there is an important consideration: communication in the AIDS effort is acknowledged as the front line of defense against AIDS. Many of the same people are involved in both child survival and AIDS prevention efforts, which could provide opportunities for integration and real synergy between the two issues.

A.I.D. at one point in its work in public administration was the leader in the intellectual world of studying the process of institutionalizing change, specifically within institutions in developing countries. HEALTHCOM might study some of these approaches, models, and experiences, in other sectors. The project can learn a great deal about institutionalization from research as well as the incredibly rich experience of people--both external and internal--who are dealing with institutionalization, particularly in the field.

The TAG acknowledged that the HEALTHCOM approach, which is research-based and behavior-specific, can generate new awareness, new knowledge, and some behavior changes within a limited range of possibilities, in mothers in the Third World. As Dr. Paul Touchette noted, HEALTHCOM is formalizing that knowledge and refining it, making it more efficient, thinking about making it cost effective--all achievable goals, as were the original HEALTHCOM goals. The central issue here--changing the focus from initiating new behaviors, awareness, and knowledge, to stabilizing and maintaining them, and making them a fixed part of a culture--is possible, provided that the project refocuses away from the change of individual mothers to change in groups of people who are not equals at the same status or functional level. There is an emphasis in shift in the direction of the health workers and health care networks, and how they interact with their clientele and other clientele interact with them. It will be difficult for projects to think about how to apply communication technology including that interaction so that it is stable, trustworthy, and communicative in both directions. The project must establish between the health worker and the mother a true, formal relationship of trust and mutual respect, concentrating not only on the behavior of individuals but establishing behavior of care givers and care consumers, so that the interaction is viable, and once viable, stable. A key element to this process is the observation study, because the behavior health workers report and what they actually do are poorly aligned. One of HEALTHCOM II's goals must be to establish truthful reporting in the health care system at the levels at which that truthful reporting can be made use of to develop functional relationships.

Dr. Jeanne Newman (PRICOR) noted that in PRICOR's systems analyses across countries and in a variety of interventions have observed that in most countries, the weakest area is in the health worker/client interaction, regardless of the intervention.

Dr. Horwitz asked if the processes--psychological, physiological, and so forth--of implementing CDD, immunization, and other interventions are different according to the issue. Dr. Smith responded that there are differences between health technologies in terms of having to do significantly different things to help mothers change their diarrheal-related behavior versus their immunization-related behavior. With diarrheal-related behavior, mothers have to manipulate new skills with a sophisticated degree of accuracy; with immunization, mothers need to know little more than when and where to go to have their children immunized. As projects begin to expand into other interventions, such as nutrition or AIDS, an enormous spectrum of separate issues dealing with policy making, social norms, and so forth are raised. Similar processes can be built into the country structures--the processes of health education, research, community participation, how to use media. Dr. Anne Gadomski (JHU) confirmed these points by noting that ARI interventions require that we enable mothers to be able to diagnose those things that should lead them to a health center to seek care for certain types of ARI.

Dr. Northrup generalized the above points further by noting that if a mother brings a sick child to a health center for treatment and receives that treatment, she experiences a satisfying interchange; on the other hand, if a mother comes in for treatment, and receives advice about immunization, she experiences a totally different type of interaction. In the first case, the mother is asking for a service and she gets it. In the second case, the mother is being "sold" something that she did not even know she wanted. This is the fundamental problem that projects face in the sense of prevention versus treatment, very simply: no country--developed or undeveloped--does not struggle with the problem of putting more emphasis on prevention. This problem may be the core of the institutionalization question--how can projects achieve institutionalization of preventive programs?

A discussion followed on the important role social norms play in leading people to adopt interventions. Ms. Cathy Wolfheim (WHO/CDD) suggested that this is true across developed and developing countries and across institutions: if one institution is putting a lot of effort, energy, or money into a given intervention--whether for communication for CDD or strengthening a health education unit--the more one institution works on it, the more other institutions are interested in the interventions. Dr. Robert Steinglass (REACH) noted that communication takes place in social contexts; if there is no trust in that situation, the message does not get across. For example, in a small community in Bhutan, while no one in the community could name any disease against which their children had been protected, all the children were immunized because the local leaders had handed down an immunization edict and these local leaders were trusted. This information may help projects determine why often training health workers to improve their communication skills may not always produce the desired results--they may be the wrong people to train. In every community local people seek advice from trusted people who may not always be health workers. In Bhutan the people go to a low-level civil service employee for health advice. Social norms are very important for interventions such as immunizations, but may be less so in the case of diarrheal disease control where many precise behaviors are involved.

The child survival community still tends to see mothers as "black boxes"--organisms that must be constantly plied with information to motivate them, or else the desired behaviors will disappear. Dr. Block pointed out that societies and individuals are

changing: the educational attainment of young women is rising rapidly in most of the countries of the developing world. When people actively want and seek information, strategy should change to make information available to people in a large menu.

Dr. Smith turned the discussion to the cost of communication interventions, and asked the TAG to address the importance of cost, particularly in affecting decision makers' choices about whether to use communication, what kind of communication elements to include in their programming, and what elements of cost HEALTHCOM should study. What cost arguments are persuasive to decision makers? Dr. Northrup responded that a cost-related concern with CDD is the role of a product sold to the public as opposed to a home-based behavior promoted in typical social marketing fashion. The HEALTHCOM research team in CDD might then stress questions of product versus behavior and sales versus free distribution. Ministries of health constantly tell projects that certain segments of the population just can not afford the commercially sold products, when in fact, these audiences do buy the products. Linking cost with the available data that demonstrates positive change can better convince decision makers to invest in our programs.

