



Communication for Child Survival  
**HEALTHCOM**

**PHILIPPINES**

# **Implementation Plan**

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*a program of the*  
**Bureau for Science and Technology, Office of Health and Office of Education**  
**Agency for International Development**

*through a contract with the*  
**Academy for Educational Development**

*and subcontracts with the*  
University of Pennsylvania, Applied Communication Technology, Needham Porter Novelli and PATH

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**HEALTH COMMUNICATION FOR CHILD SURVIVAL**

**IMPLEMENTATION PLAN  
FOR THE  
REPUBLIC OF THE PHILIPPINES  
1987 - 1990**

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**HEALTHCOM PROJECT**

**DPE - 1018 - C - 00 - 5063 - 00**

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## I. HEALTHCOM PROJECT BACKGROUND

In August 1985, the Academy for Educational Development was awarded the contract to implement HEALTHCOM for the U.S. Agency for International Development for a five-year period. The project represents the continuation of a USAID-sponsored program entitled Mass Media and Health practices (1978 to 1985). HEALTHCOM is an initiative of the Office of Health and the Office of Education within AID's Bureau of Science and Technology. In the Philippines, it is jointly funded by the USAID/Mission and this central bureau of AID.

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

HEALTHCOM will work in up to 17 countries, using its research and development approach to adapt lessons from past programs to the special needs of each country. HEALTHCOM is also committed to strengthening the local institutional capacity to use communication more systematically and will provide both short-and long-term technical assistance for training and development. Primary attention will be given to diarrheal disease control, immunization, breastfeeding, Vitamin A, infant nutrition, vector control, and personal hygiene.

It is a comprehensive program of assistance which relies on insights from several disciplines, including social marketing, instructional design, behavioral analysis, and anthropology. The project strengthens child survival programs by working with local professionals to:

- o Conduct audience and product research
- o Select appropriate messages
- o Design radio, TV, and print materials
- o Integrate different message themes
- o Select local advertising agencies
- o Train counterpart professionals
- o Link private-and public-sector resources.

The Academy for Educational Development is the prime contractor responsible for selecting and fielding 17 resident advisors and the short-term consultants, as well as coordinating HEALTHCOM activities with each Mission, other centrally funded AID activities and other donors.

The Annenberg School of Communication of the University of Pennsylvania is the principal evaluation subcontractor charged with developing practical evaluation designs to measure the effectiveness of the communication strategies in each country. Applied Communication Technology is the subcontractor responsible for follow-up evaluation studies in Honduras and The Gambia and longitudinal analysis of program impact. Needham Porter Novelli, one of the leading U.S. social marketing firms, will be providing marketing and advertising assistance to the project. PATH will use its considerable experience in the development of print materials and appropriate health technology, and its "Safe Birth Plus Two" program, to provide assistance in these areas.

In addition, the following leading institutions have agreed to collaborate with HEALTHCOM, providing specialized assistance as required. They include The Futures Group, John Snow Health Group, Management Science for Health, University Research Corporation, the Wilmer Institute (ICEPO) and the Department of International Health, and the School of Hygiene and Public Health of John Hopkins University.

This implementation Plan describes the proposed HEALTHCOM activities in Philippine from 1987 through 1990.

## II. COUNTRY PROJECT BACKGROUND

### A. Country Statistical Profile

#### 1. Demographic Profile

The Republic of the Philippines, with a total land area of 300,000 square kilometers has a projected 1987 population of 57,356,042\* distributed among 13 administrative regions. Its population growth rate estimated at 2.5% from 1980-85, remains one of the highest in Southeast Asia.

The country is basically rural with 62.8% of the population living in rural areas in 1980. Average annual family income in 1985 was ₱31,052 (approximately US\$1,478 using 1987 exchange rates).

The proportion of infants and very young children is large i.e., around 3% (or 1,720,681 in 1987) are under one year of age and 11.5% (or 6,595,945 in 1987) belong to the 1-4 year old bracket.

In 1985, the Crude Birth Rate was 32.2 per thousand while the Crude Death Rate was 7.9 per thousand.

