HEALTHCOM ISN 74890

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The HEALTHCOM Project in Jordan: Final Case Study Evaluation Report

by

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Center for International, Health,
and Development Communication at the
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Impact evaluation results prepared
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Ayman Abulaban

Consultant to the Noor al_Hussein Foundation

March 1991

The research reported here was done in collaboration with the Noor al_Hussein Foundation in Jordan and was supported in part by the Academy for Educational Development through its Communication for Child Survival contract with the U.S. Agency for International Development, Bureau of Science and Technology, Offices of Health and Education (Contract no. 1018-C-00-5036-00). This report is the responsibility of the first author and may not represent the views of those who have supported the research.

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EXECUTIVE SUMMARY

This report presents the results of a narrative case history study of the Communication for Child Survival (HEALTHCOM) project in Jordan. The HEALTHCOM project in Jordan started in July 1987, and was implemented by the Noor al_Hussein Foundation, in collaboration with the Academy for Educational Development and a number of public and private institutions in Jordan. The project in Jordan was of a smaller scale than previous HEALTHCOM projects (e.g., in Ecuador, Indonesia, or Lesotho), reflecting a lower level of funding (through buy-ins) by the USAID Mission and other institutions in Jordan. As such, it provides an interesting contrast to other HEALTHCOM projects in what can be accomplished with limited local funding and technical assistance.

The primary objectives of the project in Jordan were to carry out a successful health communication campaign and to institutionalize the ability to use the HEALTHCOM methodology to carry out health education in Jordan. This evaluation showed that the project generally succeeded in its first goal, but showed less success in its goals related to institutionalization.

The Health Communication Campaign in Jordan

The project staff developed a high quality, effective communication program following the recommended methodology, despite administrative and technical delays that effectively reduced a 24-month project to 15 months. Strategy and message development were based on formative research and also on the results of the evaluation baseline. Campaign spots were pretested and revised. After the start of the campaign, the stations were monitored to ensure spots were being broadcast and a study was carried out to monitor mothers' exposure to and understanding of the campaign

messages. A second evaluation survey was carried out after the end of the campaign.

The project addressed child-spacing and breastfeeding, specifically early initiation of breastfeeding and waiting until the child's fourth month to supplement breastfeeding. In October 1988, HEALTHCOM and the Ministry of Health sponsored a national seminar on breastfeeding for health and other professionals. Radio and television messages on breastfeeding were developed and broadcast from March to May 1989, and again in March and April 1990. Television spots were developed on child-spacing, but were never aired because of the controversial nature of the topic.

Preliminary evaluation results provide some evidence for campaign effectiveness. Initiation of breastfeeding within six hours after birth increased significantly during the campaign, but only among mothers who gave birth in a public hospital (from 43 to 69 percent) or at home (from 42 to 67 percent). Among mothers giving birth in a private hospital, initiation within the first six hours increased slightly (from 17 to 25 percent) but so did initiating late, more than a day after birth (from 31 to 43 percent). Knowledge about correct breastfeeding initiation increased to very high levels. After the mass media campaigns, correct responses to all four questions about initiation and colostrum increased from 41 percent to 71 percent.

Two measures of supplementation behavior showed different results. Comparing the exclusive breastfeeding status of children of different ages in 1988 and 1990 showed essentially no change in supplementation behavior. Large proportions of mothers were still giving supplements to children one to three months old. However, when mothers who were already supplementing were asked at what age they had started supplementing breastmilk, there was a significant increase (from 47 percent to 60 percent) in saying they had started supplementing at four months or later. The responses to the

second question may be exaggeratedly high. Mothers may have reported what they knew to be correct behavior rather than what they actually did. There were large increases in knowledge related to supplementation of breastfeeding between 1988 and 1990.

Exposure to the mass media campaign was high. Ninety-four percent of the mothers said they had heard the song played in the radio and television spots and, of these women, 79 percent correctly recognized the picture shown along with the song. Eighty-nine percent of mothers said they had seen short messages on Jordan TV about breastfeeding and 69 percent reported having heard short messages on Radio Jordan where a woman doctor answered questions about breastfeeding.

No results are available for the child-spacing campaign, because it never took place, although the materials were developed. From the start, there were difficulties with child spacing as a topic. Jordan had no national family planning policy and there was some resistance to the topic at the top levels of the MOH. Child spacing was also generally controversial, and the topic received a certain amount of negative press during the project. As an institution linked to the queen, the Foundation was very careful about promoting controversial activities.

One lesson to be learned from this experience is the importance of local participation in the choice of topics to be addressed. The choice of chid spacing as a topic seems to have been made primarily by the USAID Mission and AED. Although child spacing seemed to the foreign participants to be an appropriate topic for a communication campaign in Jordan, the local participants (Foundation and MOH) had other priorities and felt that child spacing was too controversial.

Institutionalization

The two primary goals for institutionalization in Jordan were to train the staff at the Foundation and in collaborating institutions in the HEALTHCOM methodology and to ensure the continued use of the methodology for health communication in Jordan.

Training in the HEALTHCOM Methodology

The major strategies for teaching people the methodology were to provide on-the-job training through carrying out a health communication campaign following the methodology and to carry out formal training sessions or workshops. Technical assistance was provided on a continuing basis by the resident advisor, with ongoing specialized assistance in message development and production from the Center for Development Communication in Egypt and in evaluation from the CIHDC. The primary beneficiaries of on-the-job training were the project staff at the Foundation and the media production team (primarily in production skills).

Due to its limited budget, the HEALTHCOM project planned a small formal training component, relying primarily on hands-on training to teach the methodology, supplemented by short workshops on specific topics. The formal training activities conducted were five workshops on parts of the methodology, a national seminar on breastfeeding, and special sessions to train focus group leaders. As it became apparent more training was expected and needed, USAID and AED committed more funds and technical assistance to formal training activities in the second year of the project.

The project was partially successful in reaching its goal of teaching individuals from a number of organizations to use the HEALTHCOM methodology in the future. Parts of the methodology (specifically pretesting, use of focus groups, and some formative research for decision-making) have been learned and adopted by the

various participants in the project. However, only two individuals (project staff at the Foundation) have a clear sense of the methodology as a whole and are capable of following most of the steps in the future. If both these individuals leave the Foundation (as one already has), the institution will no longer have the capacity to carry out communication projects following the methodology. This is a continuing problem in institutionalization of new methodologies -- full training and experience is limited to a few individuals and those who receive special training leave the institution or are reassigned to different units.

One constraint to institutionalization of the methodology in Jordan was that the project was not long enough to ensure greater learning of the methodology by more people. What had been conceived as a 24-month project became a 15-month activity. This created pressure to finish the communication materials rather than allowing HEALTHCOM to take the time necessary to fully involve the other members of the team in the day-to-day activities or teach them through experience.

A second constraint was that there was not sufficient formal training relative to the needs of the personnel and organizations involved. Although the project expected learning to take place primarily through on-the-job training, formal training was a priority among the participants.

On the whole, the evidence suggests that careful attention needs to be paid at the beginning of such a project to understanding what resources already exist in the country to support project activities (specifically in terms of skills related to the methodology) and where and for whom training is required. In addition, the time required for formal and informal training must be included in the budget and the schedule. In recommending improvements for future projects of this type, the majority of Jordanian participants suggested making a greater investment in

training and incorporating training activities into the project plans earlier and in a more systematic way.

Development of a Health Communication Team

The strategy used to ensure the use of the methodology in the future was to gather a team of people from different institutions to work together in learning and implementing the methodology. This team included representatives from different institutions involved in health education and promotion: the Foundation, the MOH, universities, other governmental and non-governmental organizations, and public and private sector producers. One of the roles of the Foundation was to develop and coordinate this team.

Overall, the project did not succeed in developing a lasting, coordinated health communication team. Although communication and research activities were generally a cooperative effort of different groups, the level of coordination was not as high as planned. At the start of the project, the U.S. and Jordanian participants expected high levels of cooperation between the different groups. In particular, the MOH was expected to be a major collaborator. When interviewed in 1990, the Foundation staff tended to view participants from the MOH and other organizations in a supporting role to the project, rather than as active and equal collaborators on project activities. Members of most of the participating institutions had expected to be more fully involved, but described their actual role as providing support and participating when requested.

Perhaps the largest constraint to creating an effective team was the tension between developing a good campaign and coordinating with others in a limited time frame. The project staff reported that they did not have the time to coordinate with others because high quality communication activities needed to be completed within relatively short time frames.

The HEALTHCOM project in Jordan is an example of a health project with no formal ties to the Ministry of Health. Instead, a nongovernmental organization, with assistance from AED, was responsible for overseeing all activities and for coordinating input from the other groups. One question asked of the project participants was whether the project should have been located at the Foundation or at the MOH. The majority discussed this question in terms of the goals of the project.

The Foundation was seen as better able to meet the goal of creating a health communication campaign based on the methodology within the short time frame of the project. Reasons given were the Foundation's greater flexibility and ability to cut through bureaucratic red tape, due to the institution's prestige and location outside the general government bureaucracy.

However, participants almost unanimously agreed that the project should have been located at the MOH in order to ensure greater continuity and sustainability in the future, the second major goal of the project. The strengths of the MOH were in their experience and authority in health matters and in their mandate to carry out health education. The HEALTHCOM project objectives more closely matched the ongoing goals and responsibilities of the MOH than those of the Foundation. In addition, the MOH has a network of hospitals and health centers that could have added a complementary interpersonal component to the campaigns.

