



**Communication for Child Survival**  
**HEALTHCOM**

Office of Health and Office of Education • Bureau for Science & Technology • Agency for International Development

**Institutionalizing a Methodology  
for Public Health Communication:  
A Midproject Report**

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**Institutionalizing a Methodology  
for Public Health Communication:  
A Midproject Report**



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Office of Health and Office of Education  
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University of Pennsylvania, Applied Communications Technology, Needham Porter Novelli, and PATH

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**PART I**

**OVERVIEW**

## INTRODUCTION

This special report describes how the HEALTHCOM Project is currently defining and working at the process of institutionalization. Part 1 outlines the evolution of the project's institutionalization approach and its current objectives and strategies. Part 2 contains a statement of plans for and progress towards institutionalization from each country where HEALTHCOM is working.

## BACKGROUND

The HEALTHCOM contract states a specific project objective addressing institutionalization--"to further support the process of institutionalization of the methodology at all project sites in so far as possible." The other two main project objectives are to support the mortality reduction goals of particular child survival programs and to continue research and development of the methodology. The contract further defines institutionalization as the "ability of a host country institution or set of institutions to apply the project methodology in an ongoing way, as part of the normal routine of how it (or they) conduct public health education," and outlines acceptable indicators of institutionalization:

- personnel competency such as could result from in-service training;
- the modification of routine procedures and job descriptions within operational units; and
- the modification of management expectations such as are reflected in policy and/or management directives, plans for future-year activities, and changes in staffing and budgetary allocations reflecting an on-going accommodation of the methodology within the institution(s).

Institutionalization strategy was an essential element of AED's initial planning for HEALTHCOM. The plans were based on the experience of the Mass Media and Health Practices Project, HEALTHCOM's predecessor. In MMHP, which carried out work in six countries over a period of six years, institutionalization was an explicit objective, but secondary to the higher priority objectives of developing an effective public health communication methodology and demonstrating results from its application.

HEALTHCOM's initial plans articulated a list of key elements of the project methodology which need to be institutionalized, constraints to institutionalization commonly found in developing country settings, strategies for overcoming these constraints (including a number of alternative management/delivery models), and indicators of successful institutionalization (AED, 1985). Institutionalization strategy was made a component of each country implementation plan.

Further examination of institutionalization in year one of the project was prompted by an assessment by A.I.D. of factors of sustainability in the Gambian component of the Mass Media and Health Practices Project, which ran from 1981-1984. This assessment, conducted in October 1986 (two and a half years after the USAID Mission in The Gambia decided against extending MMHP as part of an overall reduction in the Mission's health portfolio), concluded:

The project was successful in proving that mass media could be used cost-effectively to reduce morbidity and mortality...It resulted in significant learning and acceptance of its methodology. Host country staff continued to use some of the key components of the methodology. However, the evaluation team concluded that, despite the success of the project, it was not able to generate a sustained level of benefits. The Gambian Government was not able to maintain project activities at a satisfactory level after A.I.D. funding ended. (Liebersen et al., 1987).

The main constraints to institutionalization identified by the assessment were:

- too short a time frame (three years), the "most important constraint";
- the project's research and development orientation;
- no medium- or long-term participant training for counterparts;
- no phase-out or post-project funding;
- different objectives among the GOTG, the USAID mission, A.I.D./Washington, and the contractor;
- the inability of the GOTG to self-finance even a minimal follow-on project.

HEALTHCOM's own follow-up evaluations in The Gambia and Honduras in 1987 reached similar conclusions about the Gambian experience and found Honduras a case in sharp contrast. In the latter, where HEALTHCOM assistance has been continued for a period of eight years, the Ministry of Health has totally revamped its Health Education Division and approach and is now routinely planning and conducting systematic health communication programs.

These and related institutionalization issues have been discussed at each of HEALTHCOM's Technical Advisory Group meetings. Among the questions which the TAG has been asked to address are the following:

- What is the appropriate balance HEALTHCOM should seek between supporting particular child survival program objectives and supporting institutionalization of the methodology?
- What types of additional resources may be sought to assist the process of institutionalization? How can HEALTHCOM best coordinate its efforts at institutionalization with other A.I.D. projects which support national child survival programs?
- How can HEALTHCOM use the techniques of anthropology and behavior analysis to learn more about and affect the process of change within host country institutions?
- Should HEALTHCOM provide for medium- or long-term training in health communication for host-country counterparts?
- What is an appropriate technical assistance phase-out strategy for a HEALTHCOM project? What types of long-term follow-up activities can most usefully support HEALTHCOM institutionalization in a given country?

## ISSUES

In its TAG meetings and other discussions to date, HEALTHCOM has identified three main institutionalization issues:

### **Institutionalization of What**

Institutionalization may be operationally defined in a number of different ways. For example, it may be defined in terms of at least three quite distinct aspects of implementation in HEALTHCOM's country programs: (1) the specific child survival program HEALTHCOM is supporting; (2) the particular behavior changes the project is attempting to induce; (3) the communication methodology the project is developing and using. Clearly, emphasizing one of these aspects over the others will result in quite different project activities and expected outcomes.

### **Institutionalization vs. Sustainability**

The last several years have seen the emergence (or resurgence) of strong articulated support in the international health community of the concept of sustainability. Sustainability may be defined as "a program's continuing to deliver services or sustain benefits after the donor's technical, managerial, and financial support has ended" (Buzzard, 1987). As evident from this definition, a fundamental question in discussions of program sustainability concerns "the distinction between sustaining the activities and sustaining the benefits." Sustainability is a concept closely akin but not necessarily identical to that of institutionalization. For example, The Gambia program evaluation cited earlier found that elements of the MMHP methodology had been successfully institutionalized in the Health Education Unit, but that the project "was not able to generate a sustained level of benefits."

### **Institutionalization vs. Mortality Reduction**

Another of HEALTHCOM's main overall objectives, as stated in the project contract, is to support the mortality reduction goals of particular child survival programs. There is a very real tension between these two objectives reflected in the respective level of effort which the project's advisors can devote to each. At one extreme, HEALTHCOM in a particular country could devote all of its energy and resources to program activities designed to bring about immediate, visible changes in behaviors affecting childhood mortality (e.g., parents routinely treating diarrhea with ORT.) At the other extreme, the project could focus exclusively on the task of strengthening the capacity of health educators to conduct health communication routinely and expertly according to the project methodology and in a manner which would theoretically improve health behavior in the long term.

## CURRENT OBJECTIVES

HEALTHCOM'S current position on these important issues may be stated as follows.

The project continues to define its primary institutionalization objective as working to ensure that a host country institution or set of institutions will continue to apply the project methodology to support its public health programs after HEALTHCOM project support has ended. An important secondary institutionalization objective (and

clearly a key objective of the project's R-and-D mandate) is to refine and apply the Project's methodology to the difficult task of sustaining particular behavior changes over time.

Institutionalization or sustainability of a particular program HEALTHCOM is supporting (such as ORT or EPI), while of great importance, is not an institutionalization objective per se for the project. Continued application of the methodology, whether to the immediate health program or to a different one, is HEALTHCOM's main concern.

Institutionalization may or may not be the primary objective in the countries where HEALTHCOM is working. As already noted, supporting particular mortality reduction interventions and institutionalizing the HEALTHCOM methodology may conflict with each other when time and resources are limited. Different countries offer different opportunities for and constraints upon achievement of each type of objective. In extremely resource-poor countries such as The Gambia, for example, institutionalization may be a rather unrealistic goal. On the other hand, in larger countries, with more sophisticated communication systems, such as Indonesia, methodology development and institutionalization may be easier but documentation of significant, widespread behavior change quite difficult. It is unlikely that significant progress towards both objectives can be demonstrated from a two-to-three year program. Thus, it is The Project's position at this time that each of its country programs should clearly prioritize the objectives which it expects can realistically be achieved; allocate its resources according to these priorities; and be evaluated accordingly.

HEALTHCOM believes that the critical elements of its communication methodology which should be institutionalized are the following:

- **strategic integration of communication with other program elements: training, product development, distribution, and service delivery.**
- **regular, comprehensive communication planning;**
- **use of formative research to inform plans and strategies;**
- **focused instructional goals established around a narrow set of behavior objectives;**
- **use of multiple, integrated communication channels (mass media in addition to face-to-face support);**
- **careful testing of all educational materials;**
- **regular monitoring of program activities to identify and correct problems.**

Four types of skills are needed to implement these aspects of the methodology:

**Research**— Competent staff members must be able to conduct developmental research, materials pretesting, and program monitoring. They should be trained in certain basic research skills, such as pretesting of educational materials. None of these activities necessarily requires sophisticated quantitative research abilities. They do, however, require a basic understanding of qualitative research design, training in questionnaire development, and knowledge of special techniques such as how to conduct focus group discussions.

**Communication Planning**— Skills from the fields of instructional design and mass communication are essential. Planners must be able to use research results to formulate appropriate behavioral objectives and educational messages and to design effective communication strategies. They must have an understanding of how different communication channels may be integrated to achieve maximum message impact. And they must be able to write a cogent operational plan which provides a realistic scheduling of project activities.

**Design and Production**— Various professional resources and skills are needed to produce radio and TV programs, training kits and manuals, posters, flyers, logos, public relations materials, and so forth. It is important to strive for the highest level of professionalism and innovative design available within existing constraints and to balance creativity with careful pretesting so that materials are appropriate and powerful.

**Management**— A health communication program manager must be aware of the overall program. This person should have a broad understanding of communication strategies and planning procedures and the principles of behavior change and community participation. He or she should be skilled in mobilizing resources, supervising staff, and monitoring program performance in order to sustain high performance throughout the life of the project. The manager should also be able to articulate program issues and problems to various constituencies.

## CONSTRAINTS

Twelve threats to institutionalization have emerged as particularly salient. These represent serious obstacles to the achievement of this broader goal, and we believe they are generalizable to most projects, supported by the external donor assistance. This type of assistance provides special resources which ultimately constitute barriers to effective institutionalization. These barriers include:

**Outside Prestige**— Well-financed, outside projects receive special attention within most developing country bureaucracies. This attention helps overcome implementation obstacles as they occur, but the positive effects of this prestige are impossible to replicate when the project loses its "donor support" status.

**Flexible Control of Money**— All governments operate under tight restrictions for the use of money. Money is not only unavailable, but also procedures for spending money are cumbersome and result in delays. Donor-funded projects have ways around these obstacles; they short-circuit the system, often in simple but important ways. This financial flexibility is difficult to replicate once outside support is withdrawn.

**Technical Assistance Availability**— Outside experts, because they are able to focus on a single task, because they are well-paid, because they have special status as outsiders, and because they are driven by explicit project-related measures of success, create a special trust--or "overdrive"--in this type of project. This "overdrive" acts as a catalyst for action, a regular reminder of tasks to be done, and a constant agenda-setter for the program. Unfortunately, the "overdrive" disappears when the advisors leave--it is not necessarily that the advisor is more capable or dedicated, he or she is simply more single-minded than governmental counterparts are ever allowed to be.

**No Communication Slots or Budget Items**— "Slots," or administrative positions, drive bureaucracies. If there is no slot for a communication expert (and there rarely is in most development ministries), then either one has to be created, or some other slot has

to be given the new responsibilities. Temporarily assigned counterparts may work hard for a year or so, and learn a great deal, but sustained communication support tends to dissipate as the program becomes routine.

Equally difficult is the problem of communication costs. Many governmental institutions have no budgetary line items for air time, actors, field research, or promotional materials. To create a new budget line item in a government ministry is almost impossible, yet without resources to cover these costs, the job will not get done.

**Fear of Failure**— The type of formative methodology which lies at the heart of the public health communication project's success requires an empirical view of the world—a love of uncovering mistakes, particularly one's own mistakes, and fixing them. "Mistakes" within bureaucracies, however, are anathema. The fear of admitting failure constitutes a major stumbling block to successful adoption of this type of methodology.

**An Absolute Paucity of Resources**— In the poorest countries, such as The Gambia, there are chronic shortages of trained counterpart personnel with whom to work, with the best often required to serve as counterparts to several aid projects and frequently called out of the country for training courses, conferences, and so forth. Moreover, ministry budgets are so spartan that there are often insufficient funds for such essential operational commodities as paper, audio tapes, gasoline, and per diems for field trips. In such situations, aid projects are used by governments to finance these basic operational costs. The ability of these governments to absorb and institutionalize project methodologies is obviously at risk.

**A Scarcity of Communication Expertise**— Even countries with greater resources often suffer from a shortage of the skills necessary to implement effective communication programs. Sometimes the skills are available through a variety of individuals, but the management and organizational experience to tie them together is absent. Many well-trained health educators continue to hold very traditional views of health education. They may be resistant to the systematic use of mass media in addition to interpersonal communication, for example, or to an approach which focuses intensively on only one or two educational priorities at a time.

**The Resistance to Setting Priorities**— Most developing country public sector professionals feel compelled to address the whole range of health problems facing their countries. Dental hygiene often has an equal voice with diarrheal disease and immunization. Officials are reluctant to set priorities, thereby excluding other colleagues' specialties. Consensus decision-making, rather than vertical authority, often leads to programs with too many objectives.

**The Need for Visible Success and the Lack of Continuity**— Governments need to demonstrate success—often to demonstrate success when it does not in fact exist. The temptation is to go for the "flashy campaign" rather than the long haul. Public health communication programs are implemented within political, as well as cultural, pressures. Flashy television or radio spots are good public relations for a government. Systematic public health communication programs, however, have little chance to be institutionalized if the product and the delivery systems, including health worker and opinion leader training, are not developed at the same time as the promotion strategy.

**Lack of Policy-Maker Commitment**— Public health communication requires commitment from top-level policy-makers as well as middle-level practitioners. Institutionalization in Honduras, for example, was jeopardized when a new director general, unfamiliar with the A.I.D.-funded MMHP Project, wanted to do away with the

division of education and disperse staff among various divisions. This action would have made the communication management and planning necessary for a single coherent strategy impossible. Once the director general understood the value of the new approach, he became an important advocate for the division and provided additional staff and resources. The key to his conversion was the realization that the division could meet his needs for better program and increased public visibility.

**General Resistance to Change**— In the public sector in many developing countries, creativity or innovation is unrewarded; indeed, it is often discouraged. Public-sector institutions are particularly susceptible to this problem, because the measure of success is cooperation and survival, not competition or rising above one's colleagues. Yet, it is frequently creativity which makes the difference between an average program and one that changes health behaviors. The public health communication model requires creativity to succeed and the resistance to change represents a significant obstacle to its true institutionalization.

**The Print Prejudice and the Fear of Media**— Everyone wants a nice poster and pamphlet. These are tangible; you can show them to your boss. You can point to them in the health center; they are hard evidence that a health educator was there. Often program planning begins by designing a poster--and ends with printing it. Channel strategies are not well understood, but more importantly not easily tolerated. Broadcast media are threatening. A single angry call from the minister's cousin can ruin a bureaucrat's career--why take the chance? There is a sense, not without foundation, that broadcast media are not only expensive and unfamiliar but also risky. At the same time, there is a belief that broadcasting is like a miracle drug--if diarrhea is "mentioned" on TV or radio, then diarrhea has been dealt with. We often ask health educators, "Do you use TV or radio in your diarrhea program?" The answer is almost invariably, "Yes, we mentioned it on our program three months ago."

## STRATEGIES

Over the past several years, A.I.D. has conducted a number of studies to identify the factors which support the long-term sustainability of various A.I.D.-funded projects, including health projects.

These studies have identified a number of program components that seem critical to sustainability including:

- Financing
- Community participation in planning and implementation
- Host country policy
- Appropriate program design with respect to breath of objectives, and
- Program management.

These and other strategies for successful institutionalization of the HEALTHCOM methodology will be discussed below. A healthy skepticism must be maintained about strategies and expectations for institutionalization, however, especially given the constraints we have just reviewed. To date no magical solutions to program sustainability, have been identified. One summary study (Buzzard, 1987) concluded:

This review of the issues relating to the sustainability of A.I.D. effort to improve the health of the world's poor found that sustainable programs are most likely to result when they are affordable (by the country and the community), when

beneficiaries have a role in planning and managing them, when simple but effective management systems are in place, and when program objectives are focused but not limited to a single intervention.

The truth is, however, that we do not yet know what contributes to sustainability. Each project is, to some extent, unique, and there may be no single variable that determines the long-term viability of a project.

HEALTHCOM is pursuing the following strategies to achieve its institutionalization objective:

**Allocating Resources to Priority Countries**— HEALTHCOM has already identified priorities among its current country programs on the basis of population size, child survival problems and programs, USAID mission support, and so forth. The project will allocate a greater share of resources to these programs in terms of operating budgets, technical support, and home office management time.

**Extending Project Duration**— Where possible, HEALTHCOM is seeking to extend project time frames from two-three years to five-ten years, in light of abundant evidence from its own and many other projects' experiences that longer time frames are one of the most important factors in sustainability.

**Phasing-Out Technical Assistance**— The project will develop strategies in each country for a planned and gradual phasing-out of technical assistance to ensure that national counterparts assume ever-greater responsibility for program activities over time but are not abruptly cut off from needed additional technical advice or training. A strategy might consist of three-five years of full-time technical assistance followed by two-three years of targeted short-term TA and refresher training.

**Increasing Formal Counterpart Training**— Training of counterparts in the HEALTHCOM methodology has to date been primarily through the process of on-the-job training; the project contract contains no funds for long-term formal training. HEALTHCOM staff have concluded that more formal counterpart training is necessary, however, and have begun plans to implement a series of regional training workshops over the next two years.

**Strengthening Management Skills**— Many of HEALTHCOM's advisors have identified management as the skill area most in need of greater emphasis in counterpart training. Management training will focus on orienting counterparts to a communication management perspective (as opposed to the traditional field implementation perspective found in many health education divisions), and developing relevant skills such as communication plan development and management of research and materials development. It will also stress several heretofore under-emphasized areas: organizational development, including consensus building, and program supervision and monitoring.