The demographic profiles of the 13 administrative regions are found below:

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\* Interagency Committee on Population and Housing Statistics, NEDA

	POPULATION 1987
PHILIPPINES	57,356,042
I - Ilocos	4,055,639
II - Cagayan Valley	2,647,809
III - Central Luzon	5,725,567
IV - Southern Tagalog	7,488,370
V - Bicol	4,104,518
VI - Western Visayas	5,322,783
VII - Central Visayas	4,362,066
VIII - Eastern Visayas	3,185,274
IX - Western Mindanao	2,994,381
X - Northern Mindanao	3,350,018
XI - Southern Mindanao	4,032,418
XII - Central Mindanao	2,733,010
Metropolitan Manila Area (National Capital Region)	7,354,189

## 2. Infant Mortality

Although the Philippines is classified as a middle-income developing country, infant and child health status remains poor in comparison to similar developing countries in Asia. Looking at national statistics on infant mortality rates (IMR) one notes that country has the second highest IMR among countries of the Association of Southeast Asian Nations (ASEAN):

### Infant Mortality Rates in ASEAN Countries, 1983-84

<u>Country</u>	<u>IMR (infant deaths per 1,000 live births)</u>
Indonesia	79
Philippines	56
Thailand	53
Malaysia	28
Brunei	11.5
Singapore	9.3

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Source: Encyclopedia Britanica, Book of the Year 1987.

The latest official statistics on infant mortality (Philippine Health Statistics, 1984) reveal that, pneumonias, diarrheas, nutritional deficiencies, measles and acute bronchitis are among the ten leading causes of deaths.

Childhood diseases where immunizations are possible, like diphtheria, whooping cough, T.B. and tetanus, also account for relatively high rates of infant and child deaths.

Infant and child death rates per 100,000 population for childhood diseases are illustrated below:

Disease	Rate/100,000 Age Under 1	Rate/100,000 Age 1-4
Pneumonia	854.0	252.4
Diarrhea	266.0	64.1
Measles	112.5	82.9
Bronchitis	49.7	10.2
Tetanus	7.8	1.4
Diphtheria	4.6	3.3
TB	1.7	1.5
Whooping cough	1.2	0.4

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Source: Philippine Health Statistics, 1984.

The above data also reveals the significantly higher death rates from communicable disease occurring among infants below one year of age than among children aged 1 to 4. Babies are more than twice as likely as to die from measles, diarrhea, and pneumonia, bronchitis and tetanus than children aged one to four.

### 3. Immunization Coverage

Considering the incidence of infant and child deaths from communicable diseases, availment of preventive health care remains poor. A review done in 1986 of the Coverage of the Expanded Program on Immunization (EPI) in four selected regions (V, VIII, X, and NCR) showed that only 21.3% of eligible infants are fully immunized

(full immunization meaning that a child at 12 months has had one dose of BCG, three doses of DPT & Polio and one dose of measles vaccines). Of the four regions surveyed, NCR or Metro Manila had one of the lowest full immunization coverage rates (15.9%). The immunization coverage rate for measles, the most deadly of the immunizable diseases, was the lowest among all four immunizations.

A summary of EPI coverage data done for the last quarter of 1986 and first quarter of 1987 confirm the low immunization coverage nationwide. A comparison of major urban, minor urban and provincial areas shows that the lowest full immunization coverage rate is found in the major urban areas. (31.73% vs. 44.06% and 46.99% for minor urban and provincial areas, respectively).

#### 4. Diarrhea Incidence and ORS Use

On the other hand, diarrhea constitutes one of the top three killers of infants and young children aged 1-4. Diarrhea morbidity is also high, an average child experiencing 2.8 episodes per year. And yet, preliminary data from a WHO-DOH case management survey done in Metro Cebu (Region VII) in 1987 show that ORS use rate is only around 6% while anti-diarrheal drug use is 55%, almost equal to the use rate of home or herbal fluids.

#### B. Authorizing Mandate

On September 8, 1987 the Department of Health and the Academy for Educational Development signed a letter of understanding for the implementation of Healthcom activities from 1987 to 1989.

Under the HEALTHCOM contract, AED will provide a two-year program of technical assistance to the Government of the Republic of the Philippines designed to strengthen its health education system. The specific purpose of this assistance is to enable the Department of Health to apply a methodology for the use of mass media (broadcast and print) and face-to-face interventions to obtain the widespread adoption of practices conducive to decrease child mortality. An important aspect of this program is the adoption and integration of long-term systematic communication planning and design procedures into the country's health education system.

C. The Accelerated Programme on Immunization (EPI) and Control of Diarrheal Disease Programs (CDD): Goals of the Department of Health

The responsibility for public health care lies with the government's Department of Health. The Department's Division of Maternal and Child Health is charged with formulation of policies on child health including EPI and CDD. Implementation of policies are with the line departments, specifically the regional, provincial, city and municipal health offices.