Again, there is the tension between accomplishing the project activities on time and institutionalizing the methodology. Ensuring a sustainable program to use the HEALTHCOM methodology requires time -- time to train individuals in the methodology and time to work through the steps of the methodology with them so they gain experience and self-confidence -- and may result in a simpler campaign of lower technical quality. In HEALTHCOM projects, the two goals of producing an effective communication activity (one

that brings about change in knowledge and behavior in the target audience) and institutionalization or continuity seem to work at cross purposes. The competing demands of these two goals need to be carefully considered in planning, funding, and implementing similar projects in the future.

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BACKGROUND AND DESCRIPTION OF THE HEALTHCOM PROGRAM[1]

Health Communication for Child Survival (HEALTHCOM) was a five-year communication program designed to assist developing countries promote the widespread use of effective child survival strategies. HEALTHCOM was sponsored by the Office of Health and the Office of Education within the Bureau for Science and Technology of the U.S. Agency for International Development. The program was administered by the Academy for Educational Development. The Center for International, Health, and Development Communication (CIHDC) at the Annenberg School for Communication, University of Pennsylvania was responsible for evaluating the impact of HEALTHCOM activities under sub-contract to the Academy for Educational Development.

The program worked in 17 countries, using a research and development approach to promote changes in behavior that affect child health. The approach draws from the disciplines of social marketing, communications, behavioral analysis, instructional design, and anthropology, among others. Specific activities focused on immunization, the control of diarrhea, breastfeeding, nutrition, growth monitoring, hygiene, and other behavior that promotes child survival.

While its application varied from country to country, the HEALTHCOM approach used in all sites generally combined pre-program and

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[1]This case study evaluation of the HEALTHCOM project in Jordan would not have been possible without the input and assistance of many individuals and organizations in Jordan and the U.S. I would like to thank all the people who agreed to be interviewed for their time and their thoughtful insights on the process and the impact of this project. I would particularly like to acknowledge my colleagues, Dr. Ayman Abulaban, evaluation consultant to the Noor al_Hussein Foundation (who was responsible for the impact evaluation), Dr. Sima Bahous, HEALTHCOM Project Director, and Ms. Anne Roberts of the Academy for Educational Development. The evaluation activities in Jordan would not have been possible without the technical and logistic support and assistance of the Noor al_ Hussein Foundation and the USAID Mission in Amman.

continuing research with a multiple channel communication program to address public health problems on a national level. The approach has three important stages: pre-program planning and development, the instructional interventions, and ongoing monitoring and evaluation. The planning phase gathers information so that each project can be tailored to the specific needs of the target population. The instructional interventions combine some or all of radio, television, print, and face-to-face communication channels to educate an audience about a specific health theme. Ongoing monitoring and evaluation contribute feedback about the relative success of different aspects of the program, allowing for adjustments during the campaign. The final evaluation serves as an example for subsequent programs using the public health communication approach, in the same country or elsewhere.[2]

HEALTHCOM in Jordan

The programs carried out under HEALTHCOM ranged from large-scale efforts with substantial amounts of funding for technical assistance and local program costs to much smaller efforts. The level of effort in a country depended in large part on the interest and ability of the local USAID Mission in providing buy-in funds to finance project activities. The HEALTHCOM project in Jordan was one of three smaller-scale programs. As such, it provides an interesting contrast to the much larger projects in other countries in terms of what can be accomplished with lower levels of funding and effort.

The smaller scale of the Jordan project had implications for

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[2]For more information on the HEALTHCOM methodology see Rasmuson, M.R., Seidel, R.E., Smith, W.A., & Booth, E.M. Communication for Child Survival. Prepared by the Academy for Educational Development for the U.S. Agency for International Development, June 1988.

evaluation activities. The CIHDC was primarily responsible for carrying out a narrative case history of the Jordan project which would detail the history of the project and discuss institutional issues. Funding was also provided for limited technical assistance in other evaluation activities. Evaluation of the impact of the communication interventions was the responsibility of the evaluation specialist in the counterpart institution, with the CIHDC providing technical assistance as requested.

In accordance with the CIHDC mandate, this report will present the results of the narrative case history. Preliminary findings from the impact evaluation surveys available at the time this report was written are also included. The information presented in this report was obtained through interviews with project staff and individuals in Jordan who were actively involved in the project, from project documents (monthly reports, trip reports, etc.), and from preliminary analyses of the impact evaluation findings.

Objectives of the HEALTHCOM Project in Jordan

There were two major objectives of the HEALTHCOM project in Jordan:

- to carry out a successful health communication campaign, and
- to institutionalize, or assure the continuity of, the ability to use the methodology to carry out health education.

The major strategies for reaching these objectives were to provide formal and on-the-job training in the different components of the methodology, to go through the process of developing and implementing a health communication campaign using the methodology, and to build a team of professionals from different institutions to work together on health education programs.

Description of the HEALTHCOM Project in Jordan

The HEALTHCOM project officially started in Jordan in July 1987 with the arrival of the first AED resident advisor and was expected to focus on diarrheal disease and other child survival problems. However, during 1985 and 1986, HEALTHCOM had provided consultants to the Ministry of Health (MOH) to review the diarrheal disease program and health education activities, and to help with formative research and health education activities related to diarrhea.

After assessing the capabilities and interests of different governmental and non-governmental organizations in Jordan and consulting with the USAID Mission, it was decided to locate the project in the Noor al_Hussein Foundation, but to collaborate extensively with the MOH, and particularly the Health Education Department (HED) within the Ministry. The Noor al_Hussein Foundation (hereafter called the Foundation) is a private philanthropic agency established in 1985 to carry out projects of interest to Queen Noor in the areas of cultural, educational, and community development, with a special emphasis on women and children. In June 1990, the Foundation was managing 24 different projects funded through local or international funds.

The early focus of the HEALTHCOM project in Jordan was to be diarrheal disease, with possible activities in other child survival topics (acute respiratory infection, immunization, nutrition, and growth monitoring). The major collaborators were expected to be the Ministry of Health, the Ministry of Information, and UNICEF, which had already been doing work on diarrheal disease with the MOH.

The first nine months of the project did not go as smoothly as planned, primarily because of debate over the topics to be covered and the levels of effort to be provided by each party, and because of delays in developing a workable funding mechanism for local

program costs. Soon after the AED resident advisor's arrival in Jordan in July 1987, it became apparent that the topic of diarrheal disease was already being covered and that HEALTHCOM would be duplicating efforts already underway by UNICEF and the MOH. After discussions among AED, Foundation, MOH, UNICEF and USAID staff, it was decided to change the focus of the project to child-spacing and breastfeeding. However, the resident advisor had no experience in child-spacing or breastfeeding programs and could not provide the level of technical expertise required. Therefore, in April 1988, he was replaced with a new resident advisor. The change in topics and the replacement of the resident advisor took valuable time from the development of the project, essentially leaving 15 months out of the original 24 months for project activities.

A second issue that required clarification during the first 9 months of the project was the level of effort to be provided by all parties involved in the project. In the Letter of Agreement between the Foundation and USAID, the Foundation agreed to provide 5 part-time professionals and 5 part-time support staff to work on the project, including one senior staff member to be the official counterpart and provide overall coordination, and to provide in-kind support (office space, telephone, copy facilities, etc.). AED agreed to provide a part-time project manager in Washington, a resident advisor for two years, and 3-4 person months of consultant time. USAID was expected to provide funding for local project costs and general oversight.

There seems to have been some misunderstanding of the level of effort to be provided by each party. The Foundation staff expected large amounts of technical assistance from AED consultants (particularly in production and evaluation), a larger budget for local activities than was provided, and a full-scale evaluation directed by the CIHDC. Their expectations were partly based on their assessments of what was required for their program and partly on what they had heard in earlier AED visits about the activities

in other HEALTHCOM sites, sites with much higher levels of funding. The Foundation staff did not fully understand the limited scope of the technical assistance component of the project until March 1988, when the project was reorganized and project funding mechanisms were finalized. On the whole, although AED and the USAID Mission added more funds for technical assistance and other local activities than originally promised, the Jordanian staff on the project felt they had not received the level of technical assistance they expected and required.

The Foundation provided only part of the personnel required by the Letter of Agreement. During the first months of the project, they provided a part-time project director with expertise in communications and a part-time research specialist, along with some clerical support. The project director was a university professor who worked three days a week at the Foundation as the HEALTHCOM director, but also as director for public relations and communication at the Foundation. The research specialist worked one day a week for the Foundation. He was expected to direct any project research and to be the counterpart for evaluation activities. However, because he is a physician with experience in pediatrics and public health, he became the health specialist on the project. Thus, there were many competing demands on the two major Foundation staff members assigned to the project, from their other activities and from within the Foundation and the project.

During the early months of the project, it became clear that more coordination was required than could be provided by part-time staff. In January 1988, USAID provided the Foundation with extra funds to hire a local full-time project coordinator to manage logistics, finances, and paperwork. One of the first activities of the new resident advisor in 1988 was to clarify the time requirements of project activities and to obtain a commitment of time from local staff to carry out these activities. For example, the Foundation agreed to triple the amount of support from the

research specialist (from one day a week to three) to allow him to carry out evaluation and intervention activities. However, the time pressures on project personnel continued to be a problem throughout the project because of competing demands on their time.