Dr. Touchette suggested that both the retrospective and prospective research agendas look very carefully at one of the great strengths of the HEALTHCOM Project, which is the formative research. However, the formative research, as it is currently conceptualized, is difficult to replicate. For future purposes, the elucidation of the formative research to make it more efficient could in fact be a major influence in cost efficiency and social effectiveness. If the formative research (e.g., the communication channels people listen to) could be elucidated to the point where the project could tell decision makers what the options are in terms of cost, time, effect, and so forth, HEALTHCOM would have a much more effective tool. The project is already addressing this concern by studying different strategies for streamlining the overall formative research effort.

A.I.D.'s Health Financing and Sustainability (HFS) Project is mandated to assist ministries of health to ask the appropriate questions about the components of their health program--how much they cost, how effective they are, and what they get for the money they spend. Dr. Martin Makinen (HFS) noted that conceivably, most health communication programs in the future will need to demonstrate cost effectiveness. Ms. Veronica Elliott (Birch & Davis Int'l) added that one lasting contribution that BDI hopes to make with their cost studies will be methodology development that will help think through and disaggregate the cost issues which so many people who work in the field do not know how to approach. Ms. Wolfheim agreed that costs need to be measured carefully so that projects can provide decision makers with concrete data. HEALTHCOM needs to be very honest that a communication program is going to cost something above and beyond the other really basic program functions--that it is not a "magic bullet" that can take the place of other parts of the program. In addition, costing studies must be compared with some measure of effectiveness to be useful.

### Summary Conclusions

1. The TAG endorsed the "backward research design" approach that Dr. Andreasen presented, because HEALTHCOM must deal with actionable issues. The approach is practical in that it determines what key decisions are to be made using the research results and what information will help management make the best decisions. The TAG felt that this would encourage practical research on behavior change as opposed to studies conducted in an "intellectual void."

2. The TAG made several recommendations for HEALTHCOM's research agenda, which included the importance of training and how to make it effective; the importance of social norms of adopters; stressing cross-cultural differences dictating the interventions that should be implemented (preventive, worker/client, campaigns); and relating research activities to routine information collection that will be built into systems; and documenting the project's research as it is in process. The TAG recommended that HEALTHCOM continue to conduct basic research in addition to its new research agenda.
3. HEALTHCOM should focus on linking cost issues with the available data on behavior change for use by decision makers.
4. The TAG emphasized that costs needs to be considered very carefully when presenting the project to decision makers. A communication program is not a "magic bullet" but in fact requires a dedication over and above other basic program functions.
5. HEALTHCOM needs to ensure that its methodology can grow in the country context; therefore, the project must make a strong effort to build research capacity into the countries in which it works. Along the same lines, the TAG endorsed that the formative research be elucidated and formalized, which is a priority for HEALTHCOM II.

## AFTERNOON

### III. TARGETING VERSUS INTEGRATION

#### Statement of Issue

As child survival programs mature, there is increasing pressure to integrate targeted child survival interventions (CDD, EPI, ARI) into a Primary Health Care context with unified planning, training, communication, and service delivery. Integration may be: (a) logistical integration (deliver different technologies at the same time and place); (b) conceptual integration (link two technologies with a common theme in the consumer's mind); (c) behavioral integration (mothers are taught to use several technologies at the same time); or (d) management integration (research, media, and staff are combined). What is the shape such integration might take? What are the implications for health communication of greater thematic integration? What should we as HEALTHCOM be doing to help shape the direction of integration to ensure continued program quality?

#### Introduction

**Dr. William Smith**  
Senior Technical Director  
HEALTHCOM Project

Dr. Smith recalled Dr. Van Dusen's references in the morning session to the debate that is beginning to become much more intense, within at least the Agency for International Development, and perhaps in the larger international health community: a debate between what the future balance ought to be--between the "twin engines" and additional child survival technologies; a focus on maternal/child health and a focus on

adult health issues; a focus on what has principally been rural and a focus on what has principally been urban; and a focus on research on health technology and perhaps more behavioral and social science research. What should be the future balance in these particular areas? Communication can help answer some of these questions. Some people think about child survival as a process of lamination, or systematic, progressive, sequential layering of programs.

In HEALTHCOM I targeting messages at particular problems was beneficial in Mexico with the ORS program and in the Philippines immunization program. There is evidence that targeting seems to produce better program performance. It does seem to lower mortality, provide better service delivery, elicit better consumer response, at least under certain conditions, but--and this is the question the TAG was asked to focus on--how long does this kind of change last? Toward which model of health care is it leading the project? HEALTHCOM has experience both with targeted and integrated models, but needs to focus on what the project has learned from these experiences and what it should do in the future. Should HEALTHCOM try to integrate communication across health themes? Do particular aspects of communication programs integrate better than others (e.g., planning phase, production phase, research phase, delivery phase)? Are there successful models of integration?

### Discussion

Dr. Gadomski pointed out that targeting is helpful for providing specific messages at specific times--such as teaching people to identify certain respiratory illnesses that they need to seek care for before the respiratory season starts. Targeted approaches can be tied to natural disease occurrences: with respiratory disease or a measles epidemic, a large number of pneumonia cases present at health centers. Looking at the question of integration at the level of the community as being a question of grouping themes and messages about diseases, however, may be a red herring, because integration is a question of services addressing needs--what a mother or family must deal with to get by, and a whole range of other issues. As Dr. Kendall commented, services should be integrated at the community level, but the other integration issue is a management question within a ministry. Studying integration requires a reconceptualization of what a communication program is trying to do.

Communication programs must address the complexity of activities at the service delivery level. Expecting health workers to follow complex processes is not practical and does not work. Similarly, a complex educational program or a complex training program does not work. Dr. Northrup suggested that HEALTHCOM focus on the eventual outcomes and tell a minister that the project can conduct more than one program but must plan carefully how to accomplish this in clearly separated steps of a process so that the programs fit human capabilities to absorb and implement actions in both the training and case management setting.