**Changing Structures, Procedures and Norms**— Training alone is not institutionalization. The expected procedures and norms within an institution also have to be changed if health communication strategies are to survive. Staff positions must be created or filled and an operational budget allocated to the health education unit. Ideally, a career ladder for the communication specialist will be created. These changes are best achieved by working within rather than challenging a system.

**Developing New Institutional Models**— HEALTHCOM will continue to seek sources of useful skills in the private sector and promote collaboration between public and

private sectors. As already noted in the discussion of management training, HEALTHCOM will encourage its ministry of health counterparts to seek the professional assistance of private sector research, advertising, and materials production firms, in addition to collaboration with relevant public institutions. These investments can have very positive long-term effects.

**Regionalizing**— HEALTHCOM will encourage participation of local or regional policy-makers and health educators so that they can learn from the project and replicate it with minimal outside expertise. The local agency should be encouraged to articulate design and take the lead in project implementation.

**Recruiting Local Advisors**— Many countries where HEALTHCOM is working have now developed highly-skilled practitioners in the communication field and, in some cases, are also becoming very sensitive to expatriate technical assistance. Already, two-thirds of HEALTHCOM's resident advisors are nationals of the countries in which they are working, or are recruited from the same region. The project should continue and increase this practice to enhance the likelihood that the advisor's training and skills remain in the country or region when the project ends.

**Adapting the Methodology to Specific Countries**— This strategy is, of course, at the heart of one of HEALTHCOM's other overall project objectives--development of an effective health communication methodology applicable to the needs of various countries. Adapting the methodology to the particular needs of a specific country is also clearly an important institutionalization strategy. One example of how this adaptation process has already been working is the project's focus during the past year on improving the face-to-face health education skills of health workers in Nigeria, Malawi, and Honduras in response to requests from the governments of those countries. A further important area for the project to address is formative and summative research processes appropriate to both more developed and less developed countries.

**Integrating with Other Health Education Approaches**— In some of the countries in which HEALTHCOM is working, the project methodology is perceived by some as in conflict or competition with other approaches to health education. One other major health education approach in these countries is a "community participation" or "community development" methodology, which emphasizes the importance to the success of a program of the process of involving community members intimately in its initiation, planning, and implementation. Another is the "social mobilization" model, which stresses the mobilization of multiple social groups and institutions to stimulate both demand and supply of important social services. It is HEALTHCOM's position that all of these approaches are valid and valuable; that they serve somewhat different but often complementary purposes; and that each may have an important role to play in a particular health program. The HEALTHCOM methodology is an outcome-oriented approach; it has demonstrated its ability to produce measurable results. We feel that is one of its greatest strengths where institutionalization is concerned; visible results reinforce the value of the methodology.

HEALTHCOM's intent is to be as eclectic and pragmatic as possible. It is vital to acknowledge the role and contribution of the community participation and social mobilization approaches and look for ways to learn from those experiences, and to work flexibly and in a complementary fashion with them. This will be an important institutionalization strategy, particularly in countries where project counterparts have been strongly socialized into a different educational methodology and may have many different program, competing for their attention and support.

## TACTICS

In addition to the above overall project strategies, HEALTHCOM will encourage its resident advisors to take the following tactical actions in the interest of institutionalization.

**Consensus-Building**— Begin the process of institutionalization at the program's outset. Familiarize staff and decision-makers with the concept. Build it into letters of agreement. Be constantly on the lookout for opportunities to strengthen the goals of institutionalization.

**Skills Training**— Train more people than necessary at all levels. This will help lessen the effects of frequent staff turnover. Today's director of EPI may very likely be tomorrow's health education director--or vice versa. Make sure that post descriptions are changed to reflect responsibilities for performance in their specific areas.

**Building Interdisciplinary Constituencies**— Consult with people from different disciplines and backgrounds (including physicians, marketing professionals, auxiliary health personnel, community participation strategists, commercial retailers, and communication specialists) throughout the life of the project.

**Applying Behavior Change Strategies at the Institutional Level**— Establish concrete intermediate goals that are obtainable over short periods of time. Give periodic feedback to staff (such as charts of program progress) so that the entire group can see the effects of their work on program performance. Provide positive reinforcement to program participants whenever possible. Opportunities for further training or for expanded responsibilities can be appropriate rewards. Use other principles of behavior analysis, such as behavior modeling and repeated practice, to encourage staff.

**Learning to Work the System**— Look at policies, procedures, and norms. Be an expert on how to get a budget approved. Learn what motivates those individuals and organizations whose opinions and actions are crucial to program success. Keep them informed and involved.

**Focusing on measurable results**— One of the most effective variables in long-term program survival is a program's ability to show that it works. As HEALTHCOM's TAG noted in 1987, "The first goal of a resident advisor should be to apply HEALTHCOM's methodology to a working program in order to demonstrate real success. Tangible results supply the base upon which institutionalization can be furthered." Be able to show the minister of health how immunization coverage and ORT utilization rates have increased, thanks to public health communication.

**Using consultant/technical assistance visits as an opportunity to train counterparts in speciality fields.**

## INDICATORS

The following measures of institutional success must be carefully monitored throughout the program:

- stated commitment to public health communication program by leadership of ministry of health, health education personnel, and relevant private sector institutions;
- creation of permanent communication department and/or positions within counterpart institutions;
- Annual budget for public health communication activities;
- the number of personnel who have been trained in health communication through inservice workshops or more formal processes, at both national and regional levels, particularly in the areas of:
  - Social marketing
  - Behavior analysis
  - Developmental research
  - Materials pretesting
  - Program planning
  - Program management
  - Supervision and monitoring
  - Community participation
- the existence of plans and educational materials which reflect the public health communication methodology;
- the extension of the public health communication strategy from one program to others;
- the strengthening or restructuring of health education units or activities along lines suggested by the methodology--for example divisions of research, design, planning, and management;
- the emergence of post descriptions which reflect routine performance of the skills and procedures required in public health communication;
- changes in administrative norms and procedures which:
  - acknowledge the importance and role of health communication
  - integrate health communication with routine overall program planning
  - establish or increase health education unit budgets and staffs;
  - support training in health communication for personnel.
  - encourage detecting problems and correcting program policies and methods;
  - increase personnel involvement in research, in creating messages, and in program management;

- encourage collaboration between public and private sector institutions and initiatives;
- active involvement of private sector groups in public health communication programs;
- the existence of mechanisms for coordinating multi-institutional efforts in health communication.

The most reliable indication that a program will have a long-term effect upon the health bureaucracy is evident through the same measure used to test its short-term success: a quantifiable impact on health practices, and ultimately, upon child morbidity and mortality. There is no advertisement like success.

**PART II**  
**COUNTRY ANALYSES**

## ECUADOR

William A. Smith, Ed.D.

HEALTHCOM in Ecuador was part of a juggernaut called PREMI (Plan to Reduce Childhood Disease and Mortality). PREMI was a bold experiment--a prototype weapon designed to survive its own field tests so that a new generation of weaponry could be designed to fight child mortality in Ecuador. Like all prototypes it was supposed to work, but not necessarily last forever. PREMI has a dual warhead--EPI and ORT. It was powered by the boundless energy and commitment of a charismatic First Lady, fueled by two million dollars in external assistance, and guided by a coalition of national and international forces which included the military, the church, the schools, the private sector, as well as the Ministry of Health, WHO, UNICEF, and A.I.D.

From the perspective of institutionalization, Ecuador was always high risk. Those of us who helped design the program knew and accepted that fact from the beginning. It was high risk because the program would be functioning within a specific window of time--a window framed by money, political realities, and the urgency to save lives.

For HEALTHCOM, Ecuador was to be a test of "the methodology" on a massive scale. Could we pull together lessons learned from seven years--lessons learned as much by WHO and UNICEF as by HEALTHCOM--to create responsible demand for the expanded services that PREMI would be offering?

Two years of intensive work could answer that question--but the costs might be high in terms of sustainability. To test the concepts, the day-to-day routine of consensus and delay would have to be abrogated in favor of rapid decision-making and mobilization--in favor of leadership at the highest level. Three things were needed--money, power, and persistence. A.I.D. would provide the financial resources. The First Lady would provide the power for decision-making, and a special cadre of multinational advisors would provide the dogged persistence.

The intervention happened. More than 1,200,000 children were immunized, and 1,900,000 packets of oral rehydration salts were distributed. Hundreds of physicians, nurses, and health workers were trained in management of EPI and ORT. More than 2,000,000 pieces of educational materials were produced, tested, and distributed. Radio and TV were used extensively to support the program and guide women to health centers.

But what happened to institutionalization? At this point, for the purposes of this paper, we will focus exclusively on the institutionalization of HEALTHCOM's methodology--although it is critical to understand that this is only part of PREMI's goal to strengthen the MOH's overall child survival capacity. What is left, then, of communication planning, formative research, focused communication goals, multiple channels, materials testing and monitoring?

The first question is where to look for these elements in Ecuador; not to the Ministry of Health. From day one it was clear that the Ministry of Health's Health Education Unit was already overburdened with numerous other health issues. To demand that it devote the needed attention to PREMI would be to debilitate all its other efforts. It was agreed that a new institutional focus would be found for PREMI's communication elements--a focus consistent with PREMI's mandate to tap the society's full resources in support of child survival.

INNFA, the National Institute for the Child and the Family, historically a creature of the First Lady, was growing up. It was moving away from a personalized charity towards a professional organization fighting for child rights: INNFA was willing to assign staff to PREMI with the agreement that the institution as a whole would learn about communication during the two-year experiment and be able to apply communication to a broader range of childhood problems. The deal was cut. INNFA would be HEALTHCOM's counterpart and the repository of its institutionalization. PREMI therefore would be two entities. PREMI/INNFA was charged with creating popular demand for new child survival services and PREMI/MOH was responsible for overall coordination of the PREMI program and of delivering those expected services. Within the Ministry of Health special offices would be set up to manage the special child survival resources allocated to PREMI/MOH.

Within INNFA, several individuals became the focus of institutionalization. Marco Polo Torres, Ilka Andino, and their colleagues at INNFA not only adapted HEALTHCOM's principles but much enriched and expanded them. Planning, integrating multiple channels, using formative research, and maintaining focused goals are cerebral as well as complicated logistical functions. They grew in the minds and finally in the hearts of these dedicated Ecuadorans who lived with these principles intensively during PREMI's tempestuous existence. There is really no doubt that this cadre within INNFA/PREMI learned from, added to, and greatly expanded the practical underpinnings of HEALTHCOM's initial methodology.

Here institutionalization worked. And it continues to work as these talented individuals have opened their own communication firm--committed to sustaining a sense of excellence in communication--outside the ambiguous and shifting priorities of the public sector. From their new institutional home, they hope to serve the social communication needs of many programs in Ecuador and beyond.

Within the Ministry of Health, PREMI/INNFA and to a degree PREMI/MOH, became an enemy, not a savior. As resources and power were shifted into child survival, as INNFA was given wide publicity for its communication efforts, as the First Lady's interventions became more and more intrusive into the daily routine of MOH life, and as the juggernaut rolled on creating more and more materials, programs, meetings, and data, a natural jealousy developed toward PREMI, particularly PREMI/INNFA. Everything was too easy, too quick, too well-financed, to win friends within a bureaucracy that had always counted pennies and thought in terms of years, not months, weeks, or days.

But even juggernauts have feelings. As time went on it became increasingly clear to PREMI's supporters that to survive, PREMI must adapt. Energy was spent trying to win back the support of those who had turned away. The pace was slowed a bit; the resources redistributed a bit; the decision-making process reformulated a bit. But the fundamentals could not change. The project had a timeline. The data had to be collected. And people throughout the country had to receive what had been promised by each preceding wave of success. Then it was over: money largely spent, the government out of power, the advisor transferred to other tasks. The analysis of results was to begin.

An objective analysis of results in terms of institutionalization is not yet possible. We all remain too close to the reality, in emotion and time. But today the situation appears something like this:

- PREMI's name is well-known throughout the country.
- Within the Ministry of Health there is a commitment to what PREMI wanted to achieve and a desire to continue PREMI's strategies, but also a need to:
  - de-politicize child survival by replacing the forceful role played by the previous First Lady; and
  - rely less on "marketing and mass media" which are seen as superficial and expensive.

Within INNFA a new staff of communication people have been recruited to carry on the commitment to communication and public education which PREMI opened. Outside the MOH and INNFA, Marco Polo Torres and Ilka Andino have begun their own social communication firm, rooted in principles they helped create as part of PREMI.

Two insights emerge from the Ecuador experience. The first, somewhat obvious and expected lesson, is that institutionalization is hampered when programs are pushed too hard, too fast, and too single-mindedly; although to be fair, the jury is still out on what long-term impact PREMI will have. The Ministry has by no means turned its back on child survival.

The second insight is a bit more disturbing. It questions the concept of institutionalization itself. It suggests that institutionalization harbors an unintended but quiet, insidious arrogance--an arrogance that says it is not enough to have a success together--we must also ensure that "they" continue to do things "our" way. We have allowed ourselves to transform the very sound notion of sustainability (the capacity to carry on without external assistance) into a slightly distorted notion of semblance to us. Our measures of successful institutionalization are changes in their norms, procedures, and policies to be more like ours; the creating of budgets to support what we believe is worth funding (media, formative research, integrated channels, etc.). I continue to believe that those elements are sound--but are they the only way to achieve success? Is it not possible that working together we might develop some third alternative better suited to a particular institutional culture than this quiet, exciting, but somewhat narrow commitment to "the methodology?"

As HEALTHCOM matures, as it works with capable people from many different institutional cultures, it becomes clearer that many of the concepts embodied in "the methodology" are useful starting points to develop improved health communication systems. But at the same time "that methodology" is not a revealed truth to be cherished and proselytized. The greatest threat to institutionalization may be its own arrogance. The constant need to demonstrate that "they are now doing things our way" may be forcing our advisors to push too hard--to overlook opportunities for improvements in the dogma--to condense true measures of success into artificial signs of success (a new budget line-item for mass media). At midterm it may be time to assess this pillar of HEALTHCOM theology with a more skeptical and practical eye.

## GUATEMALA

José Romero, Ph.D.

### INTRODUCTION

Institutionalization is a process through which key personnel from the public and private sectors of a certain country acquire knowledge about, learn, practice, and assume a systematic methodology which will ultimately produce measurable results.

One of the greatest challenges to technical assistance in Guatemala is the institutionalization of the HEALTHCOM methodology, which aims to improve knowledge and practices related to health. When considering institutionalization of this methodology in the Guatemalan context, we must address the following questions;

- Is institutionalization of the HEALTHCOM methodology feasible in Latin American countries?
- Will the institutionalization process continue after financial support ends?

The methodology to be institutionalized depends heavily on the place and the circumstances under which it must be applied. Institutionalization of the HEALTHCOM methodology in Guatemala must be focused on the public sector.

In this respect, the HEALTHCOM Project faces several challenges. Political power successions leading to changes in technical and mid-management level personnel are common in Latin American countries, and impede attempts to institutionalize any program. When government officials remain in their posts for very short periods of time, it seems more realistic to "institutionalize" products rather than methods.

Could this be the reason why the HEALTHCOM project has achieved such success? In practice we must view institutionalization from two different perspectives--the first one deals with "delivered goods," and the second one deals with "person-to-person training" of public sector personnel.

We must know what we are measuring. For instance, in Peru we institutionalized a methodology through the "delivery of goods," rather than "total training of personnel." Nevertheless, a small group from the division of health education in Peru learned that the HEALTHCOM methodology was useful, and was more likely to apply it in view of immediately measurable results.

In Guatemala, we have chosen a combination of "delivery of goods" and teaching of the HEALTHCOM methodology on a daily basis to a multi-disciplinary promotional component. Final products of these efforts--campaigns--demonstrate the work of the communication components to high ranking government officials. This combination of delivery of goods--as a consequence of practicing the methodology--has clearly favored institutionalization.

It was immediately obvious at the onset of the Guatemala Project that the promotion unit staff had to understand, comprehend, accept, and execute the HEALTHCOM methodology. How could we prompt the unit to accept this methodology as a benefit? How could we guarantee its execution? What strategies should we adopt to make it feasible? What could we say to make them support this concept as their own

even at the highest levels? Ultimately we opted for the most tedious, the hardest, but, we believe, the most effective way--training each member of the unit, individually, in the methodology.

At this stage, we dealt with personnel who, for the most part, had not been in contact with health promotion, came from totally different disciplines (whether medical or paramedical) and had acquired communication skills in an ad hoc manner rather than systematically. Some of them had participated in workshops, seminars, and courses inside the country and abroad, offered by international organizations.

We met with team members on an individual basis and determined that the modern communication concepts on which HEALTHCOM is based appeared vague and incomprehensible to the staff. Therefore, we decided that the basic strategy for institutionalization of methodology would involve:

- Training the team as a group, subsequently focusing on individual training, and providing them with assistance related to specific consulting needs in four different areas: a) execution of campaigns; b) working with specialized consultants in different areas; c) search and selection of local resources; and d) travel abroad to expand their knowledge.
- Submission of finished products to government officials, and written reports about the work throughout the production and implementation process in an effort to gradually introduce, in a simple and clear manner, the steps related to the methodology and its benefits. Evidence of these tasks can be found in the documents that have been written for each one of the campaigns.
- Use of mass communication in an effort to provide "feedback" to government officials and the promotional unit related to their "success." Public opinion played a paramount role in the acceptance of this methodology; however, officials probably did not understand how we had reached the final product. All campaigns were structured in stages, the first stage being different from the second one, the second being different from the third one, and so forth. The common denominator was a solid methodology and the people who created the products.

The following pages describe the tasks that were carried out to achieve institutionalization.