A third issue that led to delays in project activities was in developing a workable funding arrangement for local costs. The budget for local costs was originally to have been disbursed to the Foundation through a sub-contract with AED. However, this was not satisfactory to all parties, and the USAID Mission agreed in January 1988 to de-obligate the funds directly to the Foundation. The funds were not received by the Foundation until April 1988. This delayed the start of many local activities because there were no funds to cover them.

Despite the problems discussed above, a number of implementation activities occurred during the first part of the project. Planning and formative research activities were carried out on breastfeeding and child spacing. An implementation plan for the child-spacing and breastfeeding activities was finalized. In October, a consultant from AED came to Jordan and gave a one-day workshop on television production.

Between April 1988 and July 1989, when the AED resident advisor left Jordan, the project staff, following the HEALTHCOM methodology, developed a mass-media communication campaign on breastfeeding, which was broadcast on television and radio in March, April and May 1989. The activities included formative research, strategy development, message development, production and pretesting, and monitoring and evaluation. Other communication activities included a national seminar on breastfeeding for health and other professionals, held in October 1988, and development and production of television child-spacing messages.

During this time HEALTHCOM consultants conducted workshops for the staff of collaborating institutions on message development and pretesting, evaluation, focus group methods, and script writing. The evaluation of the communication activities was developed along with the intervention. A baseline survey was carried out in August 1988, and a follow-up survey was conducted in August 1990.

After the end of AED technical assistance, the Foundation staff continued developing and revising child-spacing and breastfeeding messages. A second breastfeeding campaign occurred in March and April 1990. The child-spacing messages were not broadcast because the topic was felt to be too controversial (to be discussed in more detail later). At the time the interviews for this evaluation were being carried out, the HEALTHCOM staff at the Foundation were working on the planning and formative research for a proposed campaign on home accidents, a leading cause of child injury and a topic of interest to the Foundation. They expected to have a seminar on home accidents in early August 1990 and to produce mass media spots. USAID funding for HEALTHCOM activities ended September 30, 1990.

The following pages will examine how well the HEALTHCOM project met its two primary goals. Two questions will be addressed: did HEALTHCOM carry out a successful health communication campaign in Jordan, and was the ability to use the HEALTHCOM methodology institutionalized?

THE HEALTH COMMUNICATION CAMPAIGN IN JORDAN

This section addresses the first question, whether HEALTHCOM carried out a successful health communication campaign. Two areas are examined: whether communication interventions were developed based on the HEALTHCOM methodology, and whether they had any impact on the target audience.

The health communication activities in Jordan focused on two primary subject areas, child spacing and effective breastfeeding, under the umbrella theme of "The Health of the Mother and the Child." Results of interviews carried out in Jordan in 1983 indicated that more than 45 percent of the children in Jordan were born at intervals of less than two years and 25 percent were born at intervals of 18 months or less.[3] An interval of at least two years between births is considered to be better for the health of the new infant and also the children already born into a family. Analyses of World Fertility Survey data from Jordan indicate that the death rate for children born after an interval of less than two years is four times that for children born after an interval of two years or more.[4] Children born at the start of an interval less than two years were 1.25 times more likely to die before the age of five than children born at the start of a longer interval. Evidence that short intervals affect the mother's survival or physical health is not as striking. However, in the focus group interviews carried out by the HEALTHCOM project, both men and women frequently discussed the negative physical and psychological effects of short intervals on the well-being of the mothers.

The HEALTHCOM project decided to approach child spacing from two angles. The first was to promote the maternal and child health benefits of longer intervals between pregnancies, and to encourage women to go to their local Maternal Child Health center or private physician for child spacing information. The second strategy was to approach child spacing through effective breastfeeding because of the contraceptive effects of correct breastfeeding.

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[3]Jordan Fertility and Family Planning Survey 1983 - Report of Principal Findings. Amman: Department of Statistics and Atlanta, Georgia: Centers for Disease Control, 1984.

[4]Birth Spacing and Child Survival. Deborah Maine & Regina McNamara, Center for Population and Family Health, Columbia University, 1985.

The original focus of the breastfeeding campaign in Jordan was to encourage the extension of nursing from the current ten-month average to 12-18 months. Review of earlier research in Jordan and formative research carried out by the project personnel showed that, while the great majority of mothers valued breastfeeding and did breastfeed their children, mothers and medical personnel had a number of incorrect practices. Two of these practices, delayed initiation of breastfeeding and early supplementation, may lead to early and unintended weaning and breastfeeding that offers neither protection from disease for the child nor protection from conception for the mother. Therefore, the breastfeeding campaign in Jordan focused on immediate initiation of breastfeeding (within the first six hours) and later supplementation of breastfeeding (at 4-6 months).

The health communication activities in Jordan started with breastfeeding. In the second phase, the staff planned to continue breastfeeding messages and introduce child-spacing messages.

There are several reasons the project chose to concentrate first on breastfeeding, instead of the project's stated primary focus on child spacing. As mentioned previously, child spacing was a sensitive issue in Jordan. (For example, a number of editorials and articles against child spacing came out in the Arabic language newspapers during the project). The project staff were reluctant to start their communication activities with a potentially unpopular topic. In addition, there was no official population policy in the country or the MOH which could provide clear guidance for the messages.

A second factor was that the HEALTHCOM staff were coordinating communication activities on child spacing with another USAID-sponsored project to help the MOH increase the number of MCH clinics providing child-spacing and contraceptive services through clinical and management training, and training in child-spacing and

contraceptive counseling. The HEALTHCOM mass media messages on child spacing were expected to direct women to these services. However, because the other project had not yet provided these services, the child-spacing messages were delayed.

The Breastfeeding Campaigns

The breastfeeding communication activities in Jordan used two channels of communication -- mass media and interpersonal. Television and radio messages about breastfeeding initiation and supplementation were developed and broadcast throughout Jordan. These messages discussed the benefits of breastfeeding, the importance of initiating breastfeeding in the first hours after childbirth, the importance of waiting until four months to supplement breastfeeding, care of the mother to help her breastfeed more effectively, methods for increasing milk supply, and the necessity of breastfeeding on demand. The television spots started with the same picture of a smiling baby, and all television and radio spots included the same song. The radio messages included a program called, "Ask Dr. Huda," which answered questions commonly asked about breastfeeding. Examples of the television and radio spot scripts are included in Appendix A. The spots were broadcast daily from May 15 - July 15, 1989. Television spots were broadcast three times a night between 7 and 10 p.m. and radio spots were broadcast twice a day at 10:15 a.m. and 1:15 p.m.

A monitoring study was carried out during this phase and problematic messages or concepts were identified. Several of the messages were revised and the revised messages and some of the old messages were broadcast from mid-March through April 1990, during Phase 2.

The second component of the HEALTHCOM communication activities in breastfeeding addressed health professionals. In October 1988, HEALTHCOM sponsored a "National Seminar on Breastfeeding Practices"

for 130 representatives from health care, communication, education, community, and religious groups. Presentations were made about breastfeeding and a series of recommendations were developed by the group to promote modern and scientific breastfeeding practices in Jordan.

Evaluation of the Breastfeeding Campaigns

The evaluation of the communication campaigns in Jordan was carried out by the Foundation research specialist with technical assistance from the CIHDC. The evaluation design consisted of two surveys -- one before (1988) and one after (1990) the communication activities. In addition, the baseline survey was supplemented with more informal, open-ended interviews with a small sample of women from the same geographic areas. The women were interviewed in Arabic using a questionnaire that covered knowledge, attitudes and practices related to breastfeeding and child spacing, sources of information, media use, demographic characteristics, and exposure to the campaign.

The goal of the sampling procedure was to obtain representative samples of approximately 1000 women 35 years old or younger who currently had a child two years old or younger. This was the group for which messages about breastfeeding and child spacing would be most relevant. The sampling methods included cluster and random sampling techniques. In 1988, 930 women were interviewed (and another 33 were interviewed in-depth) and, in 1990, 966 women from were surveyed.

Preliminary results show high exposure to the campaign among mothers, change in knowledge about breastfeeding, and some change

in behavior.[5] The data reported below were weighted to account for unexplained differences between the 1988 and 1990 samples (in education, area of residence, and several other SES variables).

Early Initiation of Breastfeeding -- Results

The mass media campaign recommended immediate initiation of breastfeeding, "within the first hours after birth." Based on campaign documents, correct initiation is defined as initiating within the first 6 hours after birth. Behavior is only reported for mothers who gave birth to a child at the start of the mass media campaign in late May 1989. Those with children born before that did not have an opportunity to change in response to the mass media messages (although there could be some influence from the breastfeeding seminar).

Table 1 shows a significant increase in correct initiation among all mothers who ever breastfed. Initiation within 1 to 6 hours of the birth increased from 38 percent to 56 percent.

Table 2, however, indicates that breastfeeding initiation did not improve for all women in Jordan. The increase in early initiation was only seen among mothers who gave birth in a public hospital or at home. Those who gave birth in a private hospital showed a slight improvement in initiation within 6 hours (from 17 to 25 percent), but they also showed an increase in initiating after one day. This suggests that the influence of other people at the birth may have been very important, or that mothers who went to private hospitals may have been different from other mothers in their willingness to initiate early. (This will be examined in future analyses).

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[5]As noted previously, at the time this report was written, only preliminary results of the data analysis were available. Analysis will continue and further results will be published as they become available.