HEALTHCOM must also operate with the authorization of A.I.D., not from the angle of what the different levels of development within developing countries today in the field of health should guide programs to do. Dr. Kendall alluded that HEALTHCOM is not talking about integration versus vertical programs, but integration where health changing behaviors are needed according to the state of health development in a given place. Dr. Horwitz noted that integration is situation specific, and some of HEALTHCOM's priority countries may not really be at that stage when they need integrated health care. Dr. Meyer added that some projects have been saying that the answer to the question "how much integration" depends on what projects want to integrate: it might be useful to look at the convenience or functionality of combining several themes of study in the same survey, or to study the management question.

Integration could also be approached by examining what the goals are in implementing a program: to create the capacity within the country to do the intervention for health communication, or to save babies in the short run. Mr. Clay suggested that the child survival community is in a transition stage where the goals are both saving children and building capacity. The pressure is to save children, show results, as well as start building institutions. The much subtler issues of synergy will not be answered very clearly in the short run, so the real problem is choosing a goal, getting the capacity built, and then choosing, at a given point, where the emphasis should be--but doing all of this **over time**. Ms. Wolfheim agreed, adding that goal setting must be based on where the country program is--not just where the country is in terms of its development. Often projects are asked to do communication programs in places that are not ready for them.

When the project first goes into a place where communication is not a significant part of the public health arsenal, it must demonstrate that first time that communication makes a real difference in something that is important. HEALTHCOM then has to target, probably on a single intervention that promises a good chance of success. Dr. Block pointed out that the literature about adopters says that the mothers or families who adopt one of these interventions are the same ones who adopt the next intervention that is offered. An empirical assessment of this phenomenon could guide projects as to whether they could cross-link or even multiply address a number of issues. In addition, projects should look at the family structure where decision making takes place: is the family motivated by a complex question of improved health, or is it motivated by a specific event? This type of research, which varies not only from country to country but from region to region, has been missing in HEALTHCOM I.

HEALTHCOM has to deal with timeframes: if the project is talking about a two- or three-year commitment, the planning for a program takes that into account, and HEALTHCOM develops a communication strategy that may very well be integrated and synergistic. In many countries, HEALTHCOM works very much on the idea of both service delivery and communication matching priorities of health programs at various times of the year. Interesting models have been developed with regard to projective communication strategies and techniques that are not entirely subject-based but in fact increase the capacity for interpersonal communication to be effective and leave the choice of what the topics are up to the care provider at the time that the mother or family comes in for care.

Mr. Jose Rimon (PCS) suggested that perhaps we should look at the evidence for integration worldwide. In schools of public health, the concept of integration has meant compromise. There is a concept or assumption that integration is probably the most cost-effective way to do business. However, evidence reveals that often better targeting, as opposed to integration, achieves better results. Country to country studies demonstrate a case for better targeting. The issue of long-term results of these targeted programs, however, must be studied. Dr. Rimmon suggested that some of these integration versus targeting issues have been addressed by the private sector.

There are different levels of integration: the first is integration at the service delivery level, which almost everyone already does; programmatic integration that takes place within the ministry structure; and, more peculiar to HEALTHCOM's parochial interests, integration of the communication component into a project and within the structure of the ministry. An additional private sector level sort of integration might be the use of umbrella themes into which projects could integrate additional individual programs so that, in effect, each component functions separately but helps build the campaign theme. For example, General Electric (GE) promotes individual GE products

but also promotes GE as an institution. Dr. Willard Shaw (HEALTHCOM) noted that this is in a sense "corporate image." Projects help build people's skills and tie them to health services to give that health service and the ministry a good image, building the health service into a place consumers can trust and where they can get good, quality service.

HEALTHCOM programs have used overarching themes that related to "healthy children" or "good mothers" (Ecuador, Guatemala, Peru). The use of an overarching theme is fairly common and in some sense the programs develop sequentially. In Ecuador, however, even though the project did give out ORS packets when it provided immunizations, by and large, they really had separate activities for each intervention. In several of the countries the programs disappeared, perhaps because the project did not adequately address whether the countries were ready to take a certain thing on, which is again a management decision about where a country is in its development.

Mr. James Gombar (Johnson & Johnson/Guatemala) noted that in his experience in the private sector, he was trying to get quick results; he accomplished this goal by using very clear, very focused messages with few elements tied together with a common thread or theme. Ideally, however, succeeding with a long-term program requires that messages be taught within institutions themselves, especially within the educational system. If projects can take some basic messages and persuade the ministries of education to incorporate them into a teaching program and part of a curriculum, then society will be affected in the long run. Dr. Block noted that virtually no developing countries have managed to get a change in the mathematics curriculum introduced successfully over the last 20 years; therefore, getting something like health communication into the educational system would probably not be very successful.

Ultimately, HEALTHCOM has to work with somebody and they have to have a program that relates to a particular ministry and to particular groups within the ministry. HEALTHCOM must try to have the broader vision, modify requests, and arrange for the opportunity to interact more broadly with various groups. Dr. Northrup stated that if HEALTHCOM goes into a country and works only with the communication people, in a sense the project is not accepting what ought to be its responsibility: to see that children get what they need at the health service level, and that the organizational structure in the ministry relating to selected primary care target activities is being dealt with effectively by HEALTHCOM's and A.I.D.'s inputs. If this means an integrated set of messages or a focused set of messages, because of the practicality for operating at where the government is in a given intervention, then HEALTHCOM must make a wise decision as to where on this continuum of integration versus targeted programs it ends up. Dr. Kendall added that countries such as Chile have achieved remarkable success stories in health using a number of different strategies. A communication-based strategy that uses alternative delivery systems and strategies, deals with privatization, and so forth, provides a complete packet of services. If a project delivers only one aspect of the packet, the strategy fails.