On April 3, 1986, President Corazon Aquino signed Proclamation No. 6 which aims to attain, by 1991, full immunization of 90% of eligible children. This means that the country in 1986 was still 69 points away from the 1991 target. From 1987 to 1991, actual immunization coverage has to triple to achieve this target.

The goal of the Accelerated EPI Program nationwide is to increase complete immunization from 21% to 50% in 1989 and 90% in 1991. The Programme will focus its efforts in urban areas, where coverage rates are low.

The goal of the CDD Program is to decrease mortality due to diarrheas in children less than 5 years by 30% in 1989 using the Oral Rehydration Therapy Case Management Strategy and to reduce morbidity by 30% by 1989. In the long term, the goal is to reduce Mortality of children under 5 to 6.3 per 1,000 in 1989 and 4.5 per 1,000 in 1992 and to reduce diarrhea episodes per child to 2.5 in 1989 and 2.0 in 1992.

D. Outputs

Under the agreement, the following outputs will be delivered by AED:

1. A National Health Marketing Communications Plan for the Republic of the Philippines with an initial two-year focus on child survival programs, specifically diarrheal disease control and immunization. Subsequent programs to be addressed may include acute respiratory infection especially as it interacts with immunization programs.
2. A plan for institutionalizing a capability within the Department of Health for communications and marketing work.

3. On-the-job training conducted on communications planning, research, mass media campaign development and implementation for the counterpart DOH staff at the Public Information and Health Education Service (PIHES).
4. A multi-media intervention implemented in the Philippines aimed at promoting health practices among the low-income sector that would reduce the incidence and severity of diarrheal disease, increase the number of children who are fully immunized by one year of age and the number of pregnant mothers who have received two doses of tetanus toxoid vaccine.
5. Research findings disseminated to professional groups within the Philippines and abroad and research results utilized for more effective decision-making as the program is implemented.
6. A manual on the design, development and management of health communications programs using case examples drawn on the project's experience in diarrheal disease control and immunization. This manual may serve as teaching aid for managers of other health communication programs.

#### E. Inputs

Under the agreement, AED will provide the following inputs:

1. Initiate and manage a plan formulation workshop in Manila to develop a master plan for communications and social marketing in support of the Department of Health's Child Survival Program, with initial emphasis on immunization and Control of Diarrheal Disease/Oral Rehydration Therapy.
2. Undertake a program of formative research, utilizing both quantitative and qualitative techniques, to identify existing knowledge, attitudes, and practices among health personnel and rural families concerning the topics to be covered by the campaign.
3. Develop a comprehensive marketing plan covering the marketing and communication objectives and strategies, specific messages, channel integration strategies, broadcast schedules, production, and distribution plans for print materials, training plans and monitoring and evaluation plans.

4. Produce pilot materials (sample radio programs, draft graphic materials and preliminary training designs) for pilot testing with representative members of the target population.
5. Revise draft materials based upon results of pretesting and complete final production of campaign materials.
6. Undertake pre-campaign preparation of health personnel, including orientation of health workers, distribution of materials to decentralized distribution points, final scheduling of radio broadcasts and development of a plan to monitor campaign implementation.
7. Implement campaign activities, including transmission of radio programs, distribution and placement of graphic materials, contract between health workers and the target population and monitoring of all campaign elements. It is expected that the HEALTHCOM Project will undertake a pilot campaign for each of the two key programs, CDD and EPI.
8. Monitor and evaluate impact of the communication programs.
9. Develop a manual for public health communications program planning, implementation, and evaluation using the project's experience in the diarrheal diseases control and immunization programs.
10. conduct training on the use of the microcomputers for communications planning, research, and evaluation.

F. Participating Institutions

The project requires the cooperation of the following sectors:

1. Department of Health - which includes its top management, as well as the Maternal and Child Health Division, PIHES regional directors of the target regions and their respective health centers.
2. USAID Mission in the Philippines.
3. United Nations agencies, especially WHO and UNICEF.

4. Other centrally-funded agencies involved in Child Survival, particularly REACH and PRITECH.
5. The Philippine private commercial sector i.e., advertising agencies, consumer research agencies, pharmaceutical companies and pharmaceutical distribution firms.
6. Philippine NGOs like Kabalikat, Population Center Foundation, and Development Research and Demographic Foundation.
7. Local governments of the target areas.