Table 1
Initiation Behavior Among Mothers with Children Born Since the Start of the Mass Media Campaign

	1988	1990*
1-6 hours after birth	37.6	56.0
7-24 hours	31.0	19.6
25 hours or more	31.4	24.4
	n=500	n=525

*Difference between 1988 and 1990 significant at $p<.0001$.

Table 2
Initiation Behavior by
Location of Birth

	Private Hospital		Public Hospital		Home	
	1988	1990*	1988	1990**	1988	1990***
1-6 hours after birth	17.2/24.5		43.4/68.6		41.4/67.1	
7-24 hours	51.9/32.5		26.8/14.6		22.2/14.2	
25 hours or more	30.8/43.0		29.8/16.8		36.4/18.7	
n's	107	139	300	291	86	84

*Difference between 1988 and 1990 significant at $p<.01$.
**Difference between 1988 and 1990 significant at $p<.0001$.
***Difference between 1988 and 1990 significant at $p<.005$.

Knowledge about breastfeeding initiation increased significantly between 1988 and 1990 to very high levels (see Table 3). After the campaigns, perfect scores on four questions about initiation and colostrum had increased from 41 percent to 71 percent of mothers.

Breastfeeding Supplementation -- Results

There are two different measures of supplementation behavior, which produce different results. Again, we only looked at mothers who had the opportunity to change their behavior in response to the campaign, those who gave birth after the start of the first mass media interventions.

Table 3
Initiation Knowledge

	1988	1990	Sig. of Diff.
1.Has heard of colostrum milk	91.8	92.7	n.s
2.On first day after delivery, does mother's milk contain colostrum milk? Yes	81.0	88.1	.0001
3.Mothers should start breastfeeding babies in first six hours after birth	50.2	74.6	.0001
4.Breastmilk is not important for a child on its first day of birth. Disagrees	66.5	90.3	.0001
5.A mother should avoid giving her child the milk which she has produced on the first day. Disagrees	62.3	86.2	.0001
6.The milk in a mother's breast on the first day of a child's birth is nutritious for the child. Agrees	75.5	93.7	.0001
	n=911	n=957	
Scale of # 2,3,5 and 6			.0001
0	4.6	1.1	
1	11.6	2.5	
2	17.7	4.8	
3	25.1	20.4	
4	41.0	71.1	
	n=904	n=947	

Figure 1 shows current behavior for children of different ages, plotting whether children from 1 to 9 months of age were currently exclusively breastfeeding (receiving no other foods). The figure suggests no significant difference between supplementation behavior between the two surveys.

The figure details behavior for children who had the chance to receive supplements within the last few months. The mass media campaigns had occurred 13 months previously, with a shorter follow-up 3 months previously. We don't know if there was any change in supplementation behavior specifically around the time of the first campaign in 1989.

Table 4 shows reported time of initiation for all children who had already started receiving other foods. This measure does show a significant increase in correct supplementation -- 47 percent of mothers of children 13 months and younger reported waiting until at least four months to supplement in 1988, compared to 60 percent in 1990. This increase may be partly a function of self-report, and this measure may be a better measure of knowledge than it is of behavior. This will be examined in more detail in future analyses.

Table 5 shows large increases in knowledge about age of supplementation and some change in knowledge about breastfeeding on demand and increasing milk. Overall, by 1990, knowledge related to supplementation was quite high.

Breastfeeding Supplementation
(% Supplementing at Different Ages)

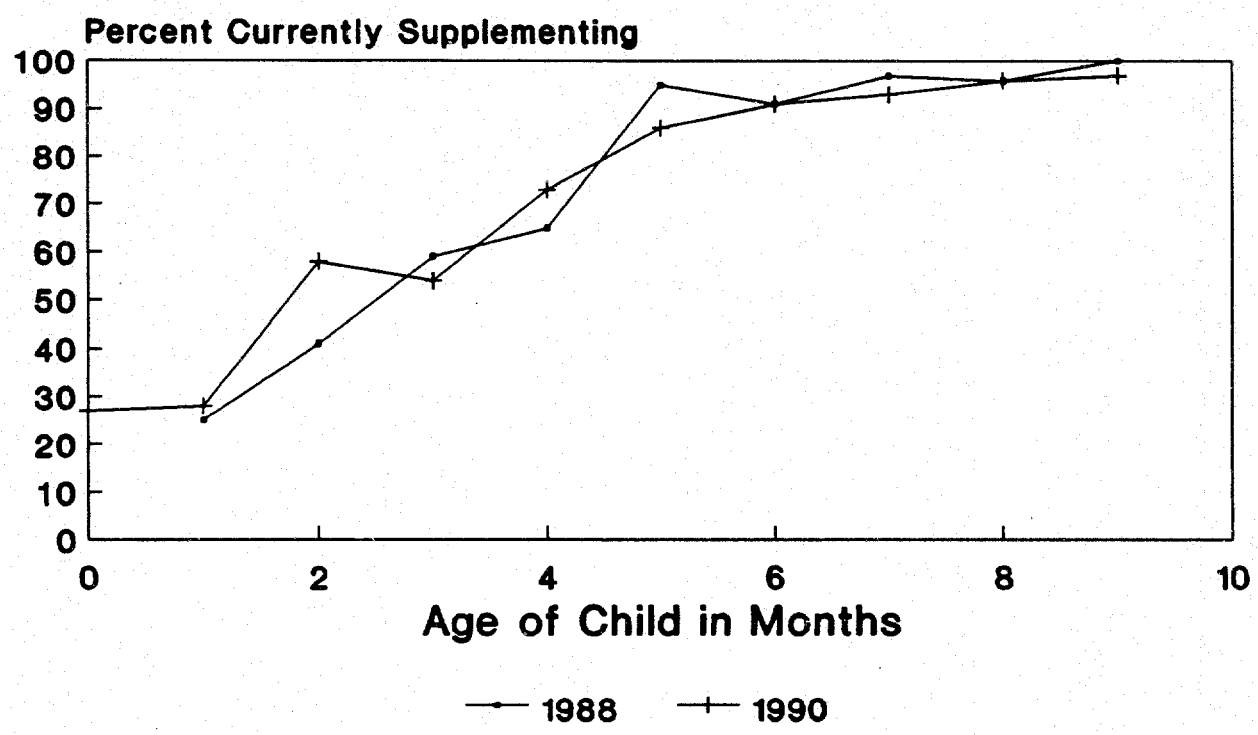

Table 4
Mothers' Reported Supplementation Behavior
(among children already supplementing)

Age at which mother said child started other foods (in months)	1988	1990*
1	20.1	12.7
2	19.9	9.8
3	12.9	17.9
4	32.1	39.3
5	4.7	8.1
6	4.9	6.9
7+	5.3	5.3
	n=383	n=409

* Difference between 1988 and 1990 significant at $p<.0001$.

Table 5
Knowledge About Breastfeeding Supplementation

	1988	1990	Sign. of Diff.
In first four months babies should be given only breastmilk	36.2	60.6	.0001
	n=900	n=963	
A baby will be healthier if mother starts food in addtn to breastmilk at 2 months Disagrees	37.5	61.6	.0001
	n=917	n=954	
Age mother thinks baby should start to have foods in addition to breastmilk (open-ended)			
1 month		1.6	
2 months		4.5	
3 months		13.2	
4 months		61.1	
5+ months		19.6	
		n=954	
A mother can produce enough milk to feed her 3 month old breastmilk only and nothing else		82.8	
		n=966	

	1988	1990	Sign. of Diff.
Babies should be breastfed on demand	71.7	90.0	.0001
Mother can do something to increase her milk	85.3	91.2	.0001
Breastfeed more often	4.2	3.0	n.s.
Eat more/eat nutritious foods	86.3	89.9	.05
Drink more/drink nutritious drinks	27.8	59.2	.0001
Rest	2.8	5.9	.005
Mother can increase amount of milk by breastfeeding more often Agrees	83.4	91.9	.0001
	n=908	n=957	

Campaign Exposure -- Results

Exposure to the mass media campaign was high. In 1990, interviewers sang part of the song used on TV and radio spots to the mothers and asked if the mothers had every heard the song. Ninety-four percent said yes. Eighty-nine percent of mothers reported seeing short messages on Jordan TV about breastfeeding (although it is possible some of these messages were part of other, smaller breastfeeding campaigns run by the HED). Of mothers who had heard the song, 79 percent correctly said that the picture always shown on the TV messages playing this song was of a baby or a baby and mother.

Sixty-nine percent of mothers reported having heard short radio messages on Radio Jordan where a woman doctor answered questions about breastfeeding. Twenty-six percent of these mothers could spontaneously name Dr. Huda as the doctor. When we asked all mothers if they had heard of a radio program with Dr. Huda (adding those who spontaneously knew of Dr. Huda), 55 percent had heard such a program.

The Child-spacing Campaign

The child-spacing communication activities were also expected to be carried out through mass media and interpersonal channels. Three seminars were planned to address child spacing and pregnancy risks with MOH staff, but these seminars were not implemented. The project staff designed and produced messages explaining the concept of birth spacing, discussing the advantages of spacing pregnancies two years apart, and referring women to their doctor or to an MCH clinic for information and services. No mention was made of contraceptives. Although these messages were ready for airing, they were never shown outside the Foundation.