### Summary Conclusions

1. The decision to target or integrate must be based on where a particular country is in terms of its development of key health programs.
2. Targeting can be useful when HEALTHCOM first goes into a country, when it must demonstrate the effectiveness of communication for the first time. At this point, the project would want to focus on targeting one intervention that can provide a good example of successful communication.

3. HEALTHCOM should study the adopters of health behaviors. If the same people are adopting one intervention after another, the project can use this information to either target or integrate issues for different audiences.
4. If the project wants to pursue integration, it must realize that there are different levels of integration and decide which levels are useful for HEALTHCOM to address. HEALTHCOM must also study the evidence for both targeting and integration worldwide.

#### IV. INSTITUTIONALIZATION

##### Statement of Issue

What should be the priority target groups for curriculum development and training in health communication: physicians? nurses and other clinic workers? community health workers? health policy makers? private sector communication firms? What are the constraints on developing closer operational links with PVOs and the private commercial sector? How may these constraints be addressed?

##### Introduction

**Mr. Mark Rasmuson  
Director  
HEALTHCOM Project**

Mr. Rasmuson articulated HEALTHCOM's mission as follows: to strengthen the capacity of developing country institutions to use effective communication strategies to improve the health and well-being of children. That the project now has a strong mandate to work at strengthening the capacity of the organizations with which it works sometimes does create tension with the other major part of HEALTHCOM--trying to bring about demonstrable changes in behavior and in infant health. Institutionalization takes time. Resident advisors and their counterparts have limited time, resources, and energy, and when they put this time and energy into training counterpart staff, they are not using that time to do something else more programmatic. But it is a mandate the project is taking very seriously.

"Institutionalization" refers to developing and transferring essential skills required for effective health communication. The topic can be discussed in terms of functional sustainability, or the essential elements to field work--formative research, monitoring, planning, management; and in terms of financial sustainability--developing the organizational and financial capacity to sustain health communication activities in the long term. Institutionalization will not occur if there are no staffing patterns, positions, budgets, lines through which health educators can advance, or commitments from ministries of health to sustain this kind of effort. Institutionalization of health communication capacities is a means to sustain behavior in the long term: if HEALTHCOM can strengthen institutions to carry out in the long term effective communication, child survival interventions have a much better chance of being sustained in the long run.

Mr. Rasmuson outlined and discussed the project's institutionalization strategies as follows:

- Streamlining
- Curriculum development and training
- Expanding private sector linkages
- Integration of child survival themes

- Strengthening infrastructure and policy maker support
- Expanding face-to-face channels
- Increasing community participation
- Coordination with other donors

## Discussion

Dr. Hornik noted that all of the strategies described by Mr. Rasmuson are good, but HEALTHCOM should not lose focus on those things the project knows how to do and does well. If a resident advisor in the field tried to implement all of the proposed strategies, would any communication programs get done? Overemphasizing all the little activities might make the project forget about saving children, when a real strength of HEALTHCOM has always been communicating on how to save children. If HEALTHCOM places a tremendous emphasis on implementing all these strategies at the field level, the strength of the program--finding out what people know, what they are doing, what they can not do, and working within that context to give them advice about what they might do--will be lost. The essence of the program is that HEALTHCOM is trying to change or affect the way people serve their children's health needs.

HEALTHCOM needs to determine which of these strategies it can focus on--not to try to do all of them because none would get done well. Someone has to decide which strategies should be focused on and emphasized. Of those things that HEALTHCOM could do, which among them will most ensure that the HEALTHCOM activity will continue? Dr. Hornik expressed caution against reaching too far, too many times, to too many groups, without focusing on really helping people develop the skills to do what they are supposed to do.

Dr. Northrup suggested that the group again approach the discussion in terms of levels: the strategies for institutionalization cover everything from the way doctors talk to mothers to the procedures that are used in the communication and health education section in the ministry. He suggested that the priority be to strengthen the communication unit that is HEALTHCOM's natural counterpart. Curriculum development in communication as carried out by health workers can be a very useful and important activity that would not necessarily distract broadly from the mission of working closely with the communication unit in developing skills. Strengthening infrastructure and policy maker support goes along with strengthening the natural implementer at the ministry of health level. Ms. Susan Eastman (HKI) stated that the private sector point of view is that strengthening capacity is important, and that HEALTHCOM should be more involved in the PVO community--especially as PVOs relate to the public sector. Projects such as HEALTHCOM have helped "convert" PVOs to social marketing.

HEALTHCOM is in the unique position of having to coordinate with both A.I.D./Washington and USAID missions in each country. HEALTHCOM II faces the situation that particularly the larger countries have been developing major bilateral programs which in many cases do not include funding for buy-ins. To some extent the type of institutionalization that should be possible in Indonesia may be programmed right out, because Indonesia's child survival project may not include a reasonable amount of money for a buy-in to HEALTHCOM. This is a problem within the A.I.D. structure itself which must be clarified by A.I.D. To some extent the comment Ms. Eastman made about PVOs is a good example: PVOs have changed because there were effective groups of people like HEALTHCOM sowing and effectively supporting activities like social marketing and convincing PVOs that these were good ideas. If the strong, central projects which allow for the pooling of technical expertise are taken away and passed out

to the missions again, a number of small projects will have to learn the same lessons over and over again.

Dr. Smith suggested that while centrally-funded projects have a timeline, and A.I.D. has a thinking process that is actually so many years of a program--in HEALTHCOM's case, now 15--countries do not think in that way. At the country level, the project is diverted in different directions. Honduras is a unique example of a country in which HEALTHCOM has been able to maintain a very long-term presence, enabling the project to implement institutionalization strategies; however, two-year projects can not be expected to accomplish the same goals. At the same time, HEALTHCOM can not just focus on doing the communication work because we have to build some level of capacity. As countries mature, the project might find that the health education unit is not always going to be the "natural" organization to carry out HEALTHCOM types of activities. The larger countries--Philippines, Nigeria--may be developing a private sector to which they can turn.