## LEVELS OF INSTITUTIONALIZATION

Although the purpose of the HEALTHCOM methodology is the same for each country, the "paths" through which institutionalization can be achieved differ in strategy, quality, and depth. In Guatemala, different paths include the following:

- **Training**— for individuals (in public health training, communication, health promotion, and so forth) to improve their skills and understand how their tasks fit into the overall methodology.
- **"Delivery of the product"**— Numerous agencies in Guatemala are involved in some way in "delivering health communication products":

- Ministry of Public Relations of the Presidency of the Republic, General Directorate of Radio Communication, Comptroller General of the Republic, local departmental towns, and villages authorities.
- Minister of Public Health, Vice-Minister of Health, Director General of Health Services, Ministry of Public Relations, Chief of Applied Programs, Director of Preschool Programs.
- Director of A.I.D., Assistant Director, Office of Human Resources, Office of Private Sector, and Office of RATC II.
- International Missions, OPS, UNICEF, Rotary International, INCAP, CARE, Peace Corps.
- Private sector--Ciba-Geigy, Johnson & Johnson, ADAMED, advertising agencies; television and radio producers; recording studios; modern means of mass communication--television and radio; participation in congresses related to communication; Association of Advertisers; Association of Managers; Association of Friends of the Country; Association of Doctors of Private Hospitals; private universities with communication programs.
- Honduras/HEALTHCOM Resident Advisor and Ministry of Health counterpart (provided technical assistance to the promotion unit through two seminars on management and team building).

If we understand that the training must lead to production of goods, then we can develop a "sellable package" as an "idea and reality." If we accept that we must deliver institutionalization as a methodology and also deliver a product, then we are heading towards success.

## THE PROCESS OF INSTITUTIONALIZATION

In Guatemala, training began during a meeting which was called the "first conversational meeting on health information." This meeting, the first of many subsequent training sessions, provided an opportunity for all promotion unit staff to discuss the HEALTHCOM methodology. The meeting was dynamic, simple, showed materials/products from other countries, sought to identify common problems with other groups, and showed solutions to these problems. Further discussions generated ideas for the use of the HEALTHCOM methodology in Guatemala. We thus embarked on our own road to institutionalization. Each stage of the methodology received a "local" name with which the participants could identify. By the end of this meeting each participant understood the HEALTHCOM methodology and the steps involved in achieving institutionalization, and all were prepared to face the challenge presented by this "new technology."

We then set our goal as the achievement of the 1986-1987 National Communication Plan for EPI-ORT (Project No. 520-0339).

Unifying the different qualifications and preferences of all the participants into a coherent whole was a difficult task in view of the fact that all of them wanted to be involved at all levels. They were ultimately convinced that we should not carry out the plan as a group, but rather develop portions of the plan on an individual basis as an

incentive for individual achievements in connection with the success of the group as a whole. At the same time, we began a person-to-person training program which started with the coordinator of the group, in an effort to identify the basic steps of the communication plan which had to be developed; likewise, through the use of question and answer exercises, we met on a daily basis and discussed each step of the HEALTHCOM methodology.

In order to turn our theories into practice, we began to attend seminars and communication workshops, which allowed the group to accept this methodology as a valid and useful tool for the distribution of health information. We promoted creativity and appropriate technology toward a single purpose--realizing the National Communication Plan for ORT/EPI using the HEALTHCOM methodology.

In Guatemala, we "created" the need for institutionalization as a high priority because we convinced the people that the promotion unit, simply by learning the methodology, could "sell"--in a prestigious manner--all their future products. Therefore, the principal goal was to establish, as a group, the National Plan for Implementation and Communication of the Promotion Unit of the EPI/ORT Project (A.I.D. 520-0339), 1986-1991, as an "initial local product"--a goal which was consistent, real, and achievable.

Individual instruction for each member of the promotional group aided in the proper assimilation of this methodology. Training strategies were increased, involving specialized consultants from several areas: Ann Jimmerson (Drawing for Nonliterates), Robert Hornik (Research), Maria Claudia de Valdenebro (Development of Graphic Materials), Diane Urban (Production of Audiovisual Material), John Elder (Instruction in Behavioral Analysis), Patricio Barriga (Administration of Objectives), Nancy Morris (Evaluation Projects), Hugo Tipiani (Mass Media Planning and Strategies), and Daniel Chauche (Health Photography). These individuals were dedicated to person-to-person teaching to enhance the methodology.

Institutionalization can be measured in the number of "products" delivered so far, and in the progress in the group's knowledge. The promotion unit, using the HEALTHCOM methodology, produced a total of five campaigns (1987-1988), including 14 television spots, a TV documentary, 86 radio spots in Spanish and Mayan dialects, seven posters, brochures, and printed material for specific subjects. HEALTHCOM methodology training was provided by 896 ECOs (individuals responsible for health in the community). We were able to show these products to many groups--A.I.D., the private sector, other international missions, all levels of the Ministry of Health--and each presentation demonstrated what the HEALTHCOM methodology had contributed to each of the aforementioned products.

Specific progress in institutionalization has occurred in two phases: from September 1986 to April 1988, different groups from the Ministry learned about and accepted this methodology; and beginning in April 1988, a new effort began on behalf of the new team of officials currently in the Ministry.

Other international organizations such as UNICEF, OPS, INCAP, and Rotary International have praised "in house" products (materials made by the promotion unit without the participation of advertising agencies). They have witnessed how the promotion unit excelled and updated its health communication concepts. A.I.D. became an enthusiastic promoter of these communication materials and processes. In the private sector, producers and manufacturers have been pleasantly surprised, and now compare the methodology's consistency with "conventional" methods. The promotion unit enjoys a high standing in the private sector.

We had to overcome several obstacles to achieve this status in the country. These constraints were:

- **Assess personnel from the Ministry of Health in charge of Health Education, within the multi-disciplinary promotion unit (nurses, educators, police officers, barbers, etc.)—** We had to perform "diagnoses" in an effort to develop individual, basic training. Subsequently, we had to train personnel in aspects of the methodology.
- **Constant changes in personnel from the promotion unit, and other officials—** During the period 1986-1988, we experienced the following changes: two ministers, five vice ministers, two public relations officials, four director generals of health, five chief of applied programs (on whom the project ultimately depends), four administrative chiefs of the project, three directors of preschool department, three heads of ORT, two directors of human resources, and so forth. These changes took place during a period of four to five months. The promotion unit has experienced three changes.
- **Lack of resources, from the most elementary to the most necessary—** Physical space, desks, typewriters, office material, secretaries, telephones, transportation, and messengers were lacking. Since March 1988, we have established a HEALTHCOM Project office to overcome these deficiencies, and we have obtained the approval of A.I.D. for remodeling offices for the promotion unit.
- **Lack of incentives for personnel—** Bureaucratic obstacles to the execution of campaigns, and delays.
- **Current domestic communication legislation—** (means of communication).
- **Government officials' belief that campaigns represent excessive costs—** There is a tendency to handle publicity through approaches which differ from the purposes of the methodology.
- **Certain steps of the methodology are considered unnecessary by officials—** Pretesting in the field, basic research, training of ECOs, paid media time, and so forth.
- **Lack of appreciation for what one should expect from communication—** (An increase in knowledge and motivation.)
- **Some agencies criticize the use of mass media to promote campaigns.**

The future of institutionalization is uncertain due to new policies of new government officials and strategies that will be implemented by the newcomers, as well as the constant destabilization generated by changes and rumors. Nevertheless, if this methodology is handled by a single group, it could prevent anyone or anything from altering it. If this group achieves further consistency and success with the products it produces, it will also gain respect and technical acceptance from the authorities.

We have learned the following about institutionalization:

- Each country must "organize a method" of institutionalization for the HEALTHCOM methodology.

- We must perform a "diagnosis" prior to introducing the methodology, taking into consideration human resources, as well as the possibilities for development of institutionalization. To this end, we must also make serious commitments with the government, without which we would only deliver "products."
- The multi-disciplinary group should include professionals in the communication process. This saves time and ensures consistency in the application of the methodology in the future, when the project is completed.
- We should attempt to couple theory with practice.
- It is necessary for the authorities to understand and accept the participation of the private sector (advertising agencies) in the introduction of their products, not as substitutes for the promotional group, but rather at their service, in an effort to save time and allow the involvement of the private industry in health products.
- Authorities must accept costs of production and distribution of material, to reach a wider audience in a shorter period of time.
- We must maintain consistency in communication plans.
- We must update our methodology constantly, using field experience and the opinion of promotion groups from each country.
- It is necessary to appeal to the methodology for the solution of problems related to health information.
- It is necessary to teach nonliterate groups how to understand graphics as part of the development of graphic material. This material reaches the nonliterate groups as well as primary education groups, both of which will benefit from enhanced understanding of written messages.
- The methodology must insist upon strategies for the distribution of printed material, in view of the fact that this is quickly being replaced by the use of TV and radio.
- This methodology must give us the assurance that, if we have followed the proper steps, we will be in a position to measure results and promote desired changes.

## RECOMMENDATIONS

The Guatemalan experience leads us to make the following recommendations with regard to institutionalizing the HEALTHCOM methodology:

- Select the promotion group in charge of health information at the outset of the project.
- Identify levels of communication knowledge of the group, prior to planning training.

- Draft strategies for teaching the methodology.
- Establish incentives for personnel from the promotional group, facilitating practices aimed at successful results.
- Promote seminars, congresses, competitions, and so forth, between groups from different countries where the projects are being developed, in an effort to match the methodology with each country's practices. We can then obtain the feedback required to make adjustments to the methodology in view of the technology of each country.
- Publicize the success of the methodology in other countries.
- Exchange teams regionally to discuss issues related to health communication. Latin American countries may have common problems and solutions.
- Promote exchange of technology--through Latin American training--between the countries where the methodology has already been applied. Groups must feel that it is possible to achieve success.
- Establish an international entity for the distribution of information--newspaper or bulletin--about health, to be published in every country, for the purposes of receiving feedback.
- Exchange of personnel for specific tasks (i.e., the team in Guatemala could help the team in Paraguay with the development of campaigns, and so forth).
- Provide the program with an academic incentive--diplomas, trophies, etc.
- Request self-evaluations from each country, to determine knowledge acquired and success.
- Establish an "international club" for all individuals who have attempted institutionalization, in order to share their ideas.
- Obtain recognition from local institutions in appropriate fields (Association of Communicators, publishers, etc.), through affiliation as representatives of MOH.
- Establish and execute systematic plans to allow domestic personnel such as ECOs to emulate this methodology.
- Reinstate communication plans every five years.
- Achieve interministerial agreements between different countries which have already institutionalized the HEALTHCOM methodology, in an effort to secure its endurance and continuity once financial support has ended.

## HONDURAS

Patricio Barriga, Ph.D.

### INSTITUTIONALIZATION AS A GOAL

The Ministry of Health in Honduras does not have stated institutionalization goals for a public health communication methodology although the institutionalization process has always been implicit in almost all the HEALTHCOM activities. Higher and middle level MOH officials have constantly requested more training in the theory and practice of the HEALTHCOM methodology and have enthusiastically participated in workshops, panels, and symposia where the methodology was presented.

### PRIORITY OF INSTITUTIONALIZATION

The term "institutionalization" has never been used in the MOH, but the idea has always been present. It has been a high priority at least during the last four years of the project. The HEALTHCOM methodology has been seen as both a planning tool to improve primary health care and as a legitimization mechanism for bureaucracy. The first is very obvious and has produced tangible results that only now are being recognized by the MOH power structure. This high priority is shown through increased emphasis on the planning, programming, and budgeting of activities. It has also been evident in the international conferences where physicians in charge of specific programs (ARI and DDC) have presented lectures on creative strategies, social marketing analysis, behavioral analysis, and so forth.

### SPECIFIC TARGETED AREAS

The developmental investigation area has received more emphasis than others, probably due to the exciting nature of this type of activity. Also, this area does not require much risk-taking and is less controversial than the implementation area.

### SPECIFIC GOALS

One important goal is to upgrade the skills of Health Education Division personnel. We have also placed emphasis on the development of new face-to-face communication alternatives, e.g., the use of inexpensive nonconventional media like puppet theatre, handmade flipcharts, community newspapers, and so forth. The latter was carried out in response to various specific requests to HEALTHCOM during the last two and a half years. These activities can be seen in six centers of the Metropolitan Health Region.

A new goal for the last six months of the project is to train regional health personnel and some 20 health educators from the six other countries of the subregion.

## Progress to date

Progress in terms of institutionalizing a health communication strategy can be measured in several ways. Evidence of success on this regard in Honduras includes the following:

- Five professionals know the theory and practice of the methodology (central level).
- Seven technicians (including graphic designers, radio producers and photographers) understand the methodology and are able to conduct pretesting activities.
- Some fifteen higher officials of the MOH show respect for the methodology and they systematically include budget resources for HEALTHCOM implementation.
- Twelve regional educators actively participate in investigation, implementation, and evaluation of HEALTHCOM activities.
- Practically all programs and divisions want to develop their own communication plan in order to organize the use of available resources and systematize the use of communication within their specific activities.
- Some international organizations--INCAP in Guatemala and UNICEF in Honduras--place major emphasis on the design of communication strategies for plans to be implemented.
- The private sector has expressed interest in learning more about the HEALTHCOM methodology (for example, CADER, INFOP, FOPRIDE, CARE, World Vision and the Baha'i Community).
- Two communication plans--ARI and ORS--are now fully funded with A.I.D. and government funds. Two more are in the process of design and development--EPI and Growth Monitoring--and have also received high priority in the MOH's 1987-1988 budget.
- The minister has assigned Dr. Davila, who is a valuable asset to the MOH, to the HED chief's position.
- At least eight new communicator/educator professionals have been hired by the MOH for recently created job positions. They all work with the HEALTHCOM methodology.
- Adequate and comfortable offices (in comparison to all MOH central level units) have been assigned to the HED. We now need to build additional office space since activities and personnel are growing.
- A semi-stable learning community has been established among the HED personnel. They share a common methodology and some basic management skills which are crucial to HEALTHCOM implementation.

## **FOLLOW-UP ACTIVITIES**

Although a great deal has been accomplished--the methodology has been consolidated, both technically and logistically--consistent support needs to be provided to the various MOH levels.

The deteriorating organizational conditions at the ministry at this time are going to have repercussions on the continuity of the HEALTHCOM effort. One of the ministry's weaknesses is the fact that most positions of power are occupied by medical doctors; more variety would be helpful. Unfortunately non-medical doctors don't have the same credibility. In the HED only the chief of the unit is a doctor, and there are no university graduates on the staff. In spite of these limitations the HEALTHCOM methodology has become respected and accepted as a viable strategy for the MOH priority program.

## INDONESIA—JAKARTA

John Davies, Dr.PH.

This report summarizes attempts to institutionalize health communication for child survival in Indonesia, with special reference to case management of diarrheal disease. The report begins with a list of goals and components of health communication, then addresses institutionalization of each component as follows: first, a description of the component as originally planned in 1985-86, then as actually implemented in the Garut test area, and as planned again in 1988; second, constraints and/or "lessons learned"; and third, comments and/or recommendations.

### GOALS AND COMPONENTS

A major goal of USAID's work is to strengthen national and provincial level institutional skills and capacities for continuing intensification of case management. The specific goal is to assist education of mothers, community volunteers (kader), and Health Department officers, to increase the use of correct case management, including oral rehydration therapy (ORT), in the home and at health facilities. The health communication methodology is based upon marketing concepts, anthropological concepts and behavioral concepts. It includes the following components: (1) consumer-oriented formative research; (2) a detailed planning cycle based upon formative research followed by testing, field work, monitoring, reporting, summative evaluation, and revision; (3) appropriate communication media; (4) a variety of existing resources; and (5) overall organization and management.

#### Consumer-Oriented Formative Research

A qualitative study of knowledge, attitudes, and practices (KAP) of mothers, volunteer kader, and health workers in West Java province led to the development of the original communication plan in 1985 which was followed by a more detailed Implementation Plan in 1986. The plans included a marketing perspective aimed at providing a consumer-oriented approach and called for market research, anthropological studies, and behavioral analysis to help planners form the most powerful sets of messages aimed at improving case management behavior. The plans included using the Center for Community Health Education (PPKM) to manage formative research and other aspects of communication.

The Health Department contracted a private sector market research firm, Survey Research Indonesia (SRI) to undertake quantitative summative evaluation during the Garut test in 1986, but hesitated to contract with other researchers, specifically anthropologists and behavioral analysts, to undertake formative studies. By 1988, the use of SRI household surveys was institutionalized in West Java Province; furthermore, the Central Java ROVITA project also contracted with SRI to provide similar surveys. SRI will also undertake at least one more important qualitative study (of doctors) in 1988. Furthermore, a consultant anthropologist employed by Helen Keller International will manage an indepth household ethnography in West Java, and a behavioral consultant will begin formative research in Central Java.

The increased use of consumer-oriented formative research in 1988 is heartening: perhaps it results from the realization among Health Department officers that the communication task for case management of diarrhea is larger and more

difficult than first anticipated and that, consequently, additional study is needed to plan powerful communication. It is also significant that most of the recently-planned formative research will be undertaken by private sector researchers and agencies, indicating that Health Department officers realize that a broader spectrum of formative research is necessary. Whether this recent trend will be institutionalized is an open question. Perhaps it will be institutionalized by the Health Department, if the current studies succeed in producing substantial improvements in KAP.

One lesson to be learned from this experience is that many Health Department officers prefer to be involved as field researchers rather than as managers who contract field work to other researchers. A second lesson is that a test market, as completed in Garut, was of enormous benefit because, among other things, it illustrated that communication managers must plan additional, indepth, formative studies of target consumers if KAP targets are to be met.

Perhaps this experience will lead trained public sector communicators to lean more toward using their scarce human resources for managing communication and less for field research and production of communication materials. The emphasis on management is probably needed because of the large size of the task and because of its complexity. For both reasons, communicators may be more successful if they restrict themselves somewhat toward management functions while harnessing existing research agencies to undertake specialized studies.