G. Project Major Constraints

Activities are constrained by the following factors

1. Undergoing Reorganization of the Department of Health (DOH)

a) Need for formal appointment of PIHES technical staff

Though the PIHES organizational structure has been finalized, formal appointment of staff to key technical positions has not taken place. These pose difficulties for the achievement of the institutionalization objective of HEALTHCOM.

b) Lack of Control by DOH of Local Health Offices/Centers

Before the reorganization, city health offices which supervised the health centers, were organizationally under their respective city governments. With the reorganization, they have now been placed under DOH. This would enable DOH to have supervision and control of all the health service delivery structures.

However, some city governments are resisting this takeover by DOH. This resistance is reinforced by the fact that, since DOH cannot presently afford to pay the full salaries of the health office and center staff, some city governments still provide funds.

This situation could, in some areas, hinder the smooth implementation of the EPI and CDD programs. It must be noted that communica-

tion activities of HEALTHCOM are only supportive of these programs where the service delivery structure plays a key role.

2. Lack of full support of Private Medical Practitioners

In both the EPI and CDD programs, the private medical practitioners would play a significant role. Traditionally, it has been difficult to get their full cooperation in public health activities and programs.

3. Central funds allotted for project implementation are insufficient. A.I.D. Manila bilateral funds are now being made available for HEALTHCOM project activities. However, in the past several years, bilateral funding has meant difficult and lengthy procedures. The administrative procedures needed for contracting and fund allocation have to be in step with the pace of project implementation. It is critical that HEALTHCOM work closely with A.I.D. Manila and the Department of Health to streamline administrative procedures and ensure timely disbursement of funds to such activities as multi-media campaigns involving media buying.

H. Opportunities

Despite the major constraints mentioned above, the Healthcom activities in the Philippines are benefitted by opportunities/resources:

1. Willingness of PIHES technical staff to cooperate with Healthcom;
2. The DOH top management's full support and appreciation of communications and social marketing disciplines as applicable to child survival and other health programs; their willingness to experiment with new strategies and schemes as well as openness to working with the private commercial sector;
3. The fairly high level of local expertise in mass media, communications and research, especially in the private commercial and non-profit sector;
4. The existence of a number of competent NGOs which are willing to assist DOH in communications and research; and,
5. The funding support by the USAID Mission for program implementation.

### III. MARKETING COMMUNICATIONS PLAN

#### A. Expanded Program on Immunization \*

##### 1. The Mission

Many children in the Philippines die each year from diseases that are largely preventable through routine vaccinations. Currently, only 39% of D, E mothers claim completion of the standard immunization series. (22% verified by card). The trend for each of the specific immunizations is as follows:

<u>IMMUNIZATION</u>	<u>AGE GIVEN</u>	<u>VERIFIED COMPLETION</u>
BCG	Birth	52%
Polio (1)	3 months	56% ) can be obtained
DPT (1)	3 months	58% ) during 1 visit
Polio (2)	5 months	48% ) can be obtained
DPT (2)	5 months	50% ) during 1 visit
Polio (3)	7 months	37% ) can be obtained
DPT (3)	7 months	40% ) during 1 visit
Measles	9-12 months	26%

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1986 - Manila only, other regions show the same general trend.

\* This EPI communication plan is based on an earlier document prepared with the assistance of Mary Debus of Doremus, Porter, Novelli and discussed with the Department of Health, the A.I.D. Mission and collaborating institutions in November 1987. It uses the research data of Annenberg School of Communications.

The long term goal for the Expanded program on Immunization (EPI) is to reach full immunization of 90% of all eligible children under 12 months of age by 1991.

2. Objectives

The overall objective of the program is to raise the national level of Fully Immunized Children from 22% to 50% by 1989: a 100% increase over current levels.

This goal will be achieved by a national urban communications campaign supported by ancillary communications materials and a strong service delivery system.

THE TARGETED ACTION OF THE CAMPAIGN IS FOR MOTHERS TO BRING THEIR CHILDREN TO THE HEALTH CENTER FOR ALL EIGHT IMMUNIZATIONS BY 12 MONTHS OF AGE.

3. Two-Phased Approach

The campaign will be accomplished in 2 major phases:

Phase I - Metro Manila Measles Campaign  
February - May 1988

Phase II - National EPI Urban Campaign  
June 1988 - May 1989  
(This takes the campaign through one complete season and therefore includes seasonal "peaks" in the disease cycles.)