Most of the institutionalization strategies on HEALTHCOM's list are not exclusive. Ms. Wolfheim suggested that what the project needs to institutionalize are the capacities of the people providing the services. HEALTHCOM and the organizations with which the project works are therefore responsible for developing the tools for the people to use. If tools can be presented, such as training curricula to be used for people in the field, and training curricula to be applied perhaps partially to the decision makers, HEALTHCOM will get decision maker and policy maker support for a program that in fact requires real training.

Mr. Gleason asserted that the last strategy--coordination with other donors--as being very important to UNICEF. UNICEF remains in countries for very long periods of time because it has permanent "buy-ins," permanent skills and staff on the ground, and obvious country programs that are oriented more towards institutionalization than a one- or two-year program. In many cases UNICEF feels that it is a matter of national obligation to coordinate donors. If projects want to be able to work effectively on communication and develop good communication strategies, then they should not send into a country consultants who spend the first three weeks trying to find out what phone numbers they should have, who they should work with, and who knows what is going on in the schools of health: WHO coordinators and UNICEF offices have employees who have been building those relationships for ten or even 20 years. This type of coordination is not done frequently enough, although the interaction would benefit A.I.D./Washington and USAID missions, as well as improve the work of countries and donor agencies at the country level.

Dr. Horwitz suggested that HEALTHCOM help determine when the better prepared countries are ready to start becoming self-sufficient and self-reliant, which only happens through education or training with different levels of complexity. He sees HEALTHCOM as a natural director of health communication; therefore, the project needs to guide governments and agencies about what should be taught, when, and how. This guidance would include curriculum development and testing, relying on evaluation; HEALTHCOM's efforts at streamlining the methodology would simplify this endeavor. In practice, therefore, the project should start a process of training health actors at different levels using curricula that will be tested in the more advanced countries. The exception to this practice would be ministers of health, directors of health, and heads of departments of health education, because normally they do not take courses. For these levels HEALTHCOM might develop very focused items in short workshops that could help convince ministers of health that they should introduce behavioral changes in specific health care programs.

One problem with institutionalization is that nobody has said they want it. There is no evidence of commitment at the national level to institutionalize health communication as a significant public health tool. Most countries have no commitment and therefore no plan to achieve institutionalization. Dr. Touchette noted that what HEALTHCOM does is not so much institutionalize a process as change the existing institutions and augment them with new processes so that the institutions have greater flexibility in problem solving. How can HEALTHCOM help solve a country's health delivery problems with limited resources and without capabilities? How can the project provide them with new tools to do that? At the service delivery worker level, it may be easy to facilitate, enable, and establish problem solving, because primarily all HEALTHCOM has to do is give countries the wherewithal to change things in a way which would solve a problem of which they are aware and to which they usually can work out some solutions: however unsophisticated the solutions may be, they are an improvement. Services and attitudes will improve, and the whole system at that level will improve. A secondary result of providing this opportunity is that HEALTHCOM then has an opportunity to talk to the ministry and supervisory people to point out to them that their system is capable of change and problem solving. People in supervisory capacities will not commit themselves publicly to a change unless they are absolutely sure they can make it. HEALTHCOM must convince them that change within their system is possible, likely, and can be carried out within the constraints of the existing system.

Unfortunately, people in country have made attempt after attempt to succeed, assisted by various people who then left, which has blunted their motivation and convinced them that accomplishments are transient and probably have very little impact. HEALTHCOM has the opportunity in the next five years to gather examples which will help the project change that preconception by setting up problem-solving programs of short duration but significant impact which work and provide high motivation at the lower levels in the system and then work back up in the system. People at the top of the system will be able to point to successes in their country that occurred within the current constraints of their budget and personnel--not something that was done by HEALTHCOM. Motivation is intimately tied to success.

Incentivization also is important and points to involving the private sector more in HEALTHCOM. As Dr. Andreasen remarked, private sector organizations have no preconceptions about commercial marketing and may well help accelerate certain program elements. One of the major developments in the area of charitable contributions of organizations is that rather than giving money to a number of charities, they are now doing what is referred to as "cause related" marketing, in which they carry out certain kinds of projects because they think it benefits their organization as much as it benefits a particular project. There are some avenues in many of the countries in which HEALTHCOM is working to potentially involve the private sector in programs--again, under some overarching theme. If HEALTHCOM thinks creatively about ways to "incentivize" the private sector, the project can work with an audience that is at least not negative towards what HEALTHCOM might want to promote and that responds well to incentives addressing the private sector's economic interests.

Dr. Foote agreed with Dr. Touchette's explicit statements about providing demonstrable cases of impact to help people to move forward and to repeat health behaviors. However, implicit in those remarks is that HEALTHCOM or A.I.D. ought to consider inside or outside of HEALTHCOM the notion of how to create the "seed crystals" in country around which these behaviors will grow. The current situation is that HEALTHCOM has some people who have counterparts who have picked up a good part of what the project would like to transfer but who are being left behind without a full level

of training or enough in-country momentum to carry forward on their own. Without some very direct commitment to promoting those skills--such as long-term training programs or drawing those people back together to give them recognition and ongoing support--HEALTHCOM will not have people with whom to work. HEALTHCOM wants to be represented in the way ministries develop their lines of work, and therefore needs an in-country agent in the long run. To date, the project has not left enough behind in the sense of a well-indoctrinated, professional category of people who are health communicators with behavior change objectives.