### Detailed Planning Cycle

Both of the original plans called for a planning cycle including formative research, pretesting, implementation, monitoring, reporting, evaluation, and revision. The plans were written in English, by expatriates. They were not translated into Indonesian. Additional written plans were not detailed; for the most part they consisted of budgets for local travel and for case management training in West Java province. Very little planning appeared on paper for other components such as staffing, distribution of ORS packets, or monitoring and reporting of field activities in the Garut test area. Although communication materials were pretested before use, there was very little monitoring and reporting of communication activities during the Garut test. The SRI before-and-after surveys provided the major assessment of progress, but could not be expected to suggest why specified effects were weaker than planned.

The major constraint to evaluation, and thus to further planning, was the lack of continuing, systematic monitoring and reporting (probably associated with supervision) in the field. In short, it was the planning cycle which was difficult to institutionalize. This seems to reflect the norm: field activities are usually implemented on the basis of an approved budget rather than on detailed written plans; monitoring and reporting are not common. Perhaps the underlying constraint is the apparent need of Health Department officers to spend budgets only on specified activities--and those activities are mostly meetings--as opposed to field work. An additional, related constraint is the enormous number of meetings and other commitments routinely undertaken by most Health Department decision-makers; many officers are committed to a large number of projects, any one of which could easily command all of the officer's time if he or she undertook detailed cyclical planning including monitoring and reporting of field activities. Another related constraint is the apparent unwillingness of some Health Department officers to spend their budgets outside their own office or division. This tends to preclude hiring others to undertake specialized functions while Health Department officers undertake detailed planning, monitoring, and reporting.

Although detailed cyclical planning, monitoring, reporting, and revision may not be routinely undertaken by Health Department officers, it is probably incorrect to conclude that the concepts are "foreign" in any sense, because they appear to be used routinely by commercial firms such as marketers of household-drugs.

There may be several answers to this issue. One is to try to ensure full-time management of field activities by Health Department officers; this is being attempted in West Java in 1988-89 where one individual has been hired, full-time, to coordinate all field activities including communication; if successful it may lead to institutionalization of the concept. A second answer is for Health Department communicators to lean more toward the three management functions of planning, monitoring, and reporting, while contracting more often with other institutions to undertake specialized tasks such as formative studies, materials design, pretesting, and evaluation. A recent example of such a trend was the June 1988 workshop which introduced communication planning concepts to provincial Health Department officers and which resulted in production of the "National Communication Strategy for Case Management of Diarrhea at the Community Level," written in both Indonesian and English; if this national strategy is adopted by participating provinces it could lead to institutionalization of modern communication management activities including more systematic, cyclical planning. One implication of this option would be the need to secure adequate budgets for field travel and reporting for those officers who specialize in planning, monitoring, and reporting. A third answer lies in the private sector; commercial marketing is alive and well in Indonesia and could probably provide a solid base for organizing and managing a successful joint venture for health communication for child survival with, of course, policy direction from the Health Department. This possibility is discussed below.

### **Appropriate Communication Media**

The original plans called for several media (or channels), including training, interpersonal meetings, radio, and possibly television, to be oriented toward the needs of targeted consumers in accordance with the results of consumer research.

The majority of energy was put into training, particularly training of Health Department officers who, in turn, trained volunteer kader at the community level; the officers and kader were expected to educate mothers of young children. In addition, salesmen for the commercial distributor of ORS packets gave brief training to retailers. A small amount of radio was also used. Evaluation of mothers' KAP showed that volunteer kader and radio had provided only moderate improvement in mothers' KAP, while substantially more mothers appeared to be seeking help from retailers.

The major constraint associated with the emphasis on training was probably the historical emphasis on training. Health Department officers are accustomed to providing large-scale training of volunteer kader and Health Department employees. This channel is often used without support from other channels.

The major lesson learned from the SRI surveys, with the help of additional analysis by the Annenberg School of Communications, was that training alone should not be depended upon to improve the KAP of mothers. The underlying lesson was that rigorous summative evaluation is a useful tool in quantifying impact and for giving some hints of problems that require attention.

From these results it was concluded that more emphasis should be placed in 1988-89 upon mass media, particularly radio and film, along with an experiment in direct

mail. If successful, it may be possible to institutionalize the use of appropriate media. One way of helping to ensure the use of appropriate media is to separate training budgets from other communication budgets. This is currently being tried in West Java.

### **Existing Institutional Resources**

According to the original plans a wide variety of existing institutions would be used to help intensification proceed: PPKM would plan and implement communication activities while the Sub-Directorate of Diarrheal Disease Control would organize and coordinate other activities--notably supply ORS packets and provide clinical training for Health Department staff at national and provincial levels. In addition, the Health Department's Directorate of Nutrition and the National Family Planning Coordinating Board (BKKBN) would be actively involved at the community level in program provinces. Private sector involvement was also planned: one pharmaceutical company, Ciba-Geigy, would sponsor production of some print material, while market research would contract to undertake consumer studies and other companies would contract to produce messages for training, graphics, and radio. USAID/Indonesia and UNICEF would be major donors. WHO would fund some summative evaluation--specifically, morbidity and mortality changes.

Institutional resources narrowed considerably. Officers from the Directorate of Nutrition and BKKBN did not attend planning meetings and their organizations did not become involved at the community level in the Garut pilot area. Ciba-Geigy and another company, Pharos, did sponsor print runs for the pilot area but have not been asked to sponsor production of communication materials for future expansion planned for 1988-89. The Pharos Company also worked in the Garut test area to expand supply of ORS packets from about 150 to 800 retailers but the Health Department has not asked Pharos, or other ORS producers, to intensify retail distribution during future expansion.

The major lesson learned about broadening institutional resource utilization concerns funding mechanisms. Recipients of donor funds appear to prefer to spend the funds themselves, rather than share with other divisions or to contract with private agencies. The simplest answer to this constraint is probably for donors to provide the funds directly to implementing units, such as national government units and provincial units, as well as to commercial firms and non-governmental organizations.

In spite of a decrease in the number of participating institutions--particularly in the public sector--there have been some heartening increases in the use of existing private sector institutions, as described above.

### **Overall Organization and Management**

Although the original plans provided details connected with the issues discussed above, they did not describe exactly how the communication activity would be organized and managed. Overall management and organization was assumed by officers in the national Directorate General for Control of Communicable Diseases, while PPKM coordinated communication.

Following the Garut field test in 1986 it became clear that management and organization needed strengthening if field activities were to progress, expand successfully and be institutionalized. Thus, USAID/Jakarta assisted the Health Department to undertake comprehensive organizational development of the Sub-

Directorate of Diarrhea Disease Control, while providing a resident communication advisor in West Java as well as at PPKM/Jakarta.

Some recent initiatives may soon lead to institutionalization of modern communication, including marketing principles. For example, current discussions will probably lead to USAID supporting social marketing study tours for one or more Health Department officers through the Academy for Educational Development. Furthermore, PPKM appears to be narrowing and strengthening its role. Instead of attempting to undertake a large variety of activities including research and evaluation, PPKM is currently focusing on applying social marketing principles to three management functions, namely communication planning, monitoring, and reporting. This trend could probably be institutionalized quite easily, using a client-consultant model; in other words, PPKM could accept funding to assist specific programs such as diarrheal disease control, immunization, and nutrition by planning, monitoring, and reporting communication activities and social marketing activities.

There is another important issue: the organization base. Given the experience of the past three years, it appears very difficult for intensification to succeed if activities are based only within the Health Department. One option may be to organize a complementary base in the marketing sector. A project management unit based firmly in the marketing sector would provide several benefits, such as ready access to commercial subcontractors, ready access to product distribution systems, ready access to large concerns which appear willing to donate funds or sponsor expensive production of communication materials, and ready access to experienced marketing managers who could operate on a full-time basis. An operation based in the marketing sector would almost certainly market products which would produce funds for financing future operations; in other words it may become partially self-financing and thus highly cost-effective. Such a system could be part of a joint venture; a governing body would provide policy to the public sector operation and to the marketing sector operation. The two operations would be complementary, targeting different audiences with different products but having the same ultimate goals--to increase the acceptance and use of correct case management and thus improve child survival.

## Summary and Conclusions

If institutionalization of health communication is perceived as long-term growth of activities which satisfy a given demand, the seeds appear to be taking root. Three years were required to sow the seeds and to let others participate in the beginnings of growth. Many recent accomplishments are positive and could develop into nationwide models for institutionalization. In addition, private sector organization and management could be tested as a method of complementing and assisting public sector activities.

## INDONESIA—WEST JAVA

Terry Louis

HEALTHCOM has been collaborating with the Government of Indonesia (GOI) West Java Provincial Health Department since 1986 in a program directed at improving the health standards at the community level. Intensification activities of the USAID-funded diarrheal disease control/child survival project are about to move ahead.

Institutionalization is paramount to all development activities and the importance HEALTHCOM has placed on institutionalization of the HEALTHCOM methodology is well-received in West Java and regarded as a high priority. Institutionalizing a program is a difficult task. A good approach is to follow activities through the process of development and let the program and the participants grow with the experience and appreciate the benefits of using an organized methodology.

The HEALTHCOM methodology in West Java includes the following components: (1) consumer-oriented formative and summative research; (2) detailed cyclic planning which covers fieldwork, testing, monitoring, reporting, evaluation, and revision; (3) developing well-planned communication activities; (4) establishing general organization and management structures; and (5) identifying and strengthening localized resources.

### BACKGROUND

USAID has been assisting 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 CDD activities with emphasis on increasing access and use of case management.

The pilot project in 1986 selected Garut regency (population 1.6 million) for its intensification program. A baseline KAP study was followed up with an intensification program of six months and a post-test in 1987. The West Java Health Department further intensified training activities in three additional regencies in 1987.

In late 1987 a comprehensive Social Marketing Plan for Control of Diarrheal Disease was developed. This plan was prepared to cover the period January 1988 to September 1989 and field activities were targeted to begin in April after a March-April baseline KAP study. The baseline KAP survey has been completed and the data is being analyzed to provide the information needed to build the communication platform. Field work has been delayed due to administrative reasons and activities have just begun to move forward.

A major goal of USAID's work is to strengthen national and provincial-level institutional skills for continuing intensification of child survival activities, especially CDD activities. USAID technical assistance for communication/social marketing includes a resident advisor for West Java employed by AED. The advisor is attached to and works with the Health Department's Center for Community Health Education (PKM). PKM has assisted CDD intensification in West Java since 1986.

## GOALS AND OBJECTIVES

The major goal of USAID's work is to strengthen the provincial level institutional skills and capacities for continuing intensification of case management. The specific goal is to assist in the education of mothers, community volunteers (kader), and health department officers, with the objective of increasing the use of 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.

## HEALTHCOM ROLE IN INSTITUTIONALIZATION

HEALTHCOM institutionalization objectives in West Java rest mainly in social marketing activities being conducted within the HEALTHCOM Project. Institutionalization will not take place without real activities that will lead to building management techniques, practices, and an appreciation for social marketing methodology applications.

The practice of social marketing, using organized methodologies of planning, research, monitoring, and evaluation, will greatly help Indonesian management to draw their own conclusions on organized management system operations. They will learn to see the value and efficiency in the social marketing approach and "institutionalize" what they learn.

The HEALTHCOM objective should be to direct and expose appropriate individuals to the different research techniques; to illustrate the benefit of monitoring which could save time, energy, and money; to identify established resources like advertising agencies, printing, and production outfits; to show them the benefit of using the talents and expertise in those organizations to produce good communication materials; and most importantly, to develop as managers.

The West Java project provides a good opportunity for institutionalization. Working closely with the two other HEALTHCOM sites in Indonesia, Jakarta and Central Java, will greatly increase the opportunities for institutionalization. The three resident advisors work closely in terms of research, communication, monitoring, and institutionalization plans and activities. This is another positive step toward HEALTHCOM institutionalization in Indonesia.

One of West Java's institutionalization objectives is to promote better interaction between field PKM officials and Central PKM staff. Presently the interaction between province and PKM Central is relatively weak. The provinces are not convinced PKM is technically competent to provide the project assistance, and this feeling extends beyond PKM province staff. The West Java CDD staff responsible for the implementation of the CDD program are often reluctant to include PKM Central in their program plans. However, every attempt is being made to develop a dialogue and provide opportunities for PKM Central to be actively involved in specific program activities such as the development of counseling cards and some formative studies.

Two important issues will have an impact on institutionalization in West Java: the first is that the management team, in terms of talent and motivation, are way above the norms of Indonesia; and the second is that the approved West Java social marketing plan

provides for activities in research, communication, monitoring, evaluation, and ample funds for each of the activities. This will enable the management team to have "hands on" experience and thus start the process of institutionalization.

The specific strategy of West Java is the systematic use of HEALTHCOM methodology in:

- **Planning**-- To illustrate the need to review plans periodically and use the monitoring results to modify plans if needed.
- **Research**-- To expose the management team to various types of research (ethnographic, indepth interviews, focus group interviews, retail audits, behavioral observations) to use the data to develop strategies and material for use in the program.
- **Communication**-- This is an area in which the management team needs development. The team is not familiar with mass media in terms of creative planning, development of a creative brief, evaluating the developed material in terms of the brief, understanding the media mix, and media planning and placement. The task is to work closely with the team and professional organizations, helping them to understand the communication development process. Plans to use private sector advertising agency professionals will help us achieve this goal.
- **Monitoring**-- The area of monitoring needs careful attention because the West Java management team spends little time on it. This is due largely to the work load of the officials who have a variety of job responsibilities. A great deal of time is spent on developing programs and plans and little on seeing how they are working. The strategy will be to prove the value of monitoring by building it into the planned activities and demonstrating that monitoring can relatively easily make a difference in program results. Monitoring will be an integral part of the West Java program process.
- **Evaluation**-- The program believes that evaluation is important and funds have been provided in the work plan for this activity. The challenge is to ensure that funds are used effectively for systematic evaluation and evaluation plans are developed with proper techniques.

In summary, the West Java institutionalization plan is to use the activities of the program to develop and install a self-sustaining system.

## INDONESIA—CENTRAL JAVA

Thomas K. Reis

### BACKGROUND

The HEALTHCOM Project in Central Java is collaborating with the Government of Indonesia (GOI) Central Java Provincial health department and Helen Keller International (HKI) on a USAID funded vitamin A capsule and diarrheal disease control child survival project, called ROVITA. HEALTHCOM is contributing long-term social marketing technical assistance by providing a resident advisor. HKI is assisting the GOI with overall administration of the project. Additionally the Public Health Department of a local Central Java university, the University of Diponegoro (UNDIP), is collaborating on the project.

The ROVITA project team consists of several medical doctors from UNDIP, vitamin A and DDC program managers from the health department, a health education specialist from the health education department (who functions as the HEALTHCOM resident advisor's counterpart), an HKI (expatriate) project manager/administrator, and the HEALTHCOM resident advisor.

One of the major positive aspects of the ROVITA project is the management team. Virtually all of the key team members are highly talented and motivated individuals committed to doing quality work within the project. This is not an everyday reality in Indonesia. Although all of the team members are very busy and have many other responsibilities in addition to the ROVITA project, there is real potential for institutionalization with this team on several fronts.

The following institutionalization plan of action is therefore built around the strengths and weaknesses of both the systems/organizations in the project (and Indonesia) and the particular people who make up the ROVITA project management team, with, of course, the Health Education specialist (the HEALTHCOM resident advisor's counterpart) being the key player in the process.

### GOALS, OBJECTIVES (and Progress Update)

#### Helen Keller International (HKI)

HKI has stated in its project implementation plan that an important overall project objective is to institutionalize the application of social marketing techniques using systematic coordinated communication within the two project interventions: increased vitamin A capsule distribution and improved diarrheal disease control. HKI purposely kept this objective general and without specific detailed plans, with the long-term social marketing consultant to be responsible for a detailed plan of action once the project began activities.

Within the ROVITA project objectives there are other institutionalization objectives such as establishing and solidifying better capsule distribution management systems, better utilization of computer technology by health department personnel, and promotion of collaboration between the Department of Health and a large academic institution (UNDIP). These are all institutionalization management priorities for the HKI management team. However, as institutionalization relates to HEALTHCOM

methodologies, HKI has clearly stated it wants to teach and incorporate systematic social marketing techniques within the health department and perhaps UNDIP, with the long term social marketing advisor (HEALTHCOM) initiating and managing the process.

#### **HEALTHCOM: As Part of Overall HEALTHCOM/Indonesia**

The HEALTHCOM institutionalization objectives in Indonesia revolve around real social marketing activities being conducted by the HEALTHCOM projects. It is our contention that institutionalization will not take place without real activities upon which to build management techniques, practices, and so forth. The process of actually doing social marketing using the systematic methodologies of planning, research, monitoring, and evaluation will enable the Indonesian management teams to draw their own conclusions about this type of management system. They will decide themselves what is valuable, efficient, too time consuming, too expensive, etc., and "institutionalize" their conclusions accordingly.

It is HEALTHCOM's job to expose them to the various techniques of research, to illustrate why monitoring will ultimately save them time and money, to begin to convince them that standardization and objectivity are vital in evaluation of activities, and so forth.

The various procedural elements of HEALTHCOM's methodology are reasonably straightforward. To what extent these components can be institutionalized depends upon the particular project setting. Central Java-ROVITA is a provincial "operations research" social marketing child survival project within the eyes of the GOI. It must follow central policies--with appropriate adjustments--and work within mandated priorities, but provides a positive setting for institutionalization, as flexibility and some experimentation are allowable within an "operations research" project such as this. Additionally, because HEALTHCOM Central Java is working closely with the two other HEALTHCOM sites within Indonesia, Jakarta and West Java, there are increased opportunities for institutionalization on a greater scale.