Measles was selected as the primary focus for the Metro Manila pilot campaign for the following key reasons:

- o As the finishing point in the immunization series, measles has the highest drop-off rate and, therefore, is the major reason for failure to complete the series.
- o Even children that have fallen out of the system can be brought back in if caught at the time of measles vaccination.
- o Measles is one of the largest killers of children in the Philippines, particularly as both diarrhea and pneumonia are associated with measles as is general nutritional status.

<u>Disease</u>	Death Rate
	Per 100,000/1984 <u>Under 1 Yr (100,000)</u>
Whooping cough	1.2
TB	1.7
Diphtheria	4.6
Bronchitis	49.7
Measles	112.5
Diarrhea	266.0
Pneumonia	854.0

#### 4. The Research

Current research data provide several general trends of potential relevance to the campaign.

- o Full immunization has been steadily increasing with marked improvement shown in the past year. This represents a positive momentum upon which the campaign can build.
- o General awareness of vaccinations as protection from disease is quite high. Mothers give their agreement to the value of vaccinations and a substantial proportion of children (73%) enter the Health Care System (at least one vaccination). This suggests that there is a receptive stage set for the campaign.
- o Mothers' knowledge about many specifics of immunization and the EPI program is weak so that, as a whole, there are few well informed mothers. This represents a possible area of opportunity for the campaign.
- o As a whole mothers' participation in the immunization process is quite passive in nature. Many do not possess active knowledge of or play an active role in what occurs during their visits to the Health Center and misperceptions are frequent. This represents a creative challenge for the Ad Agency.
- o Polio and measles appear to be the vaccinations about which mothers have the greatest awareness. That is, these are points in the vaccination process that mothers have substantial consciousness about in general terms. These represent potential hooks or "building blocks" for the campaign.

5. Target Audience

The primary target audience is mothers/caretakers of children 1 year of age or less, urban residents, of lower socio economic status (D, E).

This primary target audience can be segmented as follows:

- A) 73% are currently in the system. That is, they have received at least one immunization for their child.
- B) 27% are currently outside the system. That is, they have not received any immunization for their child.

Because mass media is, in essence, a fairly blunt instrument in the Philippines, it is anticipated that messages specifically directed toward either primary target segment will reach members of the other segment. However, the advertising agency is expected to develop a clear target audience strategy, whether phased or simultaneous in nature.

A secondary target audience would include family and peers: husbands, fathers, friends, children, etc who may reinforce behavior change and/or influence mother's awareness and attitudes regarding immunization.

6. The Message

The emphasis of the national campaign will take one or a combination of the following general directions:

- 1) Roll-out of the Metro Manila Measles Campaign to nationwide coverage. (This option assumes that the measles campaign has been successful in meeting specific action standards to increase total series coverage.)
- 2) Develop a new but complementary and sustaining strategy and campaign approach for the National Program.
- 3) Develop a phased campaign approach which will begin with but move beyond measles

nationally.

Regardless of the overall direction taken, the national campaign must incorporate two major elements:

- 1) Immunization Friday. The campaign must popularize Friday as Immunization day on a nationwide basis.
- 2) Immunization Demand. Whether the tone and manner of the campaign is emotional or informational in nature, the desired outcome is increased involvement and motivation on the part of mothers to have their children fully immunized by age 12 months.

In general it is suggested that the ad agency give consideration to a variety of campaign approaches including those that are disease specific vs. system general, those that are informational vs. emotional in nature, and those depicting rewards vs. negative consequences.

## 7. Media

The ad agency will present a media plan which reflects cost-efficiency, and appropriateness for the message approach to be employed. Additionally, a flighting schedule will be prepared by the agency which takes into consideration peak disease seasons.

A public relations plan to gain added exposure and media leader and medical community (public and private physicians) support will also be developed.

A cost-efficient promotion program to provide mothers with incentives and intermittent rewards will be considered as well.

## 8. Research Activities

### a. Concept Screening

During the three month period of the Metro Manila Measles Campaign, it is expected that the agency will undergo some exploratory/idea generation research to investigate possible approaches for the national campaign. This will be done by the agency's in-house research group.

The purpose of this process is to have back-up/complementary creative approaches assessed for quick action at the time of the evaluation of the Metro Manila pilot and the national campaign launch.

b. Materials Pretesting

As with the Measles campaign, materials developed for the national campaign will be pretested among the target audience to ensure that they meet communication and motivational/emotional response objectives. This includes testing for:

- o comprehension
- o clarity
- o possible confusion/negatives
- o credibility
- o persuasion

c. Campaign Tracking

As with the measles campaign, periodic independent research will be conducted to measure:

- o Level of advertising awareness including source of awareness and message recall.
- o Level of attitude change including attitudes towards immunization generally and other relevant dimensions addressed by the campaign.
- o Level of intention to immunize.
- o Level of general and specific knowledge change in key areas addressed by the campaign.

d. Monitoring of Behavior Change

In-depth assessments will be conducted among the target group to determine if the campaign is meeting its behavioral objectives.