### Summary Conclusions

1. One of the major challenges to institutionalization that HEALTHCOM II will face over the next five years is the increasing tendency for the larger countries to develop bilateral programs that do not include funding for buy-ins. This is in fact an issue within the A.I.D. structure itself that must be addressed by A.I.D.
2. The TAG endorsed the strategies HEALTHCOM has developed to assist in institutionalization. Some members of the group cautioned against trying to do too much, so the group attempted to define the most important strategies. Several strategies were mentioned as being important, but the group concluded that different strategies were appropriate to different situations.
3. While centrally-funded projects have timelines and goals for set periods of time, the thinking at the country level is more diffuse. Two-year projects can not be expected to achieve the same institutionalization goals as a longer program; on the other hand, HEALTHCOM can not focus its efforts solely on communication goals because it must address capacity building.
4. HEALTHCOM's strategies are challenged by the fact that most countries have no stated commitment to institutionalize health communication as a public health tool at the national level.
5. Efforts to engage the private sector in HEALTHCOM II may include research into cause related marketing.
6. HEALTHCOM II should make efforts to provide concrete examples of problem solving in countries to enable institutions to develop new processes and flexibility in problem solving.
7. Long-term training and professionalization of counterparts and development of training curricula can promote the long-term processes of institutionalization and sustainability.

## V. SUMMARY COMMENTS

Mr. Robert Clay  
Chief  
Health Services Division (S&T/H)

Discussion during the fourth Technical Advisory Group Meeting focused primarily on questions relating to streamlining the HEALTHCOM research methodology, integrating versus targeting of HEALTHCOM interventions, institutionalization of communication activities, research approaches, and the importance of social norms and their influence on individual behavior. The project realizes that even though a great deal of knowledge has been gained over the last decade, in many senses the challenge is just beginning. Many significant challenges remain in the field of health communication that HEALTHCOM II is just beginning to address.

A number of recommendations were suggested for HEALTHCOM's consideration:

- To understand the importance of looking not only at the mothers and the caretakers, but to "turn the camera around" and look at the health care provider who is giving care and assistance to the mothers.
- To look carefully at the project's impact--which in fact may be delayed after HEALTHCOM Project components have been completed. Therefore, A.I.D. must be sure that it does not task the project unreasonably with its target and goal setting for the project.
- To continue to endorse the "backward research approach" of looking at the decisions being made, or those that could be made, and then moving to the types of research that the project should be carrying out.
- To look at the fact that decision makers are often not influenced by data, information, and work that the project provides, and research why some of these decision makers are not picking up this information.
- To support community-based, country-based, quality, contact-based research, focusing specifically on what is happening in country.
- To network more with other groups involved in health communication and child survival.
- To focus not only on the synergism between the interventions the project has been focusing on, but also the institutions HEALTHCOM works in, and look at how the synergism between those institutions is important to complete the goals the project sets.
- To look at what seems to be a weak area in health systems: the health worker-client interaction.
- To promote trust and belief in the project's activities among the audiences.
- To continue formative research as a strong focus of the project, to ensure that HEALTHCOM has a feedback mechanism through which it can make necessary changes and midcourse corrections.
- To look at the importance of social norms, the influence of the society, and group behavior, and their influence on individual behavior.

- To consider that the process of assimilating information may be changing--that as individuals improve in economic situations, they actually may be processing information differently--in terms of HEALTHCOM's strategies for communication and ways in which the project approaches its audiences in the future.
- To prioritize strategies in terms of the focus on institutionalization. The project should look at those parts of its strategy that will make the most difference, because if it tries to do everything at once it will overload. Some of the different priorities suggested by the group included:
  - coordination within A.I.D.;
  - coordination with other donors and sharing responsibility with them;
  - streamlining curriculum development within the list for institutionalization;
  - looking at policy and policy makers, what will make them institutionalize the project's efforts, and what will help them in institutionalizing HEALTHCOM's efforts in countries.
- To come up with behavioral motivators tied to success, so that HEALTHCOM can demonstrate the impact of what it does, then go up through the system and make changes on a broader level.
- To design incentives in HEALTHCOM programs that can help institutionalize efforts.
- To look at ways in which HEALTHCOM can continue with core professionals in health communication for the long term, and try to provide professional support for them.

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APPENDIX C

HEALTHCOM BUDGET ANALYSIS

FUNDING ANALYSIS-OBLIGATED FUNDS  
 CONTRACT No. DPE-1018-C-00-5036-00  
 THE ACADEMY FOR EDUCATIONAL DEVELOPMENT  
 EFFECTIVE DATES: August 31, 1985-August 30, 1990