HEALTHCOM's Jakarta based resident advisor is currently spending the majority of his time in the headquarters of the health education department (PKM) within the Ministry, strengthening organizational capabilities by utilizing priority activities (mini-projects) such as workshops and various field trips. He is working closely with the HEALTHCOM's two provincial operations research projects, ROVITA and West Java, using their project activities as organizational/institutional builders for his counterpart staff. In West Java, the HEALTHCOM activity is primarily targeted towards diarrheal disease control. It is on a larger scale than Central Java--larger area, larger budgets, etc., but methodologies are similar in both projects.

Thus, HEALTHCOM has a Jakarta-based central "axis" and two "spokes on the wheel"--ROVITA and West Java. The three resident advisors are working accordingly in terms of research, communication, monitoring, etc., of activities and institutionalization plans and activities.

One of Jakarta PKM central's institutionalization goals (and Central Java's goals) is to promote better interaction between field PKM personnel and headquarters PKM staff. This involves HEALTHCOM promoting functional and relevant roles for each "player": PKM headquarters provide resources (financial, creative, technical, etc.) to the provinces when requested; provide current data on changing technical issues (such as ORT); share experiences/data from other provinces to facilitate communication among

the provinces. The provinces, on the other hand, assist PKM central and policy creation, programming priorities, strategy planning, etc., based upon their experiences and outcomes of field government policies.

**Status:** Interaction among the provinces and PKM central is still relatively weak. The provinces are not convinced PKM central has "that much to offer" them. They are also wary of the central bureaucracy. However, a formal dialogue on national communication strategy for diarrheal disease control recently took place between headquarters and the provinces with excellent results (see below), thus some positive interaction is beginning.

### **Communication Strategy Workshop**

A workshop was hosted by PKM central (with HEALTHCOM providing significant planning assistance and organizing) in June, 1988. Several DDC priority provinces were invited and essentially the national communication policies and strategies for DDC were hammered out between central and provinces (as opposed to just central deciding). This is an example of an activity promoted by HEALTHCOM geared towards reaching the institutionalization objective of better interaction a between central and provincial field.

**Status:** Central Java benefited greatly from this workshop. We had three Indonesian attendees and all participated with great animation. They now want more of this type of input into national policy.

The "axis and spokes of the wheel" relationship between central Jakarta and Central Java/West Java has begun. The prime mover on this will be John Davies, Jakarta HEALTHCOM resident advisor. This is a critical part of the overall Central Java institutionalization plan. Activities will continue to be planned that facilitate further interaction between Jakarta and the field.

### **HEALTHCOM: Specific Internal Central Java**

Two important issues affect the Central Java "localized" institutionalization plan. The first has been mentioned--the fact that the management team is well above local standards in terms of both talent and motivation. The second is that ROVITA has a relatively small budget with which to carry out social marketing communication activities. Although the budget is somewhat constraining at times, the reality is that this budget is "replicable" in terms of the current financial resources of the GOI. If HEALTHCOM can carry out high quality, systematic social marketing activities within this budget, we think the budget will be at a level to be institutionalized within PKM provincial departments elsewhere in Indonesia, if they feel the "payoffs" are sufficient for their investments.

With these two influencing factors in mind, specific strategies and goals are:

#### **Systematic use of HEALTHCOM methodologies**

- **Planning**— The ROVITA team members are already excellent planners. The only area that needs work is to convince them that "plans are plans," that they can be changed if need be (if project monitoring illustrates the need, for example).

- **Research**— The current level of familiarity with research activities, etc. is good. The various types of research—ethnographic, indepth interviews, focus groups, audits, surveys have all been previously used by the HEALTHCOM resident advisor's counterpart on the ROVITA team, Victor Sartono. He already knows that research is a necessity in all marketing activities, but his use of data is still weak at times. If pretesting, for example, results in major changes in communication materials, there is often a "denial" process that takes place--rather than a willingness to believe the data and make necessary changes. Thus, the institutionalization objective here is not to introduce the various methods of research (already completed) but rather to emphasize quality usage of research data. The strategy is simply to continue to conduct marketing research and by example promote better usage of the data. Other ROVITA team members (primarily the program managers for vitamin A and DDC) are also familiar with most types of marketing research and are quite involved with these activities in spite of their busy schedules.

HEALTHCOM will, however, introduce one new type of marketing research to the ROVITA team--behavioral observations. John Elder (behaviorist consultant) will spend August, 1988, in Central Java establishing a behavioral study for the team to conduct. The team is ready for this level of sophistication and already appreciates the difference between self-report and observational data.

- **Communication intervention activities**— Again, the resident advisor's counterpart, Victor Sartono, is already familiar with most media in terms of creative production, media mix, media planning, etc. He is very creative himself. The challenge we face in this area brings into focus the second overall issue mentioned above affecting the project--budget.

How can we best utilize our limited funds? We have decided that the private sector must play a role in the creative production process of communication materials--there is simply not enough resources or talent within the health department to do quality work. But how do we keep our costs down? In the area of interaction with the commercial marketing sector, Sartono is relatively inexperienced. He wants to work more with the private sector and realizes that if he can find ways of efficiently using private sector talent, he can stretch his budget and produce quality creative work. Thus our institutionalization strategy here is to promote efficient and economical ways for the health department to work with the commercial marketing sector.

**Status:** In our first wave of communication materials development (for vitamin A capsules) we decided we could not afford an advertising agency. We "shopped around" and found a radio station that had script writers and studio producers who wanted to earn some extra money on the side. We ultimately produced three radio spots with them "moonlighting" in their own studio for a very inexpensive price (U.S.\$50 per spot).

Additionally, the resident advisor and his counterpart negotiated heavily for broadcast prices with the radio stations that will run the spots. These were new experiences for the Health Department. Sartono is anxious for more of the same now that he has seen how the commercial sector can actually be quite efficient and inexpensive if "pushed" correctly.

- **Monitoring of activities**— This is the area that needs the most attention within the social marketing process in Central Java. Monitoring here is still considered almost a luxury. Everyone is so busy getting their programming done that there is little additional time to monitor and make adjustments. HEALTHCOM will make an extra effort in this area to convince our programmers and marketers that adjustments always have to be made once a marketing program begins. The strategy will be to prove the value of monitoring by utilizing it with our planned activities and illustrating that changes resulting from monitoring can often be made relatively easily and can make big differences in program results. Monitoring of radio broadcasting, kader training sessions, and issues such as whether or not our vitamin A cloth banners are up in priority locations in villages, are examples of activities to be conducted soon. We hope to make monitoring an integral part of the program process in the minds of our Indonesian counterparts.
- **Evaluation**— The ROVITA management does not need to be convinced of the value of evaluation. The issue is money. Evaluation is often considered a luxury which can be cut back if needed. If a programmer doesn't have enough money in his budget for radio spots or vitamin A capsules, should he set aside money for evaluation? This is a constant project management issue in Indonesia. The pressures of funding will influence these decisions greatly. HEALTHCOM can work to make our Indonesian counterparts better evaluators and more familiar with KAP techniques, etc. However it is unlikely HEALTHCOM will ensure that evaluation will always be a part of social marketing programs in Indonesia.

In summary, the Central Java HEALTHCOM institutionalization plan is two-pronged. The first strategy involves working together with other Indonesian HEALTHCOM activities, stressing interaction between the field and headquarter management. The second strategy is geared towards conducting daily quality social marketing activities within the ROVITA project, utilizing systematic HEALTHCOM methodologies. The two influencing factors throughout this second strategy are the strengths and weaknesses of the ROVITA management team and the limited but replicable budget we are working within.

HEALTHCOM Central Java is not making institutionalization a separate "piece of work" apart from program intervention activities. The institutionalization plan is built within intervention activities stressing quality control and quality usage by team members of the social marketing management process. We hope to prove the value of the various HEALTHCOM methodologies with better than average program results, thereby better ensuring their continued usage--our definition of institutionalization--once HEALTHCOM technical assistance ends.

## JORDAN

Anne Roberts

Institutionalization of the HEALTHCOM approach has been a major objective for the Noor Al-Hussein Foundation (NHF) from the inception of this project. Plans call for training staff within NHF as well as resource persons from health care organizations, academia, private and public sector media, and advertising personnel.

### STRATEGY

After discussion and some trial and error, it has been decided to establish an ad hoc group who will be able to provide expertise and experience as needed during the process of message development and program implementation. This group includes MCH specialists from organizations providing health care or health messages for low income women and children; public and private sector media production people; artists and script writers, and communication specialists from the universities. Members of the team will be involved as appropriate in various phases of the process, and training in specific skills and concepts will be provided at critical points.

### OBJECTIVES

By project completion, NHF project staff, selected members of the Ministry of Health, and team members will have an increased capacity for:

- conducting formative research to determine health education priorities and messages;
- utilizing this research effectively for project and message design;
- using effective methodologies for systematic analysis of behavioral options;
- maintaining collaborative links with other agencies involved in project implementation;
- managing program resources (financial and human) for greatest impact;
- identifying resource persons in the community to strengthen program success;
- planning production and maintaining quality;
- evaluating impact for communication projects;
- pretesting and monitoring of messages for impact; and
- using monitoring data to refine messages and objectives.

Constraints identified to date include:

- lack of private and public production people;

- lack of effective planning skills; and
- poor scheduling, resulting in lost time and over-emphasis on editing to rescue mediocre materials. We estimate that 65 percent of time could be saved with good planning. Because of time problems, steps are skipped that are needed to ensure quality.

Health care personnel tend to rely upon generic materials rather than consumer reactions or KAP. They feel that the consumer is to blame if information is not understood or retained. All lack experience in or enthusiasm for effective collaborations between and within agencies.

The project implementation plan includes training for team members during the first phase (June 1988-January 1989) in:

- HEALTHCOM methodology, concept development, team work, pretesting, and feedback on messages (entire team). Conducted by Elkamel.
- Pretesting, revision of messages, and production planning (production task force). Conducted by Elkamel.
- Final revision and production techniques (productions task force). Conducted by Elkamel.
- Developmental communication (print, television, and radio journalists). Conducted by Bahous.
- Evaluation design (ten policy-makers from universities, medical schools, and so forth). Conducted by McDivitt and Abulaban.
- Pretesting with focus groups and analysis of data (representatives from UNRWA, MOH, and NHF). Conducted by Roberts and Issam.

Training objectives during the second phase will be determined by further or remaining needs identified during the first campaign cycle.

A third cycle, to be implemented immediately after the AED involvement, will be planned and initial activities carried out with AED support to increase potential for success of this independent NHF effort.

In addition we are collaborating with the MOH to provide seminars on breastfeeding and child spacing, followed by regular review meetings, which will provide good experience in reaching out to the private sector for the ministry and NHF.

## **COLLABORATION WITH OTHER AGENCIES**

Increasing working links with the Ministry of Health has been a priority.

- RONCO Consulting Corporation is providing training in clinical and information, education, and communication (IEC) skills in child spacing for MOH personnel. HEALTHCOM is coordinating with RONCO/MOH in evaluating the two projects. Agreement has been reached on several

questions to be added to the clinic intake form developed for the RONCO evaluation. These questions will help distinguish between the effect of increased services and MOH outreach (RONCO), and that of the HEALTHCOM campaign on changes in numbers of women seeking information and services.

HEALTHCOM will also provide the MOH with information from our baseline data study on child spacing KAP for those clusters surrounding the new MOH child spacing service centers. Dr. Ayman Abu Laban, research specialist at NHF, assisted in RONCO training for MOH personnel on methods of interviewing clients on their needs and practices, and in January may assist in training these same personnel in evaluation of project impact at the clinic level.

- The Ministry of Health and the United Nations Relief and Works Agency (UNWRA) will be working with the project to organize and assist in facilitating the pretest focus groups, and if practicable, the monitoring of the message reception, comprehension, and acceptance.
- The Ministry of Health and HEALTHCOM are collaborating closely on a series of seminars for health providers, in both child spacing and breastfeeding management.
- Staff met with the Minister of Health and MOH staff to discuss their policies on the practices HEALTHCOM planned to advocate in messages and in the National Breastfeeding Seminar. Although some of the Ministry educational materials do in fact advocate, for example, exclusive breastfeeding for four months, other materials advocate supplementation as early as the second month, and many senior staff were doubtful of the wisdom of delaying supplementation past this point. HEALTHCOM and several specialists attended the meeting, which concluded in official and public ministerial support of early initiation, delayed supplementation, and avoidance of bottles and the practice of sending formula home with mothers from hospitals. The MOH agreed to revise their materials to be consistent with these practices.
- The MOH and the NHF collaborated in sponsoring a National Seminar on Breastfeeding, October, 17-18, under the patronage of Her Majesty Queen Noor Al-Hussein. The seminar brought together 130 influential representatives of all segments of health care, communication, education, community, and religious groups that can play a role in breastfeeding policy, promotion, and practices. Funding was provided by A.I.D. (Office of Health and Office of Nutrition). The seminar featured presentations by Drs. E.F. Patrice and Derrick B. Jelliffe, international specialists on infant nutrition, and specialists from the Ministry of Health, HEALTHCOM, and UNICEF. A.I.D.'s Nutrition Communication Project made arrangements for the program and distributed materials. The participants strongly recommended the creation of a National Task Force on Breastfeeding, a multi-sectoral National Breastfeeding Campaign, and universal adoption by professional medical associations, hospitals, and clinics of scientific, modern breastfeeding practices, and specific policies to support them (such as rooming-in, pre- and post-natal breastfeeding education, etc.) Participants also recommended changes in legislation to enable working women to continue to breastfeed.

## CONSTRAINTS

- **Time Limitations**-- Because of the administrative and personnel problems encountered in the first year of this project we are in fact left with only a fifteen-month activity. It will be difficult to complete reliable institutionalization during this period.
- **Funding Restrictions**-- We must rely on persons who are interested in contributing their time or assisting NHF, instead of offering realistic monetary incentives. This problem is exacerbated as USAID is simultaneously mounting a related communication project with a production budget reportedly at least five times ours. This has made it difficult to compete for the interest and commitment of local media people.
- **Informal and loose liaison with MOH and other service delivery organizations**-- The fact that the Foundation is not a health care organization, and that our relationship with the MOH Health Education Unit is tenuous, makes team building for the future difficult. There is a feeling at the MOH that this should have been their project and therefore they have some resentment of our role.
- **Further training needs**-- In addition to the planned activities there is a need for technical assistance in project management for senior staff. Similar to most health care projects, project management is the responsibility of staff with sound technical and research skills, but with little experience in project management, budgeting, goal setting, planning, or supervision. While much of this can be acquired through the process of project implementation, a manual with field tested, simple methods of developing action plans, conducting meetings, role or task assignment, reporting procedures, priority setting, team building, money management, and so forth, would be useful to regional advisors and senior staff. If these tools were drawn from HEALTHCOM experience and were therefore directly relevant to the problems and opportunities such projects face, they would be particularly effective and easy to use. A regional training workshop incorporating methods with suggested application, adaptation, and so forth, would be valuable. My experience here as well as that in other similar projects suggests that institutionalization will in the long run depend upon effective management. Management of these projects presents special problems to project staff and a plan for assistance should be available.

## LESOTHO

Edward F. Douglass, Ph.D.

In the context of international development, institutionalization is a process of insuring that what a project has introduced and taught a host organization becomes an integral part of the organization's operation. Whether the project introduces new personnel, skills, equipment, objectives, or ways of accomplishing goals, these changes must be self-sustaining in order to say that institutionalization has occurred. It will not occur if the project fosters dependence on short-term expatriate expertise or short-term donor resources.

Institutionalizing a health communication methodology is one of the goals of the HEALTHCOM Project. A resident advisor--a specialist who lives in the country for at least two years--is charged with implementing the HEALTHCOM Project in collaboration with health education specialists of the host country, called counterparts.

The pattern of behavior to be inculcated at HEALTHCOM Project sites is a particular way of going about the creation, presentation, and testing of health education materials which is known as the HEALTHCOM methodology. This communication methodology has as its ultimate aim a change in behavior of mothers so that the incidence of sickness and death in their children under five years of age will be reduced.

The Academy for Educational Development and USAID/Washington have a serious interest in implanting the HEALTHCOM methodology in health education units in ministries at HEALTHCOM Project sites. And why not? The methodology has proved effective in promoting several health technologies in several countries, and there is confidence it will be effective when applied to an even wider range of public health problems. If the methodology is embraced and utilized by the staff of health education units, there should be a noticeable increase in the effectiveness of public health education, and a resulting change in behavior in desired directions.

It would be ideal to have at least a generation to institutionalize a complex human activity like the HEALTHCOM methodology. Unfortunately, HEALTHCOM resident advisors have only from two to perhaps four years. If progress toward institutionalization is to be made, with what should the resident advisor be concerned?

The experience with institutionalization to date in the Ministry of Health in Lesotho suggests two major tasks for the resident advisor. One is to introduce and teach the methodology and demonstrate its effectiveness to Health Education Unit staff and management personnel, as well as to their superiors at every opportunity. The second task is to create or strengthen structures and systems of management so that the methodology has a favorable environment in which to live after the life of the project.

### TEACH AND DEMONSTRATE

Formal classes, seminars, and workshops are the usual ways to teach a methodology. These have certain advantages which include focused attention on aspects of the methodology, systematic coverage of the topic, and some useful public relations visibility for the HEALTHCOM Project. But there are disadvantages, too. The first is that seminars and workshops can be time-consuming for the advisor. Secondly, protocol and custom may require elaborate proceedings which take up time which might be better

spent on teaching and practicing the methodology. A final disadvantage is that seminars tend to be theoretical and the practical applications which are included tend to be underemphasized and divorced from reality.

An alternate approach to formal teaching involves the application of the methodology while working one-on-one with the staff. The advice-giving fits more naturally with the work and has a less authoritarian ring to it.