Summary and Discussion

The HEALTHCOM staff created a campaign of integrated television and radio messages on breastfeeding using the HEALTHCOM methodology. This occurred within a context of relatively low levels of funding (compared to other HEALTHCOM sites) for outside technical assistance and local costs. Strategy and message development was based on formative research and also on the results of the evaluation baseline. The spots were pretested and revised. After the start of the campaign, the stations were monitored to ensure spots were being broadcast and a study was carried out to monitor mothers' exposure to and understanding of the campaign messages. Breastfeeding spots were revised in response to monitoring findings and rebroadcast in a second phase.

The campaign spots were attractive and of high technical quality. The evaluation also provides some evidence that they were effective. Mothers in Jordan had high exposure to the television and radio messages, there was significant change in breastfeeding knowledge, and there was some change in breastfeeding initiation behavior.

The child-spacing activities were not as successful. This seems to have been primarily a function of the controversy surrounding the topic in Jordan.

It is not entirely clear how the decision was made to focus on child spacing and breastfeeding. The Foundation was interested in addressing acute respiratory infections, home safety, cancer, and sanitation. The USAID Mission was very interested in child spacing, based on the findings about the particularly short birth intervals in Jordan, and less interested in breastfeeding as a topic.[6] They also felt child spacing was an area where the Jordanian government was starting to show more acceptance and in which a communication project could make a difference.

On the whole, the consensus among the Jordanians interviewed is that child spacing was not an appropriate topic for the project. Because of frequent news about developments related to the Intifadah, child spacing, or any topic related to family planning, was considered controversial and received a certain amount of bad press. As an organization linked to the Queen, the Foundation could not risk being seen as a proponent of a controversial practice. In addition, there was no strong support in the government. The country did not have a clearly stated policy about family planning, and the project personnel found a certain amount

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[6]USAID interest in this topic was addressed further in their development of a $5 million social marketing project on child spacing which started in Jordan in 1989.

of resistance to the child-spacing component at the top levels of the MOH.

Overall, there was evidence that the topics to be covered had been chosen primarily by the foreigners (USAID and AED staff). There was some tension between Foundation and MOH views of which topics were of greatest interest and AED's mandate to carry out child survival projects focusing on particular topics. For example, Foundation and MOH staff say that they were not particularly interested in focusing on diarrhea at the start of the project, because the topic was already being addressed. However, implementing communication efforts addressing diarrheal disease was one of the major mandates of the HEALTHCOM project.

Several of the people interviewed for this evaluation suggested that the choice of topics for projects of this type be based on a more thorough needs assessment of the country, with more local involvement in the choice. This might have avoided the choice of child spacing, a topic that seems to have been problematic for the MOH, the government as a whole, and the Foundation. Another suggestion made was to choose a topic high on the list of priorities for the MOH. This would ensure greater MOH interest and support and perhaps greater coordination with the health centers.

INSTITUTIONALIZATION

This section addresses the project objectives to teach counterparts in Jordan to use the HEALTHCOM methodology in carrying out health education and to assure the continuity of this ability at an institutional level.

The two primary goals for institutionalization in Jordan were to train the staff at the Foundation and in collaborating institutions

in the methodology used by HEALTHCOM and to ensure the continuity of the methodology as an approach for health communication in Jordan. The major strategies for teaching people the methodology were to provide on-the-job training through carrying out a health communication campaign following the methodology (with technical assistance from a resident advisor and consultants as needed) and to carry out formal training sessions or workshops. The strategy used to ensure the use of the methodology in the future was to gather a team of people from different institutions to learn and work together to carry out development communication projects in the future.

Training in the HEALTHCOM Methodology

On-the-job Training

The three staff members provided by the Foundation worked through the methodology several times, for the breastfeeding messages and their revisions, and for the child-spacing messages (see Table 6). The project director and the research specialist were involved in all stages of the process, with the project director spending more time on production and the research specialist more involved in the evaluation activities. The project coordinator received extensive experience in planning, budgeting, and management, and also in monitoring spots and carrying out focus group discussions.

Technical assistance was provided on a continuing basis by the resident advisor, an individual with expertise in health communication, research, and the subject matter covered by the campaigns. The resident advisor guided the process and the management of project activities and ensured that the methodology was understood and followed. In addition, technical assistance in message development and production was provided by the Center for

Table 6
Activities of the Foundation Staff in Creating the Communication Campaigns

1987	
September	Development of formative research plan
October	Development of implementation plan
November-December	Formative research
1988	
February	Review of formative research results and planning.
April-May	In-depth interviews and focus groups. Preliminary planning of strategy and messages.
June	Development of detailed plan of action. Identification of team of producers as collaborators. Clarifying messages and media. Evaluation planning.
July	Refining of messages. Pretesting of evaluation questionnaire. Review of message concepts and messages with collaborating institutions. Planning for pretesting of messages.
August	Development of draft scripts on breastfeeding and child spacing. Planning of breastfeeding seminar. Collection of baseline data.
September	Review and revision of draft messages.
October	Breastfeeding seminar. Review of draft messages by MOH and other groups. Review of evaluation results and preparation of draft report.
November	Pretesting of breastfeeding television spots. Preliminary work on radio messages on breastfeeding.
December	Revision of breastfeeding television spots. Development of radio messages on breastfeeding.

<u>1989</u>	
January	Development of radio messages on breastfeeding. Production of television spots on breastfeeding.
February	Completed production of television and radio spots on breastfeeding. Pretesting of television and radio spots.
March	Proposed launch of campaign delayed until after Ramadan.
April	Review and pretesting of child-spacing messages. Production of television spots on child spacing. Pretesting of child-spacing spots.
May	Launch of breastfeeding campaign. Monitoring of broadcasts. Planning of evaluation analysis and monitoring study of target audience. Production of child-spacing spots.
June	Pretesting and revision of child-spacing spots. Monitoring of breastfeeding campaign.
From July on[7]	Revision of breastfeeding messages in response to monitoring (development of new messages, pretesting, and production) Revision of child-spacing messages to fit into Phase 2 breastfeeding campaign.
<u>1990</u>	
March	Broadcast of Phase 2 breastfeeding messages.

[7]The information used in this table was taken primarily from AED monthly and semi-annual reports. When the resident advisor left Jordan at the end of June 1989, these monthly reports stopped. Thus, we have less detailed information on activities after June 1989.

Development Communication (CDC) in Egypt and assistance in evaluation was provided by the CIHDC. See Table 7 for a list of technical assistance activities.

The collaborating production team, staff from Arab Tele-Media, were heavily involved in script writing and message production and revision. The staff at other collaborating institutions (e.g., the Health Education Department at the MOH, Save the Children Federation, Catholic Relief Services, and UNRWA) were primarily involved in the more formal training activities, but did participate in discussions to help develop the strategy and messages, and helped conduct formative and pretesting focus group discussions.

Formal Training

The HEALTHCOM project in Jordan had a small budget for formal training and outside technical assistance. The original plans for the HEALTHCOM project in Jordan did not include a large interpersonal training component, instead proposing to conduct one or two-day workshops on specific topics such as formative research methods, evaluation, message development, communication planning, and the subject areas covered by the program. These workshops would be carried out by experts who were in Jordan to carry out other activities related to HEALTHCOM.

The formal training activities conducted under the HEALTHCOM project were five workshops on parts of the methodology, the breastfeeding seminar, and special sessions to train focus group leaders (see Table 8). These activities lasted from half a day to five days. Seminars on child spacing and on development communication were also planned, but were never conducted.

Table 7
Technical Assistance to the HEALTHCOM Project in Jordan

1987	
July	Full-time resident advisor arrives
1988	
February	Foundation staff trip to Egypt to review formative research results and identify new areas for research
April	New full-time resident advisor arrives
June	CDC/Egypt consultant trip to Jordan to work on message development and media strategy
August	CIHDC trip to Jordan to assist with baseline survey.
September	CDC/Egypt consultant trip to Jordan to help in production of messages and to carry out training in pretesting
1989	
February	CDC/Egypt consultant trip to Jordan to assist in completion of breastfeeding spots and to review child-spacing messages. Foundation project director trip to Egypt to review and revise scripts.
April	CDC/Egypt consultants to Jordan to assist with pretesting and production of child-spacing messages.
May	Foundation project director and research specialist trip to Philadelphia to plan monitoring and analysis of evaluation data.
June	CDC/Egypt consultant trip to Jordan to help revise and produce final child-spacing messages.
1990	
June	CIHDC trip to Jordan to help prepare for the follow-up evaluation survey.

Table 8
List of Formal Training Activities
Carried out by the HEALTHCOM Project in Jordan

1987	
October	One-day **workshop on television production** (25 attenders - staff from the MOH, UNICEF, Yarmouk University, Jordan TV, Jordan Family Planning and Protection Association, Foundation, and USAID/Jordan).
1988	
June	One-day **workshop on development of message concepts from** research results (25 attenders - staff from MCH programs, television and radio producers, advertisers, artists, and script writers).
August	Half-day **workshop on evaluation of communication programs** (10 attenders - policy makers and officials from the MOH, UNRWA, the national hospital corporation, and several universities).
September	One-day **workshop for focus group leaders** (8 attenders - staff from the MOH, UNRWA, and the Foundation).
October	Two-day **breastfeeding seminar** (130 attenders from the fields of health care, communications, education, community and religious groups).
1989	
February	Four-day **workshop on focus group methods** (17 attenders - staff from the MOH, UNRWA, Save the Children, Catholic Relief Services, USAID, and the Foundation)
April	Follow-up sessions to focus group workshop.
June	Five-day **workshop on message development and script writing** (21 attenders - script writers and producers from radio and television, health educators from MOH, UNRWA, Save the children, Catholic Relief Services, UNFPA, and the Foundation).