FUNDING SOURCE	NO.	CURRENT OBLIGATED FUNDS			TOTAL OBLIGATED FUNDS	ACTUAL EXPENDITURES THROUGH Sep. 30, 199	CENTRAL S&T/W EXPENDITURES THROUGH Sep. 30, 199	CENTRAL BUT-IN EXPENDITURES THROUGH Sep. 30, 199	MISSION BUT-IN EXPENDITURES THROUGH Sep. 30, 199	ACTUAL FUNDS REMAINING Sep. 30, 199	CENTRAL S&T/W FUNDS REMAINING Sep. 30, 199	CENTRAL BUT-IN FUNDS REMAINING Sep. 30, 199	MISSION BUT-IN FUNDS REMAINING Sep. 30, 199
		S&T/W CENTRAL	BUT-INS CENTRAL	BUT-INS MISSION									
HOME OFFICE	2700	\$3,312,961			3,312,961	3,255,968	3,255,968			56,993	56,993		
DIFFUSION/DOCUMENTATION	2738	\$350,402			350,402	350,402	350,402						
HEALTH PRACTICE STUDIES	2735	\$86,893			86,893	86,893	86,893			(40)	(40)		
PPC STUDY	2743		\$101,000		101,000	67,214		67,214		33,786		33,786	
BREASTFEEDING ACTIVITIES	2751	85			5	5	5						
LA REGIONAL CONFERENCE	2750	\$27,129			27,129	27,129	27,129						
AFRICAN REGIONAL CONFERENCE	2755	\$16,292			16,292	16,292	16,292						
ASIA/NEAR EAST REGIONAL CONFERENCE	2758	\$23,949			23,949	23,949	23,949						
ANNEMBERG	2700	\$925,661			925,661	806,427	806,427			119,234	119,234		
PORTER NOVELLI	2700	\$246,707			246,707	230,961	230,961			15,746	15,746		
ACT	2700	\$496,537			496,537	489,542	489,542			6,995	6,995		
PATH/PIACT	2700	\$57,662			57,662	39,480	39,480			18,182	18,182		
CHILD SURVIVAL ACTION	2704	\$95,000			95,000	95,000	95,000						
AFRICA REGION													
AFRICA REGIONAL	2727	\$83,497			83,497	83,497	83,497						
LEBOTHO/CENTRAL	2716	\$224,653			224,653	225,554	225,554			(901)	(901)		
LEBOTHO/AFRICA BUREAU	2715		\$150,000		150,000	150,000		150,000					
LEBOTHO/MISSION	2757			\$183,000	183,000	183,000			183,000				
NALAMU/CENTRAL	2707	\$537,665			537,665	537,665	537,665						
NIGERIA/BUREAU & CENTRAL	2728		\$703,485		703,485	857,125	153,640	703,485		(153,640)	(153,640)		
NIGERIA/CENTRAL	2764	\$125,000			125,000	101,115	101,115			23,885	23,885		
ZAIRE/CENTRAL	2744	\$180,501			180,501	180,501	180,501						
ZAIRE/MISSION	2749			\$260,000	260,000	246,838		246,838		13,162		13,162	
ZAIRE/AFR BUREAU	2747		\$300,000		300,000	260,380		260,380		39,620		39,620	
ASIA/NEAR EAST REGION													
ASIA/NEAR EAST REGIONAL	2703	\$43,542			43,542	43,541	43,541	100,000		1	1		
ASIA/NEAR EAST REGIONAL 2	2740	\$23,877			23,877	23,874	23,874			3	3		
BANGLADESH/MISSION	2719			\$29,000	29,000	29,000			29,000				
BURMA/CENTRAL	2718												
BURMA/MISSION	2717			\$18,598	18,598	18,599			18,599	(1)		(1)	
INDONESIA	2701	\$642,652			642,652	641,753	641,753			899		899	
INDONESIA/MISSION 2	2739			\$355,800	355,800	346,293			346,293	9,507		9,507	
INDONESIA/CENTRAL	2725	\$184,798			184,798	154,534	154,534			30,264		30,264	
INDONESIA/TRAINING	2723			\$171,000	171,000	170,974			170,974	26		26	
INDO./CENTRAL JAVA	2736	\$240,154			240,154	229,677	229,677			10,477		10,477	
INDO./CENTRAL JAVA/BUT-IN	2737			\$150,000	150,000	150,000		150,000					
INDONESIA/W. JAVA BUT-IN	2731			\$668,270	668,270	669,885			669,885	(1,615)		(1,615)	
INDONESIA/W. JAVA	2763												
JORDAN/MISSION	2712			\$46,222	46,222	46,222			46,222				
JORDAN/MISSION 2	2733			\$145,537	145,537	145,537			145,537				
JORDAN/CENTRAL	2732	\$336,167			336,167	335,337	335,337			830		830	
JORDAN/BREASTFEEDING	2754	\$36,251			36,251	36,164	36,164			87		87	
PAPUA NEW GUINEA/CENTRAL	2741	\$240,509			240,509	241,655	241,655			(1,146)		(1,146)	
PAPUA NEW GUINEA/MISSION	2744			\$50,000	50,000	50,000			50,000				
PAPUA NEW GUINEA/BREASTFEEDING	2753	89			9	9	9						
PHILIPPINES/CENTRAL	2729	\$678,482			678,482	614,769	614,769			63,713		63,713	
PHILIPPINES/MISSION/IEC	2730			\$508,226	508,226	516,853			516,853	(8,627)		(8,627)	
PHILIPPINES/MISSION/ORT	2756			\$506,000	506,000	500,275			500,275	5,725		5,725	
YEMEN/CENTRAL	2742	\$73,433			73,433	73,433	73,433						
YEMEN/MISSION	2745			\$300,000	300,000	193,646			193,646	106,354		106,354	
YEMEN/ASIA	2706	\$29,170			29,170	29,170	29,170						
LATIN AMERICA REGIONAL													
LATIN AMERICA REGIONAL	2726	\$60,320			60,320	60,327	60,327			(7)		(7)	
Ecuador/CENTRAL	2721	\$345,385			345,385	345,385	345,385						
Ecuador/MISSION	2705			\$454,000	454,000	454,000			454,000				
GUATEMALA/CENTRAL	2709	\$338,207			338,207	338,255	338,255			(48)		(48)	
GUATEMALA/MISSION	2711			\$339,117	339,117	338,410			338,410			707	
GUATEMALA/MISSION II	2761			\$317,134	317,134	320,679			320,679	(3,545)		(3,545)	
GUATEMALA/CENTRAL II	2762	\$235,707			235,707	203,281	203,281			32,426		32,426	
HAITI/MISSION	2714			\$94,533	94,533	94,533			94,533				
HAITI/MISSION	2713			\$44,027	44,027	44,027			44,027	173		173	
HONDURAS	2702			\$774,468	774,468	774,468			774,468				
HONDURAS/CENTRAL	2759	\$107,128			107,128	106,865	106,865			263		263	
HONDURAS/MISSION2	2760			\$273,000	273,000	273,190			273,190	(190)		(190)	
HONDURAS/ORT	2710			\$203,000	203,000	203,000			203,000				
MEXICO/CENTRAL	2708	\$272,114			272,114	272,114	272,114						
MEXICO/MISSION	2722			\$40,000	40,000	40,000			40,000				
MEXICO/MISSION 2	2734			\$97,244	97,244	97,244			97,244				
MEXICO/CENTRAL 2	2748	\$35,704			35,704	35,704	35,704						
PARAGUAY/MISSION	2720			\$330,000	330,000	330,000			330,000				
PARAGUAY/BREASTFEEDING	2752	\$119,006			119,006	89,593	89,593			29,413		29,413	
PERU/CENTRAL	2724	\$3,628			3,628	3,628	3,628						
TOTAL		10,194,065	1,504,485	6,851,001	18,549,551	18,100,839	9,941,334	1,431,079	6,728,426	448,711	252,730	73,406	122,575