In addition to teaching the methodology, the way a resident advisor works with the staff and management of the Unit has an important effect on the permanence of the implantation. The advisor should not do the work him or herself. Despite the formidable temptations and time pressures from Washington, the rule should be: always work with at least one member of the staff. People do not learn very much from watching. Tasks accomplished by hard-working advisors on nights and weekends have practically no potential for instilling belief or building skills in the methodology. (Thinking through, planning, and preparing what needs to be done to involve counterparts in the methodology are appropriate after-hours activities.) It is unlikely that any of the local staff will feel much pride or take much responsibility in the work if they do not personally take part in it.

The advisor's internal temptations to break this rule include most of the human foibles: the creative desire to do something of one's own, the need to demonstrate one's skills, a drive for perfection that doesn't sit well with the early products of staff who are in training, and, most significantly, impatience. The external pressures on the advisor stem from: project "deliverables," and the requirements of at least three "bosses" to list some "concrete" accomplishments on an evaluation form. (The "bosses" will include the head of the health education Unit, the project officer at the USAID Mission, the backstopping officer at AED, and, in a quadruple blessing, the technical officer of a CCCD project as well.)

## PUBLICIZE RESULTS

Although teaching counterparts in the ministry instills a certain amount of belief and confidence in the methodology, these only become self-reinforcing when counterparts see desired results coming from their own efforts. Practicing the skills and techniques during the life of the project are critical to institutionalization.

It is difficult within the time frame of a HEALTHCOM project to prove that the methodology as a whole works and works better than what has been in use before because results on a grand scale only appear near the end of the project. Results from other such projects, from the Mass Media and Health Practices Project (the precursor of HEALTHCOM), and other ongoing HEALTHCOM projects may help to convince, but these results are not local proof. However, results from early stages of implementing the HEALTHCOM methodology can begin to prove its value, especially if the resident advisor calls attention to these results. One example would be to identify results from qualitative studies of the target audience. The findings can be very revealing to health educators as well as to professional health staff.

In Lesotho, for example, qualitative studies showed that mothers made distinctions between eight different kinds of diarrhea. Mothers had differing levels of concern about these diarrheas and they had quite different behavior patterns in the treatment of each kind.

This was new knowledge for most of the health educators and health professionals. It made them realize that they were not as conversant with diarrhea and its treatment as mothers were. Furthermore, it was not difficult for the health educators to recognize that without this knowledge of what mothers knew and typically did, communication with mothers would have been off target. For example, one kind of diarrhea is thought to be caused when a child crosses the path of or gets too close to a woman who is wearing a kind of perfume thought to be irresistible to men. The child then contracts a virulent kind of diarrhea which, by its symptoms, appears to be dysentery to Western medicine. Because of the perceived cause, the mother takes the child to a traditional healer and does not believe that ORS or SSS are appropriate treatments for this particular kind of diarrhea.

As a result of this experience with research results, the terms "KAP studies" and "focus group interviews," techniques of formative research in the HEALTHCOM methodology, are among the new buzz words at the Ministry of Health.

The results of the pretesting of health education materials provides a second opportunity to demonstrate the efficacy of another essential stage of the HEALTHCOM methodology. Health education unit staff are often capital-bound. They generate materials for a target audience, taking as much care as they know how to create messages that seem to be clear and unambiguous. The process of pretesting frequently reveals that the target audience understands the materials in an entirely unforeseen way. In some cases, the intended message is lost or, worse, misunderstood. (See Field Note entitled, "Pretesting Health Education Materials" by this author.)

The graphic artist or the radio producer is usually deeply embarrassed by the miscommunication and quickly learns that pretesting can save him or her from making a serious communication mistake. He will come to rely upon this part of the methodology. To the extent that pretesting is felt to be crucial to and is used regularly in the creation of educational materials, institutionalization has taken place.

## STRUCTURE AND ORGANIZATION

Beyond the resident advisor's teaching efforts, work behavior, and the highlighting of the value of particular steps in the HEALTHCOM methodology, lie a series of potentially more difficult impediments to institutionalization.

One fact which was immediately apparent in Lesotho was that the HEALTHCOM methodology is much more labor-intensive than the approach to health education used before. Because the methodology aims to achieve behavior change, it implies communications programs in support of diarrheal disease control or immunization, and not just campaigns. It calls for an integrated effort involving health workers at all levels to teach the target audience(s), the extensive use of print and graphic materials, as well as the intensive use of radio. To produce behavior change, this tripartite effort has to be sustained over time, with special periods of intense work timed to a diarrheal season or a repeating urban vaccination cycle.

In Lesotho, this much energy and resources have never been put into health education efforts. The implications of the methodology in terms of size and skills of staff and in terms of the management of human and material resources are very significant. Obviously, without appropriate staffing levels the methodology cannot be sustained, let alone extended to additional public health problems.

What can an advisor do when there are not enough staff? There are a number of possibilities. One action which should have been taken when setting up the HEALTHCOM project in Lesotho was to be sure that the advisor would have counterparts. In Lesotho, the advisor advises on the development of the Health Education Unit. The appropriate counterpart was the head of the Unit and this working arrangement existed from the beginning. But the advisor is also responsible for carrying out HEALTHCOM-style communication interventions in support of the country's programs in the Control of Diarrhoeal Disease, the Expanded Programme on Immunization, breastfeeding and infant nutrition, and child spacing. There were no counterparts for the tasks of designing and implementing complex programs of communication support for these four public health topics. Working with the graphic artists and the radio producers was a part of what was needed. But the other important steps of the HEALTHCOM methodology, especially the management of a complex of activities, could not be carried out without counterpart(s) if institutionalization was a goal.

It has been very difficult for the government to provide the necessary staff positions to carry out health education in the HEALTHCOM way. The advisor needed to put considerable energy into working with the head of the Unit to persuade the ministry authorities to fund new staff positions. The effort has paid off: the staff of the HEU has nearly doubled in size in the first 18 months of the project and there is a counterpart for the design and implementation of communication interventions.

Several tactics were used to increase the size of staff. First, it was found that health education unit staff positions had been previously "borrowed" by other units in the ministry and not returned. It was easier to reclaim lost positions than to find new money.

Efforts are also being made to secure the transfer of positions from other units of the Ministry of Health. The ministry is placing a higher priority on health education at present. It may be politically feasible to move positions away from programs of the ministry which do not enjoy as high a priority and attach them to the Health Education Unit. Caution is advised, though, on at least two counts. One is that an individual gained this way may be willing and able, but may come with little or no experience in health education, let alone in the HEALTHCOM way of doing things. A period of training is required before the new staff member can be fully productive. The other caution is that the "contributing" unit may see this as the opportunity to rid themselves of a problem employee.

It is important for the resident advisor to appeal for new positions consistently whenever taking on or being given new responsibilities, or to encourage interministerial transfers (secondments). The sudden and massive attention now being given to AIDS is a case in point. The Health Education Unit acquired three new positions for health education on AIDS, keeping staff who were being counted on for immunization and oral rehydration therapy from being swallowed up by the AIDS effort.

It is worth noting that none of the tactics above for obtaining more staff involve the use of donor-funded positions. Donor funding is usually of short duration and does not contribute to the long-term building of the Unit. Donor-funded positions are very useful, however, for two things. One is to cover a position while a regular staff member is sent off for further training. The second is to contribute to the on-the-job training programs of the Unit.

If there are enough staff to carry out HEALTHCOM-style interventions and if the training of the staff in the methodology has been effective, there are still other factors which may need attention if institutionalization is to occur.

## ORGANIZATION AND MANAGEMENT

One of the factors is the organizational structure of the health education unit itself. Does the structure favor the methodology? For example, does the structure allow for the design and implementation of integrated, multi-media programs of communication support? Do the graphic artists work rather independently of the radio producers or do they work in teams? Who designs and coordinates the work of the graphic artists, radio producers, and researchers? Does nearly everyone report directly to the head of the unit with no middle-level management?

The staff in the Health Education Unit in Lesotho has grown in size to the point where no human being can keep adequate track of and provide guidance for as much activity as is presently going on. There needs to be a middle level of management with delegation of responsibility and authority to the midlevel managers. Without such a system, the HEALTHCOM methodology cannot be carried out on more than one or two health topics at a time.

Institutionalization requires a look outside the health education unit at the organizational structure of the ministry. Is the health education unit in a position to control health education in the country or is health education carried out by several organizations which are not well coordinated? Is the health education unit an integral part of the development of the ministry's health care programs or is the unit brought in only to promote the desired practices? It is most fortunate in Lesotho that in terms of structure and responsibility, the Health Education Unit is in a position to participate in every aspect of health education in the country.

The HEALTHCOM methodology relies very much on face-to-face teaching of the public by professional health workers of all grades. In Lesotho, the Unit can work with the faculty of the training institutions so that course content is consistent with what the Unit is teaching by other means. This means that in the long run, professional health workers such as nurses and pharmacy technicians will know and be able to teach the public what the public is learning from a communication medium such as radio.

The Health Education Unit also participates in the continuing education of health workers of all kinds. The Unit provides training materials and teaching aids which effectively control the content of what nurses and village health workers teach mothers. The promulgation of standard health education messages helps to avoid the danger that disparate parts of the health system will be communicating different messages to the target audience(s). If mass media messages conflict with and undercut the teaching of mothers by nurses, a problem of serious proportions would exist.

The structure of the ministry in Lesotho also favors the coordination of the work of the Health Education Unit and programs such as immunization, the control of diarrheal diseases, family planning, and acute respiratory infections. The Unit is represented on the coordinating committees of all these programs. Furthermore, one of the Unit's stated purposes is to provide communication support to these programs and the heads of these programs are regarded as the experts on the technical aspects.

Doctors in government service and private practice in Lesotho have an important influence on the success of a health program such as ORT because of the high regard mothers have for them. The number of doctors in Lesotho is growing rapidly. Many of the doctors are expatriates who come only for two-year tours, creating a large

turnover. These doctors are often given important positions of responsibility such as heading district hospitals and health management teams. Unfortunately, there can be wide differences in levels of enthusiasm for ORT among these doctors, for example, depending on their training and prior experience.

Recently the Unit has enthusiastically supported what will become a regular orientation program by the ministry for new doctors. The Health Education Unit presented the doctors with an overview of our most active health education programs, provided them with health education materials, and appealed to them to support the ministry's policies and programs through their patient education efforts.

About half of Lesotho's hospitals and 60 percent of its clinics are operated by religious mission organizations. They organize themselves through the Private Health Association of Lesotho (PHAL). Because of their importance to health care delivery and health education, it is important that mechanisms of coordination on health education be developed. The danger is that mass media messages generated by the Health Education Unit could conflict with different health messages given out by PHAL nurses. The Unit is in the process of developing standard messages to be used by all health educators in Lesotho. The messages are accompanied by a cover letter, signed jointly by the head of the ministry program and the chief health educator, explaining the critical importance of offering consistent information to our audiences.

Weak or inappropriate organizational structures can be impediments, not only to institutionalization, but to progress in implementing the project. Assisting in the process of making structural adjustments can consume an enormous amount of the advisor's time. These are inherently slow processes and are sometimes impossible within the lifetime of a HEALTHCOM project. Yet, if at the beginning of the project the resident advisor sees that the structure is inappropriate for the HEALTHCOM methodology, the structure needs to be strengthened first in order to carry out the project's objectives.

Another area which may require the resident advisor's attention if institutionalization is going to take place is the unit's system of management. As a result of the introduction of the HEALTHCOM methodology and new skills learned by the staff, the kinds of work performed by the staff are changing. In Lesotho, partly as a result of HEALTHCOM's presence, the staff has not only grown in size but its members have become more specialized in the work they do. Health education in the Unit is changing from being essentially a one-person effort to a team effort involving specialists: radio producers, newspaper writers, developers of materials for the educational system, creators of training manuals for health workers, persons who work through existing traditional and modern social organizations, artist-illustrators, and printers.

As these kinds of change occur, a change in management technique is necessary. Emphasis needs to be put on coordinating staff efforts to create and implement a sustained and mutually reinforcing set of research, health education, and formative evaluation activities. The head of the Unit needs to become more of a manager of health education activities and less of a doer. If the management system and style are not appropriate to the methodology, institutionalization will be difficult to achieve.

The resident advisor has worked with HEU staff to help with the development of an appropriate management system for the HEALTHCOM methodology. One of the steps is the writing of a mission statement for the Unit. This is a declaration of what the Health Education Unit exists to do (and by implication, what it is not prepared to do). This helps to develop a sense of unity of purpose, particularly among the staff.

A second step is writing or re-writing job descriptions for each staff position to fit new tasks inherent in implementing the HEALTHCOM methodology. This exercise has helped the staff know what is expected of them and has required management to think through the Unit's personnel needs.

A third step is to encourage management to build incentive and reward systems for correct behavior. For example, consideration could be given to a system of performance review which yields rewards of value to members of the Unit. It would be nice to be able to reward outstanding work performance with higher pay or upward job reclassification. However, these are difficult times financially for Lesotho. At the risk of fostering dependence on donor funds, money is often available for overseas training or to pay for equipment long sought after by a deserving employee. Although financial rewards are powerful, especially for some employees, they are not the only reinforcers management can use. Therefore, management needs to be encouraged to find appropriate social rewards for outstanding staff performance.

The HEALTHCOM Project itself can also create barriers to institutionalization. The project has money to pay for many of the costs associated with the methodology. The temptation to spend at rates or in amounts which the Health Education Unit's budget could not sustain after the project is over has been resisted. More work has to be done with the Chief Health Educator during the life of the project to increase the size of the budget so that the costs of the HEALTHCOM methodology are provided for. Without the money to pay for research, media talent, large numbers of radio spots, printing costs, and so on, the methodology cannot be kept alive.

It has also been important not to pay more than the going market price for commodities or services. One example will illustrate the point here. Paying more for radio spots than one ought to because HEALTHCOM is a donor-funded project creates a precedent for the ministry which it may not be able to live with after the project is over.

Is institutionalization achievable in the time frame of a typical HEALTHCOM country project? A lot depends on the country situation and how the resident advisor goes about his or her work. In the space of two years, the answer to the question is probably "no." However, progress toward institutionalization--the elimination of some of the impediments to carrying out the HEALTHCOM methodology--is realistic.

## MALAWI

Deborah Helitzer-Allen

### DEFINITION OF INSTITUTIONALIZATION

There are several elements to consider when discussing the process of "institutionalization" in the context of a HEALTHCOM project in the field. Whether or not institutionalization has occurred will be, to a large degree, dependent on whether these elements are successfully covered during the course of the project.

First, the HEALTHCOM methodology--research-based, culture-specific, including marketing principles, multiple channels, a communication strategy, and so forth--should be accepted as a theoretical base within the Ministry of Health and other institutions whose responsibility it is to promote healthy behavior. In theory this would mean that all persons in any way connected with health promotion would believe that this methodology is the accepted model for planning and implementing all health promotion activities. This can and should be accomplished both on the micro and macro levels, that is: within the Health Education Unit staff (microcosm), and in the ministries concerned with health promotion--policy-makers, administrators, program managers, and field workers (macrocosm).

Second, institutionalization should take into account if and how the HEALTHCOM methodology is being applied as a practical tool. In other words, persons whose responsibility it is to produce health education messages and materials, as well as those whose responsibility it is to design new products and services, should be utilizing the HEALTHCOM methodology in their daily work. Their annual work plans should be designed on the basis of this methodology, and their progress reports should demonstrate this step-by-step logic.

Third, the HEALTHCOM methodology works best if it is implemented within well-organized management structures and with specified and adhered to administrative procedures. Obviously, unless a new organization is being created to run health promotion activities, the HEALTHCOM methodology must be flexible enough to work within unwieldy bureaucratic structures such as government ministries, as well as those with less cumbersome administrative and procedural operations such as advertising agencies. However, no matter which organizational structure is used to implement communication strategies, institutionalization should have a positive impact on the management structure and administrative procedures relating to the implementation of communication strategies.

Fourth, in order to ensure the institutionalization of the HEALTHCOM methodology, persons with specific skills and talents need to be available. A list of such skills is too lengthy for this paper, but may include areas as various as graphic art, interviewing, data analysis, photography, video production, counseling, and training. It is possible to utilize full-time personnel attached to the organization, or to contract out specific activities to other individuals or organizations. If persons with these skills are not available, in-service or formal training can be undertaken to assist this process.

These four elements will be considered below as objectives, accomplishments, constraints, and lessons learned in the context of the HEALTHCOM Project in Malawi.

## **OBJECTIVES**

Institutionalization of the HEALTHCOM methodology within the Health Education Unit and within the Ministry of Health, outside organizations, and ministries in any way involved in health promotion activities, was a primary objective of the HEALTHCOM Project in Malawi. Since the HEALTHCOM process is lengthy, requiring many steps and budget allocations, it was important that the policy-makers and administrators buy into the concept of how to go about promoting behaviors related to diarrhea and malaria. This facilitated the work of those whose responsibility it is to carry out the activities and provided a positive and supportive environment in which to work.

Equally important as a project objective was that the staff members within the Health Education Unit believe in the methodology. In some ways, this was a more difficult objective, because these were the people who had been working as health educators for a long time with perhaps a less structured methodology and undemonstrated success, but nevertheless with enthusiasm and pride in their work.

Institutionalization of the process, or application of the principles guiding the methodology, was the next objective for the HEALTHCOM Project. This meant that every member of the Health Education Unit, depending on his or her position and capacity, should be involved in some way in applying this methodology to his or her work. For the most part, this meant that new skills had to be learned, and that the Unit staff members had to learn to work together as a team rather than as separate entities.

In order to assist the Health Education Unit to improve their efficiency and effectiveness, another objective of the HEALTHCOM Project was to support improvements in the management structure and administrative procedures of the Unit. This included simple changes like bi-monthly staff meetings, planning sessions, and larger changes like annual work plans, divisions within the Unit, and divisional reporting responsibilities.

Finally, since many of the skills required for implementation of the HEALTHCOM methodology were lacking within the Health Education Unit, transfer of new skills was an important objective of the Project. These skills included graphic arts, script writing, audio cassette production, formative and summative research skills (interviewing, designing questionnaires, coding, entering, and analyzing data, and report writing), and pretesting. While most of these skills could be gained through on-the-job training, some needed assistance through formal course work.