Ability to Apply the Methodology in the Future

As discussed previously, the Foundation and HEALTHCOM hoped to develop the capability to conduct health education using the HEALTHCOM methodology by training individuals from a number of relevant organizations (health, communication, mass media). The program has been partially successful in reaching this goal.

On the whole, the methodology has been institutionalized in two individuals. The project director and the research specialist at the Foundation have a clear understanding of the methodology and its steps and are capable of following most of the steps of the methodology in the future. However, only the project director knows the entire process for producing messages from start to finish and only the research specialist knows the details of evaluating the program. At the time of these interviews these individuals were involved in planning a new home safety campaign and reported following the HEALTHCOM methodology.

The methodology has not been institutionalized within the Foundation as a whole. The other Foundation staff member most involved with the project was the project coordinator. She did not participate in the majority of the in-service or formal training activities (although in 1989 her time was freed up to allow her to participate fully in the focus group workshop and partially in the script-writing workshop). She could only follow parts of the methodology in the future (primarily management of project activities, budgeting, coordination with USAID, and conducting focus group discussions).

Other Foundation staff, although invited to participate in meetings and workshops, had other work priorities and in general were not involved with HEALTHCOM and would not be capable of using the methodology themselves. Thus, any future Foundation activities applying the HEALTHCOM methodology will depend almost entirely on

the two major counterparts, one of whom left the employ of the Foundation in 1989. If the project director also leaves, the Foundation's ability to carry out similar health education programs will leave with her.

The staff of the collaborating institutions most heavily involved in the project showed familiarity with parts of the methodology, but little understanding of the methodology as a whole. Staff from the health education department (HED) attended meetings about project activities, reviewed messages, helped carry out focus group discussions, and attended the workshops. However, they were not heavily involved in the day-to-day activities of the project. The HED staff will be able to carry out parts of the methodology, but not follow the process as a whole. The activities they expected to carry out in the future were pretesting, collecting and using formative data, and implementing focus groups discussions. The health education department had carried out some of these activities before the project, but the staff felt they would do them better now because of what they had learned through their participation in HEALTHCOM.

Mass media production staff interviewed felt they had learned a lot from their participation in the project. However, they do not have a clear sense of the overall methodology as they were generally involved only in the production phases. The primary information learned about the methodology was to produce very simple and clear messages, the need for pretesting and revision of messages, and the focus on the audience's needs rather than selling a product. One producer says she is now more particular in her work, paying more attention to details, and is more aware of the sensitivities due to culture and religion.

The production team did not participate in formative research activities or in actual pretesting and, although invited, did not attend the workshop on message development and script writing based

on research results. Thus, although they have developed a stronger orientation toward their target audience, it is unlikely they would be able to carry out audience research following the HEALTHCOM methodology or to translate the results into messages without outside help. However, they are a good resource for production work for other efforts following a similar methodology.

Representatives from the other collaborating institutions have a view of the methodology limited to the activities in which they participated. They report that they never received an overall view of the methodology or of the overall objectives of the program. Instead, they learned pieces of the methodology through participation in the workshops and some of the research activities. They found the workshops on focus groups and script writing to be particularly useful and had incorporated some of what they learned into their own activities.

Discussion

Parts of the HEALTHCOM methodology have been learned and adopted by the participants in the project, but only two individuals have a clear sense of the methodology as a whole and are capable of following most components of it in the future. The parts of the methodology that will be carried out again by the participants are pretesting, use of focus groups, and some formative research for decision-making. No clear assessment could be made about the quality of future activities by any of these groups.

One reason that the methodology was not learned more thoroughly by a larger group of people was that the project was just not long enough. What had been conceived as a 24-month project, in essence became a 15-month project. With the pressures to create an effective communication campaign, the HEALTHCOM staff reported not having sufficient time to fully involve the other members of the team in day-to-day project activities.

A second explanation is that there was not sufficient formal training. The major concern voiced by the Jordanians interviewed was that there was not enough training overall and that the workshops were too short to provide the kind of training needed. Formal training to upgrade skills was seen as very important. Another concern was that the training did not occur in the order the activities occurred in carrying out the methodology. Thus, the material learned in the workshops did not feed into the day-to-day activities of the project, but were essentially a separate activity.

Formal training of project personnel and collaborating groups was not a major component of the HEALTHCOM project plans in Jordan. However, once it became apparent that training was a Jordanian priority. AED attempted to respond to this need within the small budget available. In the first year, workshops were conceived as add-on activities by consultants already in Jordan to work on other HEALTHCOM activities and were not fully integrated into the other activities.

In the second year, AED provided extra funds from other sources to devote to formal training. The training activities in the second half of the project (the national breastfeeding seminar, the focus group workshop, and the script writing workshop) were specially planned, were longer, and were conducted by experts flown in specifically to conduct the workshops. These are the activities that the people interviewed tended to remember and to have found more useful than the earlier, more ad hoc activities.

On the whole, the evidence suggests that careful attention needs to be paid at the beginning of such a project to understanding what resources already exist in the country to support project activities (specifically in terms of skills with parts of the methodology) and where and for whom special training is required. The kinds of skills identified by project participants as important

for a project of this kind were: qualitative and quantitative research, health education or communication, subject matter expertise, use of research to develop strategies and messages, practical production skills, management and planning skills, and skills in coordinating with funding agencies and other participating institutions. If these skills are not available among those expected to participate in the project, plans should be made early to address some of the deficiencies. In recommending improvements for future projects of this type, the majority of the Jordanian participants suggested making a greater investment in training and incorporating training activities into the project plans earlier and in a more systematic way.

A third explanation for the lower than expected rate of institutionalization of the HEALTHCOM methodology was that the creation and coordination of a national team did not occur as planned. It was expected that much of the methodology would be learned through hands-on experience of the team members. The following section will discuss the institutionalization of a team to carry out health communication in Jordan.

Development of a Health Communication Team

Because the Noor al_Hussein Foundation lacked experience in some of the areas of importance to the HEALTHCOM project, particularly in health, the project was planned as a team effort. A major goal of the project was to create a team that could carry out development communication projects in the future following the methodology. This team would include representatives from different institutions involved in health education and promotion: the Foundation, the MOH (and particularly the health education department) and other government organizations, universities, Save the Children (U.S. and Sweden), United Nations organizations (UNICEF, UNRWA), Jordan TV and Radio, and private sector producers.

The team was expected to work together under the leadership of the Foundation. The Foundation was chosen as the umbrella organization because of their prestige in the country and their ability to bring many different people and organizations together. This goal was particularly important to the Foundation who saw themselves as developing the capacity to manage and carry out health communication for other agencies in the country and to use the methodology in other Foundation activities.

The original expectations of the U.S. and Jordanian participants was that there would be high levels of cooperation. One of the Jordanians interviewed expected that the representatives of the collaborating institutions would learn with the Foundation how to use the HEALTHCOM approach, and then share in the process of developing a media campaign, with each giving special input in his or her area of expertise. Although the project activities were generally a cooperative effort of many different groups, the level of coordination was not as high as expected and a lasting, coordinated team was not achieved.

Collaboration with others was more frequent at the start of the project, when the staff were determining the problems to address and developing the messages. The project staff had numerous meetings with MOH and hospital staff to obtain information and to coordinate the HEALTHCOM approach to breastfeeding and child spacing with national policy. Project staff met with MOH policy makers to clarify the policy on delaying breastfeeding supplementation until four months (some MOH physicians believed supplementation should start at two months). The Ministry of Health designed a new poster on supplementation in accordance with this new policy. The Ministry of Health also helped to sponsor and organize the breastfeeding seminar held in October 1988.

Most participating institutions were not involved in the specifics of message development or production, except the production team.

During and after message development, the MOH and other collaborating institutions were asked to review and comment on the messages. They also provided logistic support for research activities (drivers, access to health centers, and staff members to conduct focus groups or other research activities). Jordan TV and Radio collaboration was primarily in giving the project free air time for the messages, a process which was aided by the MOH.

The Ministry of Health was considered the primary collaborating institution. Although institutionalization activities were to be directed primarily toward the Foundation, the implementation plan included the HED as a collaborator in creating a health communication program and proposed to develop the managerial and organizational capabilities of both the Foundation and the MOH. One of the methods for reaching the goals of the project is to involve "the MOH Health Education Unit in all facets of project activity planning, monitoring, and evaluating."[8]

The HED personnel had expected to be more heavily involved in project activities, working together with the Foundation to implement the project. However, after reading the Letter of Agreement, they realized they had a lesser role. Overall, the HED saw themselves as having been in a supporting role, rather than a collaborative role. "We support the whole thing and try to help if asked." They gave the required approval for the major topics to be covered, gave feedback on messages and materials, attended training courses, helped collect data in the formative research, pretesting, and the evaluation, and provided logistic support for some of the research.

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[8]HEALTHCOM Implementation Plan - Jordan: 1987-1989. Prepared by the Academy for Educational Development for the U.S. Agency for International Development, May 1987, p. 45.

Some of the other collaborating institutions also did not see themselves as such - they participated when asked, but did not feel they were given the opportunity to actively collaborate in the project. They attended workshops, assisted with some of the research at different points in the project, and provided information about breastfeeding and child spacing from their experiences in working with Jordanian women.