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FUNDING ANALYSIS-OBLIGATED FUNDS  
 CONTRACT No. DPE-5984-Z-00-9018-00  
 THE ACADEMY FOR EDUCATIONAL DEVELOPMENT  
 EFFECTIVE DATES: August 31, 1989-August 30, 1994

FUNDING SOURCE	NO.	CURRENT OBLIGATED FUNDS			TOTAL OBLIGATED FUNDS	ACTUAL EXPENDITURES THROUGH SEP 30, 1990	CENTRAL S&T/H EXPENDITURES THROUGH ORRRANGE1	CENTRAL BUY-IN EXPENDITURES THROUGH SEP 30, 1990	MISSION BUY-IN EXPENDITURES THROUGH SEP 30, 1990	ACTUAL FUNDS REMAINING SEP 30, 1990	CENTRAL S&T/H FUNDS REMAINING SEP 30, 1990	CENTRAL BUY-IN FUNDS REMAINING SEP 30, 1990	MISSION BUY-IN FUNDS REMAINING SEP 30, 1990
		S&T/H CENTRAL	BUY-INS CENTRAL	BUY-INS MISSION									
<b>HOME OFFICE</b>													
	9800	\$538,398			538,398	449,431	449,431			88,967	88,967		
DIFFUSION/DOCUMENTATION	9810	\$12,473			12,473	8,389	8,389			4,084	4,084		
WORLD HEALTH ORGANIZATION	9811	\$8,579			8,579	8,106	8,106			473	473		
ANNENBERG	9800	\$3,612			3,612	3,612	3,612						
PORTER NOVELLI	9800	\$90,000			90,000	88,908	88,908			1,092	1,092		
ACT	9800	\$8,860			8,860					8,860	8,860		
FUTURES GROUP	9800	\$10,000			10,000	10,000	10,000						
BIRCH & DAVIS	9800	\$10,525			10,525	10,322	10,322			203	203		
JOHNS HOPKINS UNIVERSITY	9800	\$30,000			30,000	12,756	12,756			17,244	17,244		
<b>AFRICA REGION</b>													
AFRICA REGIONAL	9805	\$50,057			50,057	48,635	48,635			1,422	1,422		
LESOTHO/CENTRAL	9808	\$163,978			163,978	134,505	134,505			29,473	29,473		
ZAIRE/CENTRAL	9809	\$198,431			198,431	178,432	178,432			19,999	19,999		
SENEGAL/MISSION	9814			\$158,094	158,094					158,094			158,094
<b>ASIA/NEAR EAST REGION</b>													
ASIA/NEAR EAST REGIONAL	9807	\$7,486			7,486	6,422	6,422			1,064	1,064		
INDONESIA/CENTRAL JAVA/CENTRAL	9801	\$173,543			173,543	176,065	176,065			(2,522)	(2,522)		
INDONESIA/CENTRAL JAVA/FVA	9812		\$225,000		225,000	14,800		14,800		210,200		210,200	
PAPUA NEW GUINEA/CENTRAL	9804	\$140,855			140,855	137,561	137,561			3,294	3,294		
<b>LATIN AMERICA REGIONAL</b>													
LATIN AMERICA REGIONAL	9806	\$70,203			70,203	62,381	62,381			7,822	7,822		
ECUADOR/CENTRAL	9802					2	2			(2)	(2)		
MEXICO/CENTRAL	9803	\$50,000			50,000	5,287	5,287			44,713	44,713		
MEXICO/MISSION	9813			\$25,000	25,000					25,000			25,000
<b>TOTAL</b>		<b>1,567,000</b>	<b>225,000</b>	<b>183,094</b>	<b>1,975,094</b>	<b>1,355,614</b>	<b>1,340,814</b>	<b>14,800</b>		<b>619,480</b>	<b>226,186</b>	<b>210,200</b>	<b>183,094</b>

**APPENDIX D**

**HEALTHCOM STAFF, SUBCONTRACTORS, & A.I.D. PROJECT MANAGERS**

# HEALTHCOM STAFF, SUBCONTRACTORS, AND A.I.D. PROJECT MANAGERS

OCTOBER 1, 1989 - SEPTEMBER 30, 1990

## ACADEMY FOR EDUCATIONAL DEVELOPMENT

### Washington, D.C.

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William A. Smith, Senior Technical Director for Dissemination  
Alan Andreasen, Senior Technical Director for Research  
Willard Shaw, Deputy Director

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Anne Bergin  
Elayne Clift  
Kristin Cooney  
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Judith Graeff  
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Rebecca Holland-Davis  
Hilary Jordan  
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Renata Seidel  
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### Field Staff

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#### Honduras

Patricio Barriga

#### Indonesia

Terry Louis  
Thomas Reis

#### Lesotho

Edward Douglass

#### Nigeria

Anthony Agboola

#### Papua New Guinea

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#### Paraguay

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#### Philippines

José Rafael Hernández

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Elaine Douglas  
Carol Hooks  
Carol Kazi  
Linda Morales  
Mary Beth Moore  
Susan Schneider

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Phyllis Piotrow  
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**BIRCH AND DAVIS**

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**THE FUTURES GROUP**

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