## **WHERE WE STARTED**

### **Institutionalization of the Methodology**

At the time of the arrival of the resident advisor, the Ministry of Health (MOH) was undergoing the early stages of what was to be an ever-evolving movement of restructuring. Between the time that the project was requested by the MOH, and the date on which the resident advisor arrived, the individuals who had learned about HEALTHCOM (through a trip to see the Mass Media and Health Practices Project [MMHP] in Swaziland) were no longer policy-makers and administrators within the MOH. This meant that the first job of the resident advisor was to "sell" the concept of the project both within the Health Education Unit, and to the Ministry policy-makers, administrators, program managers, and field workers.

## **Institutionalization of the Process**

One of the first responsibilities of the resident advisor was to take a familiarization tour around the country, observing and talking to field workers and other health workers about health education. At the same time, within the MOH, recommendations were being made about potential candidates for counterparts to the resident advisor. The familiarization tour included discussions with HEU staff to learn about the process by which they designed communication activities, and with the program managers to understand how they had worked with the HEU in the past.

These early investigations led to the conclusion that health education efforts had been haphazard and crisis-oriented. Those program managers with health education ideas had most often approached a graphic artist for assistance with a poster. Some of the ideas originated in a committee of professionals within the MOH. These ideas were translated into messages by the program manager, and a poster was produced. This poster was then distributed to all health centers. There was no formative research, little if any pretesting, and no monitoring or evaluation of the effort. Channels were limited and therefore not considered in terms of their appropriateness or potential reach.

## **Institutionalization of Management Structure and Administrative Procedures**

When the HEALTHCOM Project began, the HEU was divided into several sections: Radio, Graphics, Mobile Cinema Vans, Band, Materials Production, Photography, Editorials, and Clericals. There is at least one staff member within each section. There was no section for research, pretesting, monitoring and evaluation, for communication/message development, or for training. On individual assignments, there was a great deal of cross-over into other sections, depending on the availability of the staff member. There was an annual work plan, drawn up by the Administrative Officer in Charge. In reality it was followed loosely, if at all. The HEU did not have a separate budget of its own. Bi-weekly or monthly meetings of HEU staff were not held. Job cards were not used, and there was no priority structure for assignments. There was little coordination between members of the HEU, and even less between the HEU and other divisions of the MOH.

The HEU was not called in to sit on committees where their input could have been useful, and they were not consulted in the design of annual work plans for other MOH divisions, not even in those in which their input would be required.

## **Institutionalization through Training**

At the time of the arrival of the resident advisor, the HEU staff totaled 14 professionals. These included three graphic artists, seven band members, two radio officers, one mobile cinema van operator, one materials production specialist, and one administrator. Most of the staff had had little or no training opportunities. Skills such as interviewing, data entry and analysis, audio production, script writing, graphic arts, message development, pretesting, and monitoring were not finely honed within the HEU.

## **ACCOMPLISHMENTS**

### **Institutionalization of the Methodology**

In the more than two years of the HEALTHCOM Project, most MOH officials had several opportunities to learn about the HEALTHCOM methodology, and to see demonstrations of its application in improving health education techniques, materials, messages, and strategies. Within the HEU, all 14 professional staff members participated in some way in the HEALTHCOM cycle; after several discussions about the various steps in the development of communication strategies, it seems that all professional staff within the HEU were aware of and supportive of the reasoning behind the HEALTHCOM methodology.

Within the ministry, the policy-makers, administrators, program managers, and field workers who have been exposed to HEALTHCOM materials and reports of research, workshops, and efforts to support the CDD and Malaria Programs appreciate the active role which health education can play if it utilizes the HEALTHCOM methodology. For the first time in many years, these professionals are looking to the HEU to assist in the development of communication strategies for programs such as AIDS, child spacing, and EPI.

### **Institutionalization of the Process**

During the two years time period, the HEALTHCOM methodology was used for the development of five different communication strategies. Formative research was conducted:

- on the use of village volunteers for diagnosing and treating malaria and diarrhea;
- on the use of salt/sugar solution and home available fluids;
- on the priority disease, communication, and health education planning skills of supervisors and health workers;
- on the use of materials by health workers in their health education efforts; and
- on the compliance of pregnant women to the malaria chemoprophylaxis program.

Communication strategies and materials were developed for each of these areas. The project ended as those materials were distributed to each of the "channels"--community health workers, health clinics, district supervisors, and communities.

Through these activities, all the professional staff of the HEU had an opportunity to participate in undertaking communication strategies through the HEALTHCOM methodology. Through bi-weekly meetings, staff members had the chance to share ideas and contribute to the strategies, no matter what their individual roles were in the overall whole.

## **Institutionalization of Management Structure and Administrative Procedures**

At the time of the resident advisor's arrival, a new career structure for the HEU was being developed for consideration by the highest levels of government. The resident advisor had several opportunities during the two years to contribute to discussions on this structure. At the time of writing, there is still no final decision on this topic; however, there are indications that a favorable decision will be forthcoming.

Within the HEU, several changes were instituted which could contribute to smoother functioning of the daily work of the HEU. This includes bi-weekly meetings, the use of job cards and realistic work plans, and coordination by professional staff on travel and workshops outside the office. The establishment of several subcommittees has been recommended to the MOH, including a Chichewa Committee for examination and approval of all materials produced in Chichewa within the MOH. Health Education professionals now sit as full members of the Disease Program Committees (EPI, CDD/Malaria, CHSU, Environmental Health, Child Spacing, AIDS/STDs, and so forth), and allocation of specific funds to the HEU during the next fiscal year is under discussion.

## **Institutionalization through Training**

Transfer of new skills was an important accomplishment during this two-year period.

- Seven staff members learned how to conduct survey interviews, focus groups, observations, and indepth interviews.
- Two staff members learned script writing and audio production in a four-week course in Swaziland.
- Two graphic artists learned how to develop new types of materials, how to do color separations for printing, how to discuss production with commercial printers, how to pretest, how to adapt materials for local use, and how to improvise with less than ideal equipment and facilities.
- Two staff members learned how to use the computer, including word processing, data entry, and graphics packages.

## **CONSTRAINTS**

The numbers and professional level of staff in the HEU is insufficient, and their relative positions within the MOH are quite low in the pecking order. This means that HEU staff will always be in a position to take orders rather than to initiate and make suggestions. This translates into program managers asking for messages to be made into posters, and not allowing the time for pretesting, much less message development.

At the same time, those upper cadre professionals will have a difficult time recognizing the value of health education and its relative importance if the HEU staff do not begin to demonstrate skills associated with a systematic "scientific" methodology. This means that the HEU staff will have to respond to the program manager with: "let's sit down and discuss how you can best get your message across, and the timetable which will be required to carry out this activity." Even more difficult changes in behavior

would be required for the HEU staff member to initiate suggestions of communication activities and strategies to the program manager and other policy-makers.

These problems are not unique to Malawi. This situation is common in those countries in which tribal customs are dominant in everyday life, in which the doctors who run the ministry perceive all other professions to be of secondary importance and stature, and where the level of training of health educators is less than optimal.

Other constraints include lack of budget for health education, lack of adequate equipment and trained personnel to utilize equipment, and insufficient commercial facilities to support health education activities.

## LESSONS LEARNED

In order to increase the probability that health education professionals can work within a supportive environment, HEALTHCOM Project efforts in the first few months in a new site should concentrate on orientation of upper echelon MOH staff, regional and district health officers, artists, communicators, commercial services (such as printers, etc.) and politicians (where feasible) to the HEALTHCOM methodology and the supporting facts. Perhaps a video presentation could be developed to support this need.

The counterpart to the HEALTHCOM resident advisor should be at the top level of HEU management. This person should be influential in the policy-making of the MOH, and should have the ear of administrative and planning officials at the highest level.

HEALTHCOM projects should run for a long enough time so that HEU staff can successfully integrate the methodology into their everyday work, and so that policy-makers can see, through objective evaluations, that the methodology has contributed to behavior change in the communities, and through that, to a lower incidence of mortality and morbidity due to preventable diseases. The minimum time for a HEALTHCOM project should be five years, and countries should be preselected to ensure continuation.

HEALTHCOM projects should not invest in countries in which communication channels are primarily limited to face-to-face interventions. Countries with insufficient communication infrastructure and access (less than 80 percent of families having access to working equipment) should be considered lower priority for full-scale HEALTHCOM interventions.

## MEXICO

Michael Ramah, Porter/Novelli

During 1987 and 1988, the Government of Mexico, in conjunction with USAID/HEALTHCOM, undertook an extensive program of consumer research to aid in the development of a new package design for the existing ORS product, as well as an instructional flyer to establish country norms for ORT. This project was a collaborative undertaking between private and public sector groups, including the Department of Health (DOH) Health Education Unit of the Government of Mexico, USAID/HEALTHCOM, Porter/Novelli, McAnn-Erikson Mexico, Gallup/IMOP Mexico (market research firm), and Arouesty y Asociados (advertising firm).

While the overall purpose of the project was to complete the activities mentioned above, a secondary purpose was to instruct the DOH Health Education Unit in the design, execution, and analysis of such an undertaking. The DOH assigned full-time personnel to collaborate with HEALTHCOM for the duration of the project. It is anticipated that subsequent collaborations of this nature will take place at the initiative of the DOH.

### BACKGROUND

For the most part, this collaboration worked well. The DOH counterpart sought to accomplish two internal goals:

- strengthen existing pool of talent; and
- expand, through subcontracting with the private sector, into areas of perceived weakness in the core group.

The DOH core group is made up of a director (who is an M.D.), a graphic artist, a psychologist, and two project managers. The day-to-day workload of the staff is exhausting. One of the areas for consideration in undertaking this project was lightening the workload on the one hand (through subcontracting) and, on the other hand, strengthening the skills of the two project managers through their "apprenticeship" in this process.

### THE PROCESS

Because of the understandable desire to "control" all aspects of the project, the DOH clearly recognized the need to contract a market research agency to conduct the research necessary to develop insights for package prototype development. Using the results of the research, the DOH staff took on the project management role, and then contracted an advertising agency to develop prototypes. The apprenticeship at the ad agency was often rocky, but by the end of the process, mutual understanding of roles emerged.

From HEALTHCOM's point of view, the objective of this exercise was to demonstrate a **project management model** in practice that could be followed by the DOH. While the model itself was understood, its application was a little tougher (see below).

In the end, however, the DOH did assume ownership of the project and took on full responsibility for the new product in its revised, consumer-oriented presentation.

The learning process has had very promising results. New programs in AIDS and substance abuse are, indeed, collaborations between public and private sector institutions such as the one described here. Meanwhile, the DOH has acknowledged the need to enhance its overall management skills without neglecting the "hands-on" aspects of its workload.

## LESSONS LEARNED

A few practical pointers are presented for consideration below. As is often the case in social marketing, these pointers deal with concerns in trying to maintain equilibrium while working on a collaborative project between public and private sector groups.

- Levels of expertise will vary among Department of Health (DOH) counterparts. Every effort should be made to acknowledge this, and, insofar as possible, turn it to an advantage. One way to do this is to explain beforehand each step of the process. Make sure consensus is achieved, especially with regard to project management. A unified expectation regarding "process" will eliminate hurt feelings and avoid potential derailment as the project progresses.
- If, as was the case here, private sector advertising and/or market research firms are to be contracted, the DOH counterparts must understand the operational and fee structures of the respective agencies. Very often, with an eye towards economy, the temptation will arise to take back portions of a given product (printing, final art work, data processing, etc.) because an analogous function or facility exists within the DOH structure. Unless an agreement is reached regarding such matters at project onset, this will surely cause delay, not to mention breach of contract, if allowed to happen.
- Brief the contracting agency thoroughly on the project and its management structure. Social marketing is as new a concept to the private sector as it is to the public. Once the agency understands the technical assistance/technical transfer (institutionalization) goals of a project, they can be converted to allies as opposed to adversaries.
- Expatriate consultants must be sensitive to the professional pride of DOH counterparts--working with outside resources may be perceived as a slight to their capabilities. The best solution in this situation is for key DOH individuals to play an **active management role in their areas of expertise.**

## NIGERIA

Clarence Hall, Dr.PH.

In Nigeria, HEALTHCOM will work with the Federal Health Education Division to apply and adapt the HEALTHCOM methodology to the particular conditions and needs of different regions of the country. The strategy will be first to apply, adapt, and carefully evaluate the methodology in a northern state during the first 12-18 months of the project, in close cooperation with the State Ministry of Health. At critical junctures throughout this first state intervention, zonal training workshops will be held to disseminate strategies and results to the other states in the zone. During the second 12-18 months, a similar state intervention and zonal diffusion process will be implemented in one of the southern zones. The project will provide technical assistance on a less intensive basis to at least one state in each of the remaining two zones during the life of the project.

**Objective One:** To develop and demonstrate innovative health communication methods and techniques.

- A comprehensive child survival communication intervention in a northern state to demonstrate, test, and refine the public health communication methodology.
- A comprehensive quantitative evaluation of the impact of the intervention in the first state.
- Application of the methodology developed in first state to a second southern state targeted by the CCCD Project.
- Technical assistance to communication interventions in at least two other CCCD targets states.
- Dissemination of the methodology and results of these interventions to Ministry of Health Personnel from all states through a series of zonal training seminars.

Staff from the Health Education Divisions of the Federal Ministry of Health and the Niger State MOH will be involved in the development, implementation, and evaluation of the project objectives. This is the first step in the institutionalization process.

**Objective 2:** To develop and produce public health education materials.

- A set of national prototype print materials for public education on immunization, diarrheal disease control, malaria control, and birth spacing. Production of ample stocks of these materials for dissemination (as prototypes for adaptation) to all states.
- Adaptation and production of adequate stocks of national prototype materials to support the communication interventions in four states to be conducted under objective #1.

- Production of an innovative series of both motivational and instructional radio programs in appropriate local languages to support each of the four state interventions.
- Production of a series of national radio and television programs on child survival themes appropriate for national broadcast.

**Objective 3:** To strengthen national and state health communication capabilities through the training of health and communication personnel in the design, execution, and evaluation of systematic communication programming.

- Establishment of a modern graphic design studio in Federal Health Education Division.
- Training of at least ten staff from FHED and at least two from each state Health Education Unit in the basic fundamentals of educational materials development, including message development and pretesting.
- Advanced training of at least three technical staff at FHED in all aspects of educational print materials development--design (including computer graphic design), testing, and production.
- Training of at least five core staff at FHED and at least two from each state Health Education Unit in fundamentals of health communication planning and management, including needs assessment, objective-setting, consensus-building, writing plans, etc.
- Advanced training of at least five staff from FHED and from at least four selected states in specialized health communication skill areas, such as methods of formative research (e.g., conducting focus group discussions), design of campaigns, monitoring techniques, and scriptwriting.
- Training of at least ten staff from national broadcast institutions (NTA, FRCN) and from state broadcast institutions in at least four states in program planning and design for child survival and in program monitoring.

HEALTHCOM has a fundamental commitment (and indeed a contractual obligation) to do everything possible to ensure the long-term institutionalization of its methodology in each country where the project works. The outputs under objective 3 are explicitly devoted to institutionalization. They are intended to establish a strong cadre of Nigerian health and communication professionals who have experienced and been trained in the key elements of the public health communication methodology over the life of the project. Having also had the opportunity, by virtue of HEALTHCOM's evaluation and dissemination components, to observe the results of the methodology, these professionals will, it is hoped, continue to apply it to health problems long after the HEALTHCOM/CCCD Project in Nigeria ends.

HEALTHCOM fully recognizes that many training and other capacity-building activities are already underway in Nigeria under the leadership of the Federal Health Education Division, other Ministry of Health Units, UNICEF, and other institutions. It will be HEALTHCOM's strategy to support and complement these activities to the greatest extent possible.

## **ACCOMPLISHMENTS**

The project has been operational for about fifteen months. During this short period of time, the HEALTHCOM Project Director, County Program Manager, and the resident advisor have had several opportunities to discuss the HEALTHCOM project and methodology with a number of senior personnel in the Federal and Niger State ministries of health. The heads and/or staff of the respective HEUs have been intimately involved in the formative and behavioral research in Niger State; in the development of an EPI flipchart; and by participation in the various state and zonal HEALTHCOM training programs. This has afforded all involved a first-hand experience with the HEALTHCOM methodology.

### **Local Government Areas (LGAs), Niger State**

In recognition of the government's priority program (primary health care) and project development at the LGA level, HEALTHCOM has trained LGA health staff to use the EPI flipchart. The flipcharts have been introduced to health workers in other states in Zone C as well. The EPI flipchart is a product of the HEALTHCOM systematic materials development process--starting with formative and ethnographic research materials development drafts, pretesting, and final product.

LGA health educators from the ten LGAs in Niger State participated in the first week of the three-week Zone C mass media workshop on communication planning and production. They were part of the MOH team which received an in-depth briefing of the Niger State formative research results and analyzed the implications for health education. They have been exposed to one of the fundamental components of the HEALTHCOM methodology and now have an appreciation for the relationship of research to message development and improved health education programming.

### **Niger State**

- A health education management and supervision workshop for 16 zonal health educators and EPI managers was conducted from June 28 to July 1, 1988. The aim of this workshop was to improve health education management and supervision within the state. An EPI and ORT health education supervision checklist was developed and four zonal health education plans were formulated by the participants. This was their very first exposure to and experience in planning. The Niger State MOH demonstrated its commitment to the institutionalization process and project by funding the four workplans for a total of ₦10,000.
- The HEALTHCOM resident advisor provided technical guidance to the MOH in the drafting of a budget request for governmental assistance to strengthen the Niger State Health Education Unit, including specifications for supplies and equipment, staff requirements, and career structure for health education personnel. This will ensure that Niger State has an adequate infrastructure to make institutionalization possible.
- The first HEALTHCOM zonal liaison officer was hired on July 20 and will begin his duties on October 1, 1988. He will coordinate and supervise all HEALTHCOM activities in Zone C covering five northern states including

Niger and the Federal Capital. He will be based in Niger State and spend most of his time there monitoring project activities. It is anticipated that three additional zonal liaison officers will be hired in phases as HEALTHCOM expands to other parts of the country.