The most successful collaboration in the project was with the production team from Arab Tele-Media. The Foundation staff and the production staff worked closely together to develop specific messages and jingles from the concepts brought to the group by the Foundation. The relationship described was one of back and forth discussion about audience needs and the messages done in a spirit of teamwork. On the whole, the two groups coordinated their activities effectively. However, there were budget and scheduling problems, and Arab Tele-Media reports losing money on the work.

The UNICEF office in Jordan was expected to be a major collaborator during the months that the project focused on diarrhea, and to be a collaborating institution in the breastfeeding campaign. This collaboration did not occur as expected. There seems to have been primarily a problem between personalities, thus it is not very useful to discuss it in detail. Because of problems in the early stages of the project, the UNICEF staff were not willing to cooperate at a high level later in the project.

One constraint to collaboration was that, in the actual working of the project, the cooperating institutions tended to be viewed more in terms of what they could provide to the project, rather than as true collaborators. The Foundation staff described collaboration activities in terms of other institutions' ability to "help," to "deliver quality service," or to "contribute." The commonly held view of the Foundation staff was that the Foundation was responsible with "some input" from others when needed.

Perhaps the largest constraint to creating an effective team was the tension between developing a good campaign and coordinating with others in a limited time period. The project staff reported that they didn't have the time to work with representatives from the cooperating institutions because the work needed to be done quickly. They felt they didn't have the time to provide the training that would be required either formally or on-the-job. The methodology is considered to be quite difficult to explain to others, particularly the use of research in choosing strategies and in designing and producing messages. The Foundation staff stated that more formal training was required at the beginning of the project to give everyone a firm grounding in the overall methodology and its research-oriented approach. This could provide a team of people all with the same general orientation toward approaching the problem. As it was, the team felt they had to introduce this approach as they went along.

This is related to the very high expectations the Foundation staff had for the quality of the messages. Because the Foundation is allied with the Queen, the staff felt under pressure to produce very professional messages. This meant the project director spent large amounts of her time on actual production of messages, when her role was expected to be more in managing a team of producers and other collaborating groups.

Discussion

In general, HEALTHCOM projects are located within a unit of the Ministry of Health or have some kind of formal tie to the Ministry. In this project, there were no formal ties to the MOH. In Jordan, at the recommendation of the USAID Mission, all project responsibilities were vested in a nongovernmental organization (the Noor al_Hussein Foundation), which was expected to collaborate with the MOH. This leads to the question, should the project have been

located at the Foundation or at the MOH? Both institutions had strengths and weaknesses.

Because of its smaller size and location outside the government system, the Foundation could be more flexible than the Health Education Department, allowing the staff to cut through bureaucracy to get more done more quickly. Flexibility is important in the HEALTHCOM methodology. However, the Foundation had its own bureaucracy. Project activities had to be approved by the director, and ultimately by the Queen. The director of the Foundation was very busy and was not always available for important meetings or to approve decisions. In addition, the Foundation bureaucracy slowed down the availability of funds, delaying project activities.

The Foundation was also seen as having an advantage because of its prestige and high visibility as the Queen's foundation. The staff had a large circle of contacts all over the country that they could call on for collaboration or assistance. The Foundation has the political power to reach any organization in the country and to obtain cooperation and interest from different groups. The Foundation was in a strong position to allow it to fulfill the role of coordinating all the institutions working on HEALTHCOM.

However, the prestige and royal links of the Foundation were also constraints. There was pressure in developing the campaign to produce attractive and extremely high quality messages that would reflect well on the Foundation. This led to a strong focus on the production stages of the methodology, taking up a lot of the project director's time that might have been better spent on larger management and coordination activities. The prestige of the institution also had an impact on what topics it was possible to cover. Because of the Foundation's links to the Queen, the Foundation could not promote controversial practices, and child spacing became more controversial as the Intifadah progressed.

Although the focus groups suggested that everyday Jordanians would be open to messages about child spacing, the Foundation could not risk being involved in a topic that would bring bad publicity through political or religious criticism.

On the other side, the HED at the Ministry of Health had experience and expertise in health, which the Foundation did not have. The MOH also had prestige. One interviewee described the MOH as being the voice of authority in the government for health, thus people may be more willing to listen to and follow messages coming from the Health Department. The main job of the MOH is health, and the primary responsibility of the HED is health education. Thus, the HEALTHCOM mandate fit well into their overall goals and responsibilities. The MOH also had a network of hospitals and health centers that could add an interpersonal component to what became primarily a mass media intervention. The staff of these centers already worked with the people and had greater contact with them.

On the whole, those interviewed saw the HED as being less able to carry out a health communication project like HEALTHCOM within the time frame allotted. In addition, at the time the project was being planned and funded, health education seemed to be a low priority for the MOH, thus there would have been internal competition for funds and staff time. (At the time these interviews took place, this had changed somewhat. The HED had received more training and been involved in other health education projects funded by USAID). It is also seen as more difficult to introduce new activities into government institutions within the time frame of the HEALTHCOM project because of the lack of flexibility and the larger bureaucracy.

The answer to the question about whether to locate HEALTHCOM in the ministry or at the Foundation is that it depends on what one wants to accomplish. If the major goal of the project was to carry out

the health education activities within the allotted time frame, the project should have been located at the Foundation. However, although the HED may not have been able to produce a HEALTHCOM campaign as rapidly as the Foundation or to have been able to develop spots of such high technical quality, there was almost unanimous agreement that the project should have been located at the MOH in order to ensure greater continuity. The HED is an institution with a mandate to carry out education and communication in health.

Although the project director at the Foundation is capable of using the methodology, the Foundation does not usually work in the field of health and has little health expertise. Because most of the in-service training and experience was limited to the Foundation staff, the HED staff are not currently capable of using the entire methodology in their work. It is unlikely that the MOH would use their small budget to hire the Foundation to develop a campaign for them when they have their own health educators and production staff.

Again, there is the tension between getting the project activities done on time and institutionalizing the methodology. Ensuring a sustainable program to use the HEALTHCOM methodology requires time -- time to train individuals in the methodology and time to work through the steps of the methodology with them so they gain experience and self-confidence -- and may result in a simpler campaign of lower technical quality. In HEALTHCOM projects, the two goals of producing an effective communication activity (one that brings about change in knowledge and behavior in the target audience) and institutionalization or continuity work at cross purposes. One interviewee summed up the problem with, "If you have sustainability, it means you have less impact." Those planning and funding the projects have to decide which goal is more important.

Appendix A

Examples of Television and Radio Scripts for Breastfeeding Campaigns

HEALTHCOM Project
The Noor Al Hussein Foundation
Jordan
March 1989

Breastfeeding Campaign
Television Messages

Song

Mother's Milk — the symbol of well-being
Your infant's health — is the most beautiful smile

Mother's milk is health, strength and immunity

Let your milk — with breastfeeding
Make his body grow — and give him immunity

Mother's milk is health, strength and immunity
Health, strength and immunity

Film "6" *

Are you pregnant?

Start preparing to breastfeed now....

Consult your doctor or the Ministry of Health Center to provide you with the correct information.

Breastfeeding is best

Film "5"

Taking good care of pregnant mother along with good nutrition are essential for a successful pregnancy....

Taking good care of the mother after childbirth provides her the strength she needs to breastfeed her newborn baby....

Nutritious food and liquids increases the mother's milk and helps her to continue breastfeeding her baby for the longest period possible.

The pregnant mother and the breastfeeding mother deserve all the care we can provide them

* numbers given are those used in media plan

Film "1 a"

Breastfeed your baby colostrum milk during the first hours after childbirth.
It is nutritious and healthy,
Cleans your baby's stomach
And gives him immunity.

Breastfeed your baby Colostrum milk

Film "1 b"

The best thing to start your newborn's life with is colostrum milk.
Breastfeed your baby colostrum milk during the first hours after childbirth, because that will:

* Increases your milk supply
* Relax you after childbirth

Breastfeed your baby Colostrum milk

Film "2"

Your baby has not reached his fourth month yet, he needs your breast milk.
There is no need for any other food or drink.
Remember, your milk alone is all that your baby will need to grow normally up until the end of his fourth month.
Breastfeed him, breastfeeding is the best....

Your milk alone is sufficient for your baby until the end of the fourth month

Film "3"

The more you breastfeed your baby, the more your milk supply will increase.
In order to increase your milk supply, drink more nutritious liquids and eat more healthy foods.
Breastfeed your baby more often, because increased breastfeeding will increase your milk supply.

The more you breastfeed your baby,

The more your milk supply will increase.

Film "7"

Mother: Ahmad's health is perfect... You see how beneficial it is to breastfeed him.

Daughter: But mother, I feel that my milk might not be enough for him.

Mother: No...no...Do not worry, your milk will be enough for him. Actually, your milk increases the more you breast-feed him. Listen to your experienced mother, you and your brothers grew on my breast milk alone, and you must do the same with Ahmad.

Daughter: Mother, how can I increase my milk supply?

Mother: The best thing you did was to breastfeed him as soon as he was born, and now you must continue to breastfeed him and whenever he needs to, because this will increase your milk. And of course when you eat right and drink healthy liquids, this will also help to increase your supply of milk.

(Child cries, indicating he needs to nurse).

Go ahead, he looks like he needs to nurse.