- HEALTHCOM was instrumental in establishing a graphic design section within the Niger State Health Education Unit. Two graphic artists have been hired by the MOH. Equipment and supplies are in the process of being secured by the MOH with the assistance of UNICEF.
- Health education unit staff, the Niger radio station program manager and two producers have completed a three-week workshop organized by HEALTHCOM, CCCD, FMOH, FRCN, and the Niger State MOH to review the formative research conducted in the state, develop messages based on the results of the research, and produce radio programs accordingly to increase the immunization completion rates. A Niger State Communication Plan which will reflect HEALTHCOM principles and methodology is in the process of development.

### Zonal

Chief health educators and two radio producers from each of the five states and the Federal Capital in Zone C participated in the three-week mass media workshop on communication planning and production held in Minna (week one) and Kaduna (weeks two and three) in July 1988. The purpose of the workshop was to expose the participants to the Niger State formative research results, determine the implications for EPI and ORT health education strategies, and produce broadcast quality radio programs which will improve child survival programming. The major outcomes of this workshop in relationship to institutionalization were: (1) the commitment by each radio station to strengthen or establish a child survival and development unit; (2) team building between health educators and radio producers in each state; and (3) a core group of radio resource persons was exposed to the HEALTHCOM methodology and will be available to participate in future zonal mass media workshops.

### National

All project activities have been planned with the collaboration of the head of the Health Education Division, Federal Ministry of Health. At least one, but more often two staff members from the communication units of the Federal Health Education Unit have participated in most HEALTHCOM related research and training activities. Their roles have ranged from co-planner to facilitator, trainer, resource person, and trainee. The head of the division, Mrs. F. Henshaw, was a facilitator and discussion leader at the HEALTHCOM/FMOH-sponsored health education management and supervision workshop in Niger State. This kind of active participation in the HEALTHCOM Project in a number of different capacities by the FMOH Health Education Division staff will facilitate the institutionalization process at the national and state levels.

## PARAGUAY

Diane Urban

The HEALTHCOM Project in Paraguay is one of the few USAID-funded projects there, due to Paraguay's status as an advanced developing country. Although the budget has been small, the project has been very popular, due largely to the interpersonal skills of the Paraguayan resident advisor: his ability to put the Ministry of Health (MOH) health educators into the limelight; establish relationships between the Health Education and Maternal/Child Health Departments; involve the national Medical School in the project; and coordinate with private sector agencies, such as an advertising agency, a research agency, and a pharmaceutical company that has begun to produce ORS under a contract with Project SUPPORT. Since he is Paraguayan, his knowledge and skills will remain in the country when the project ends.

One of the goals of the institutionalization plan was to involve key MOH decision-makers, from the Minister on down, in health communication activities, including training of health workers and community leaders, establishment of oral rehydration units (UROs) at the National Medical School and at eight strategically located regional medical centers, production and distribution of ORS, and production and distribution of print and broadcast materials. The resident advisor involved key leaders in decision-making through periodic visits, letters, approval of materials at different stages of development, launching the ORT media materials at a special event for health workers, and participation in public relations events, such as donating cribs and other items to UROs.

At the central level HEALTHCOM provided health educators with opportunities to incorporate new ideas into an already firm foundation of health education principles and to apply skills learned in training or in on-the-job situations. For example, in June 1986, a team comprised of a health educator, a physician, and a nurse from each of nine UROs received a week of training in communication and management skills. Each team developed an action plan which included follow-up work in their own URO plus training community groups, such as Rotary Club members and their wives, to develop their own action plans for ORT. HEALTHCOM paid for central level staff to visit areas and supervise the training, and paid for per diem and course materials for participants. The training led to local events and broadcasts on local radio stations.

After the June training event, the central level health educators added a day about HEALTHCOM methodology to a week-long in-service training program for all Paraguayan health educators. In July 1988, they trained community leaders from the nine URO areas to train their local peers, and went to the field to supervise the training.

The central level health educators spoke at an ORT conference in Mexico City and attended an international conference in Lima sponsored by PAHO, UNICEF, A.I.D., and AED where they applied the HEALTHCOM methodology to writing an implementation plan for the Expanded Program of Immunization (EPI). In Paraguay the health educators adopted the HEALTHCOM methodology for the national AIDS health communication plan. They made a TV documentary, presented the communication aspect of the ORT project at an international conference on health education in Houston, and discussed the project with faculty and students at the University of Puerto Rico School of Public Health. The ability to absorb ideas, transfer them to other health interventions, train

colleagues and community leaders, and diffuse the ideas in international arenas is evidence that the health educators can widely apply the HEALTHCOM methodology.

One important way to ensure that ORT services be provided on an ongoing basis was to have reknowned medical school professors and leaders in the Paraguayan Pediatric Association train and supervise medical students and nurses who intern at the newly-established ORU in the teaching hospital. The prestige and acceptability of the program was enhanced 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; and the Medical School curriculum was expanded to include ORT.

Cribs, scales, mixing utensils, and so forth, were provided to enable eight regional health centers, in addition to the Medical School, to establish UROs. During the HEALTHCOM Project, the clinic chief, URO coordinator, and nurses were trained in ORT and procedures for running the UROs. HEALTHCOM organized the events, provided transportation for central level personnel to attend, and paid per diems for participants. The director of the Maternal/Child Health Department in Asunción insisted that URO directors obtain ORS. Reluctant chiefs were called to special seminars in Asunción to discuss the situation and receive ORS.

One of the most difficult parts of the training process was to make ORS locally available by selecting and training community leaders to teach caretakers both to use ORS correctly and continue feeding during bouts of diarrhea. Training community leaders enabled mothers to have easy access to ORS and understand how to use it, while pamphlets prepared at the central level reinforced the messages delivered. Outstanding leaders participated in a workshop in Asunción on how to train their peers. Other backup support for follow-up community training included supervision, materials, and money to pay for local expenses.

Various private sector firms were engaged to teach aspects of the HEALTHCOM methodology. The local advertising agency subcontracted by the project was most open to the HEALTHCOM methodology. They supported the program by contributing a speaker to the training workshop in June 1986; by frequently attending meetings at the MOH and in the field; by organizing a workshop at the ad agency to teach MOH staff to conceptualize media campaigns and produce materials; and by revising materials as many times as necessary to incorporate the results of pretest focus groups and the comments of MOH and HEALTHCOM staff. The result was attractive materials containing information consistent with MOH and WHO norms. They found local companies to donate funds to print materials and obtained free radio and TV time when the limited broadcast budget could no longer cover these costs. They produced a documentary about the ORT program--at their expense--which has been shown in international arenas. They also helped write a model contract between AED and an advertising agency in a developing country. It was the first such contract ever signed in Paraguay.

A less successful venture was contracting a local research agency to conduct focus groups with caretakers of children under five to ascertain their knowledge, attitudes, and practices (KAP) with regard to ORT. Questions were insufficient and results were not analyzed in such a way as to be very useful for designing the communication objectives and messages. The agency conducted interviews with 50 pediatricians to ascertain their KAP with regard to ORT; however, the analysis of the data was so poor that the results could not be used to plan curricula for medical training or messages for materials.

Other efforts to extend the methodology in the private sector involved working with a Paraguayan pharmaceutical company under contract to Project SUPPORT to produce, package, and promote ORS. The package design and drawings were pretested to ensure that content agreed with MOH norms. Arrangements were made to use the MOH logo for ORT, their pamphlets for point-of-purchase distribution literature, and their pricing suggestions to make it affordable for those most in need. HEALTHCOM was asked to coordinate product launch activities by organizing seminars for physicians and community leaders who would be trained and supplied with Paraguayan ORS.

Logistical issues--importing the machine, redesigning the laboratory to accommodate it, quality assurance tests, and so forth--delayed production and distribution of ORS during the 1987-88 diarrhea season. HEALTHCOM adjusted its advertising messages to include only generic, not product-specific, ORS information.

Monitoring and impact evaluation are components of the HEALTHCOM methodology; however, due to budget constraints, little has been done to design forms for data collection, supervise its entry and delivery, and analyze results. A narrative qualitative evaluation based on end-of-project interviews is planned. No training in research and evaluation techniques has occurred.

Evidence that use of the HEALTHCOM approach and methodology will be sustained include:

- In July 1988, the MOH decreed that it is creating UROs in all Paraguayan health care institutions. The budget was increased to enable the MOH to do this.
- The health educators include the HEALTHCOM methodology in other health care interventions, training, and materials development.
- A good relationship with the advertising agency has developed and a plan for obtaining post-project help should be created before the project ends.
- Links with the secondary schools have been initiated--students are being taught to mix ORS and to teach their families. Elementary schools could be targeted as well.
- The private sector contributed funds to print materials. Their continued support should be sought.

Funding remains a difficult issue in Paraguay. The MOH would like to extend the HEALTHCOM intervention to breastfeeding and has begun negotiations to obtain funds from A.I.D. to accomplish this goal.

The MOH needs to allocate more funds to research, training, supervision, and materials production to continue to support efforts of regional health educators and community leaders. The former director of health education has been elected to Parliament and promises to initiate activities to increase the MOH budget; however, an increase for the MOH does not necessarily mean an increase for the health educators.

Areas to extend the reach of the HEALTHCOM methodology to increase impact and sustainability include: work with private physicians and nurses, fundraising with the private sector, more reliance on local research agencies that are adept at data analysis, and better collaboration with UNICEF and PAHO. Both of these agencies also have

limited funds and small local staffs; therefore, cooperation is essential to share scarce resources.

The HEALTHCOM methodology will be more likely to be sustained if:

- its objectives coincide with those of public and private sector agencies involved in health programming;
- its application has resulted in perceived proven successes; and,
- it is feasible and sensible to apply it, given human and fiscal resources.

So far, the HEALTHCOM methodology as applied to ORT has resulted in more cases of diarrhea treated in UROs, more sales of ORS in pharmacies, and according to the MOH, a reduction in infant mortality.

The application of the methodology to ORT in at first nine, then six more centers, proved that it is feasible. The MOH should continue to apply it to other interventions, such as breastfeeding, and in other areas of the country. The resources needed to finance the production of materials and use mass media time, as well as funds to travel for supervision and training purposes, present challenges for the future.

Aspects of the methodology that have been applied are:

- strategic integration of communication with training, product development, distribution, and service delivery;
- national implementation plans for ORT, EPI, and AIDS using the HEALTHCOM approach;
- instructional goals established around a narrow set of behavior objectives;
- the use of multiple, integrated channels; and,
- the pretesting of materials with the target audience and MOH leaders.

Formative research, monitoring, and evaluation are weaker elements in the chain.

To aid in institutionalization, HEALTHCOM should not phase out abruptly, but plan a conference at the end of the current contract for all who have been involved in the project to share experiences and plan for the future. The office should be maintained on a part-time basis and occasional site visits should be made if funding permits.

## PHILIPPINES

José Rafael Hernández

### PRESENT INSTITUTIONALIZATION PLANS

The Chief of the Public Information Health Education Service (PIHES), Dr. Dayrit is very concerned about the issue of institutionalization. HEALTHCOM staff have met with him on this issue on several occasions. We have explained that since January, institutionalization in PIHES is a major objective of HEALTHCOM activities in the Philippines. Currently, we are trying to achieve this in the following manner:

- The former officer in charge of PIHES, Ms. Marietta Bernaje, assigned PIHES technical staff to our specific projects. These staff members regularly attend meetings and participate in the deliberations. In this manner, they "learn by doing" the social marketing process we follow in our EPI and CDD projects.
- The assigned PIHES staff participate in key decisions regarding development of communication plans and materials. Their involvement in decision-making is intended to enhance their ability to manage activities on the development of communication plans and materials.
- In order to attach a theoretical framework to staff experience, seminars/workshops on communication and social marketing are planned.

### INSTITUTIONALIZATION OBJECTIVES

HEALTHCOM intends to pursue more vigorous efforts of institutionalization and is now viewed as a "training ground" for PIHES staff. A more overt scheme to develop the capability of PIHES staff for social marketing has been planned. The following objectives, stated in specific and measurable terms, have been identified.

### HEALTHCOM INSTITUTIONALIZATION/TRAINING OBJECTIVES

By the end of 1989, key PIHES technical staff will be able to:

#### **Plan a Social Marketing Program/Project—**

- write an appropriate and feasible social marketing plan for a child survival program area, specifically EPI and CDD;
- make an oral presentation and respond to questions raised about this plan;
- select an advertising agency;
- negotiate with and write a scope of work/creative brief for the advertising agency.

### **Manage Research Relative to Social Marketing—**

- identify market research and evaluative research needs relative to the social marketing plan/creative brief;
- review a research proposal and questionnaire;
- effectively manage research study implementation;
- make an oral presentation of research findings and respond to questions raised about data;
- write a report relating the research findings to the social marketing plan/project;
- write a synthesis report on all research findings relative to the program area addressed by the social marketing plan.

### **Monitor/Manage Social Marketing Project Implementation—**

- coordinate with service delivery network on plan implementation;
- provide strategic directions in the development of communication materials and review technical as well as creative/communication quality of communication materials--media, print, and so forth.
- make an oral presentation of communication materials for approval by DOH Management Committee;
- plan and conduct sales conferences;
- supervise production of communication materials, ensuring that materials are distributed according to plan;
- develop a monitoring system including the necessary forms for the social marketing project;
- supervise the implementation of the monitoring system;
- analyze results and write a monitoring report on the communication project;
- effectively address other communication problems/issues raised by monitoring.

### **Evaluate/Document Project Implementation—**

- document/write progress reports on the project;
- write a final report on the communication project, including lessons learned/implications of project for future projects.

These objectives still must be finalized.

## ACTIVITIES PLANNED

In addition to continuing with an on-the-job training scheme, other institutionalization activities planned are:

- **More intensive apprenticeship** activities which give PIHES staff specific tasks to do in CDD and EPI. The idea is for HEALTHCOM to be able to turn over major responsibilities and tasks to the staff by the end of the project.
- **Training Needs Assessment (TNA)** activities which have been initiated by HEALTHCOM through Ms. Mary Debus. Ms. Debus interviewed key PIHES staff in order to identify their current concepts and skills levels regarding communication and social marketing. This TNA activity will be used to design an appropriate Seminar/Workshop on Integrated Marketing for PIHES in September 1988.

TNA activities will form part of each seminar/workshop to be planned. This is to ensure that formal training activities are relevant to PIHES staffs' needs and skills.

- **A Seminar/Workshop on Integrated Marketing** is planned for September 1988 with Ms. Debus and the resident advisor as main resource persons. This activity will be for PIHES Central Office staff and selected regional office PIHES staff (in the HEALTHCOM project regions 6, 7, 10 and NCR).
- **Seminar/Workshop on Research Needs Identification and Research Management for Health Communication**

By the end of the workshop, PIHES staff will be able to:

- identify research requirements of health communication projects for child survival;
  - monitor research project implementation for PIHES Central and regional staff (1989).
- **A Series of Communication Planning and Management Workshops** is also planned to cover PIHES Central and all regional staff.

## PROBLEMS/CONSTRAINTS

Hopefully, these activities--particularly the apprenticeship--will lead to the achievement of the institutionalization objectives stated above. However, HEALTHCOM faces the following constraints:

- **Current Skills Orientation of PIHES Staff Needs to be Broadened**

PIHES technical staff are divided into two categories--the health educators and the Public Information Officers (PIOs). The health educators, generally the older, more experienced group, have a health education orientation and are skeptical about media.

The PIOs, on the other hand, are a younger, less experienced group. They are basically press relations staff--they communicate with the media and write press releases.

The two groups now need to be re-oriented to communication and social marketing and their value. They must be made to appreciate PIHES' enhanced role as the communication group of DOH, and the increased importance of using media communication/social marketing techniques. In doing this, a lot of "un-learning" has to occur.

- **Poor Remuneration of PIHES Staff Requires Other Forms of Recognition.**

PIHES staff are low-salaried government employees. The demands of HEALTHCOM activities--working in the evenings or weekends during production time--are heavy on them, since they receive no overtime pay or allowances. However, those assigned to HEALTHCOM have been very conscientious and uncomplaining in their work.

Non-monetary incentives--such as sitting in meetings with the undersecretary, learning new things, dealing with the private advertising and research sector--have played a key role in sustaining their interest. More important forms of recognition--getting the chance to publish, training here and abroad, and so forth) are necessary to further sustain this interest.

- **Need to Clarify Roles of PIHES--Managers or Implementors**

One constraint HEALTHCOM faces is the vision PIHES sees for itself. Will PIHES staff manage communication/social marketing projects or implement them? HEALTHCOM views PIHES' role as that of a manager. Accordingly, skill needs should concentrate more on the ability to become effective managers--rather than implementors--of communication programs. However, it appears that PIHES management sees itself as both implementor and manager. With the present skills capability of most PIHES staff, this may be a very difficult objective to accomplish.

- **PIHES Leadership is "Stretched"**

With the accession of Dr. Dayrit to the position of Chief, PIHES has a dynamic leader. However, Dr. Dayrit continues to be involved in other key DOH programs for PIHES--AISCOM/AIDSTECH and the National Drug Policy Management Committee. He also continues to be involved in a program outside PIHES, the Field Epidemiology Training Program, which he had spearheaded for the DOH before he took on his PIHES post. These involvements diffuse his focus on PIHES. As one consultant puts it, he is "very stretched."

Dr. Dayrit's plans of reassigning his staff to other programs and giving the PIOs more program responsibilities have not yet occurred. PIHES staff are beginning to feel a little neglected.