Daughter: Not yet mother, there is still one hour to go before his next feeding.

Mother: Breastfeeding is not by the hour Leila. You should breastfeed him every time he wants to, just as I did with you.

(Leila starts to breastfeed her baby...Close up of baby breastfeeding happily).

Breastfeed your baby whenever he demands

Film "4"

A shot of a number of mothers talking about breastfeeding.

Another mother talking about breastfeeding with her baby girl sitting on her lap.

A doctor addressing the audience on the benefits of breastfeeding.

SAMPLE RADIO SPOTS—"ASK DOCTORA HUDA"

Spot 1: Convincing mother she is able to increase the amount of her milk

(At the clinic)

Mother: Doctor, what shall I do? I feel Khaled is not getting enough of my milk.

Dr. Huda: No, no need to worry, believe me. With my experience as a doctor, and as a mother--and that of all mothers who have breastfed before you--I assure you that mother's milk increases the more she breastfeeds her child.

Mother: But, Doctor, he demands to feed a lot, and there is only one hour between each feed.

Dr. Huda: This is normal because **his body is growing and of course he needs more food. If you let him feed each time he wants to, you will have more milk in one or two days.**

Mother: Well, what else can I do to make sure that my milk is enough for him?

Dr. Huda: Very simple. You must try **to get enough rest** and reasonable nutrition. You must eat one and a half times your usual amount. Take a lot of nutritious liquids. The increase in your child's weight and his normal growth are the greatest proof that your milk is sufficient.

Announcer: My dear mother: Breastfeed your child whenever he demands it, because you are able to provide the amount of milk he needs. But you must maintain proper nutrition and rest for yourself, and take nutritious liquids.

Spot 2: Breastfeeding during illness

(At the clinic)

Mother: I feel a little tired, Doctor, and I am afraid this might affect my breastfeeding my daughter.

Dr. Huda: All you have is a slight cold. You must never stop breastfeeding your child at all.

Mother: It's good that I asked you.

Dr. Huda: It's good you came to me before you stopped breastfeeding. Every woman who breastfeeds should go to her doctor if she feels unwell and is thinking of stopping breastfeeding.

Mother: What should I do if she gets sick?

Dr. Huda: This also doesn't mean that you should stop breastfeeding. You must see your doctor who will advise you on what you should do, according to the baby's condition. For example, if she has diarrhea, you must continue breastfeeding. **A child who is sick needs nutrition more than ever, and mother's milk is best. Children with diarrhea who breastfeed get well faster.**

Announcer: Madam, if you feel slightly unwell or if your baby becomes ill, don't rush and stop breastfeeding. We advise you to continue breastfeeding and to see your doctor.

Spot 3: Weaning (part A)

(At the clinic)

Dr. Huda: His health is excellent. Is he already three months old?

Mother: Yes, Doctor.

Dr. Huda: And I hope you are still breastfeeding him?

Mother: I do, but I feel I have little milk. I am thinking of weaning him, What do you think?

Dr. Huda: No, no. I don't agree with you. Your own milk is the best nutrition for your child. The more you delay weaning him, the better it is for him. And when you do intend to wean him, it must be done gradually because abrupt weaning is bad for the child physically and psychologically.

Mother: How do you mean weaning him gradually, Doctor?

Dr. Huda: At the end of the fourth month, you must begin to give him food and drink in addition to your milk, while you continue to breastfeed him for the longest possible time.

Mother: Well, then when it is time to feed him, which should I give him first, breast milk, or additional food?

Dr. Huda: Breastfeed him until he has **taken all of** your milk first, because your milk is the best nutrition for your baby. Then, give him the additional food you have prepared for him. As I told you, you will then gradually start increasing the amount of food according to what he accepts.

Mother: What do you think, shall I give him a bottle?

Dr. Huda: No, because it is difficult to keep clean, and its contamination may cause him to become ill. He may then also come to prefer it to your breast, which would make the amount of your milk less. It is best to use a clean cup and spoon while continuing to breastfeed for the longest possible time, and remember that God Almighty said: "Mothers breastfeed their babies for two whole years for those who want to complete it."

Announcer: My dear mother: Gradual weaning ensures bodily and spiritual comfort for your child. Begin by gradually giving the child additional meals at the end of the fourth month and continue to breastfeed him for as long as possible.

Spot 4: Weaning (part B)

Mother: Doctor, I am now gradually weaning my son, as you told me to. But about additional meals...what do you think of my giving him a bottle?

Dr. Huda: No, no, because it is difficult to keep the bottle clean, and its pollution may cause **diarrhea and other illnesses.** It is better to use a clean cup and spoon for the additional meals and continue to breastfeed him as long as possible.

Announcer: In the name of God the Merciful,
Mothers breastfeed their children.
God the Great has told the truth.

Spot 5: Prevention

(At the clinic)

Dr. Huda: Thank God your pregnancy is normal. One more week and you will be a mother.

Mother: Dr. Huda, this will be my first birth and I wish you would advise me, especially about breastfeeding.

Dr. Huda: The most important thing is that you must breastfeed the newborn child immediately after birth, and you must care for your breasts beginning from the first day. They must always be clean. Use a special cream and be careful not to pull the baby from your breasts before he lets go himself.

Dr. Huda: (You must start taking care of your breasts today...they must always remain **dry and clean.** You may want to use a special cream to prevent cracking of the nipple.)

Mother: But they say that sometimes the breast becomes hard and engorged after the birth.

Dr. Huda: If you follow my advice this rarely happens, so don't worry at all. **to avoid problems, start breastfeeding early and feed him whenever he wants it.** If you feel your breast is beginning to harden, give it to the child **at once.** If the problem is not solved this way, then go to your doctor.

Announcer: Madam, caring for your breast from the beginning of pregnancy, and **immediate and continuous** breastfeeding is the best **way to avoid problems.**

Spot 6: Convincing the mother that her milk is sufficient for the child in his first four months

(At the clinic)

Mother: I don't know what happened to him, Doctor. I am not satisfied with his weight.

Dr. Huda: Let me weigh him and compare it to his age. (The movement of weighing...baby's voice) How old is he?

Mother: Nearly three months.

Dr. Huda: His weight is excellent compared to his age. He is not in need of additional food and drink until he completes his fourth month.

Mother: You mean he would not benefit from anything else I give him during the first four months, not even juice?

Dr. Huda: Mother's milk is the basic food and is enough for the child's nutrition.

Mother: But, Dr. Huda, I wish you would prescribe a milk that would help me.

Dr. Huda: But your milk is plenty. At this age the child does not need additional meals.

Mother: Are you sure my milk alone is enough for him?

Dr. Huda: Of course I'm sure, mother's milk alone is enough for her child until the end of the fourth month. And if you would like the amount of your milk to increase, then you can sure that the more you breastfeed your son, the more milk you will have. It is necessary not to give the child any substitute for mother's milk in the first four months because he cannot digest any food in a normal way--except mother's milk. It has been proven that the health of children who breastfeed from their mothers is better than others and they are less prone to illness.

Announcer: My lady mothers: Be sure to breastfeed your child and keep away from giving him additional meals until the end of his fourth month, because mother's milk is complete and best.

Spot 7: The effect of breastfeeding on the child—"first milk"

(At the hospital on the delivery table)

Dr. Huda: Thank God for your safe delivery. You must now begin to breastfeed him.

Mother: Breastfeed him? There is no milk yet in my breast.

Dr. Huda: (Laughing) There is first milk, which is the most important for the child.

Mother: First milk...

Dr. Huda: Yes, first milk, which God Almighty granted to your child to cleanse his stomach and give him immunity against many diseases.

Mother: Will the baby accept this milk?

Dr. Huda: Of course he will. Come on, put him to your breast and try once, twice. Let him benefit from the first milk.

Spot 8: The effect of breastfeeding on the mother

(At the clinic)

Mother: Doctor, Khaled is breastfeeding a lot and I am afraid of getting tired.

Dr. Huda: On the contrary, breastfeeding your baby often helps you regain your health and your strength and your figure.

Mother: What do you mean, Doctor?

Dr. Huda: Breastfeeding **immediately after birth** is very beneficial for the mother because it helps the womb return to its normal condition after birth and reduces the complication of breast congestion. Breastfeeding **on demand** helps the baby to feel secure, and you will feel tenderness. Your milk will increase and your child will get more nutrition and will grow.

Announcer: Breastfeeding is better for both mother and child.

Spot 9: Intensive breastfeeding

(At the clinic)

(The voice of a newly born baby crying in the background)

Dr. Huda: God be praised, he is two months old now.

Mother: And a few days. That is why I came to you, Dr. Huda, because he demands to feed often, even at night.

Dr. Huda: This is normal because his body is developing and growing, and of course he requires more food.

Mother: Do you think my milk would be enough for him?

Dr. Huda: The milk of every mother who breastfeeds her child is enough until the end of the fourth month. All you have to do is to look after your health and your nutrition. And any time your son wants to breastfeed, let him, because each time you breastfeed him your milk will increase. As long as he is growing normally, then your milk is enough for him.

Mother: And how can I be sure he is growing normally?

Dr. Huda: You must visit the mother and child clinic regularly to know the weight and height of your child. We can find out if the child is growing normally from the information we record on his health card.

Announcer: Madam Mother: Breastfeed your child whenever he demands it. The requirement of the child for mother's milk increases as he grows older, and rest assured that the more you breastfeed your child, the more milk you will have.