This evaluation will be carried out as an independent activity and will focus on obtaining a clear picture of immunization level by type of vaccination and by the

following population segments:

- Those entering the system for the first time
- Those completing the Immunization Series
- Those returning to the system

9. Timetable

The target date for completion of the Metro Manila Measles Campaign is May 1988. At that time key decisions will be made regarding the National Campaign. The agency should be prepared to present a comprehensive national strategy, including alternatives, in May. The national campaign is scheduled for launch in late June 1988 and will run for a 12-month period.

10. Budget

Total anticipated budget for the National Campaign is \$838,000. This will cover all activities including creative development, production, media, and research for the Campaign.

B. CDD Test Markets: Regions 6, 7 & 10 \*

The Department of Health will be launching a pilot project in Regions 6/7 and 10 during the 1988 diarrhea season. Regions 6 & 7 will represent Test Market A and Region 10 will represent Test Market B.

1. Test Market A

In regions 6 and 7, where government service delivery networks are relatively strong, Oresol, the powder sachet for one liter volume of oral rehydration solution, will be promoted as early home treatment at the onset of diarrhea. Free Oresol used in Rural Health Units, Barangay Health stations and government hospitals will be promoted starting May 1. A commercial Oresol will be marketed for sale at municipal drugstores and, hopefully, sari-sari stores in the barangay level by September. Mass media will be used to increase demand for Oresol. Other promotional activities will be undertaken to gain support of public and private physicians, pharmacists and sari-sari store owners for Oresol.

This CDD communication plan is based on an earlier document prepared with the assistance of Mary Debus (DPN) and Caby

Verzosa in November 1987. These plans have been discussed with the Department of Health, the A.I.D. Mission and collaborating institutions.

2. Test Market B

In Region 10, where the government service delivery networks are fairly weak, Oresol will not be promoted as home treatment at the onset of diarrhea. The campaign in this region will promote the use of home available fluids to be given at the onset of diarrhea to prevent dehydration. As soon as dehydration sets in, mothers will be taught to immediately bring their children to the health center where Oresol will be given. Mass media will be used to disseminate these messages. In region 10, no commercial Oresol will be marketed.

3. Expansion Program

After the market tests, situations wherein only Oresol or only home available fluids are given are not anticipated. Rather, a combination of treatments will be applied according to the conditions prevailing in the region/province.

These are two separate test markets and are not comparable. They will be evaluated on their separate set of communication and marketing objectives. Findings of these test markets will help identify components and activities to be replicated for regions with similar conditions in the nationwide expansion.

4. Demographic and Health Profile

Below is a demographic and health profile of the 3 regions:

	<u>6</u>	<u>7</u>	<u>10</u>
Population 1987	5,322,783	4,362,066	3,350,018
Population under 5 yrs of age (14.5%)	771,804	632,500	485,753
Crude Death Rate (per 1,000 pop.)	8.3	7.9	11.1
Life Expectancy at birth (1980)	62.2	63.9	55.0
Percentage Urban (1980)	28.3	32.0	26.6
Literacy Rate (1980)	81.2	76.1	83.4

Average Annual HH Income (1985)	24,807	20,756	20,402
No. of CDE House- holds (1983)	870,000	712,000	558,000
Diarrhea Morbidity Rate/100,000 pop (1984)	871.8	946.2	1,572.5
Diarrhea Mortality Rate/100,000 pop (1984)	21.4	21.9	27.3

Sources: PCF, Selective Dissemination of Information,  
vol. 1 no. 3, 1987.  
Department of Health, Philippine Health  
Statistics, 1984  
Trends 1983 survey of HH per Class

The baseline survey conducted by Healthcom of  
respondents in the 3 regions in October 1987 give  
the following datae:

Of mothers whose child had diarrhea and did  
something about it:

	<u>6</u>	<u>7</u>	<u>10</u>
Aware of Oresol	87%	73%	78%
Gave Oresol	26%	20%	28%
Awareness/Practice Gap	3.3	3.7	2.8

##### 5. The CDD National Program

The pilot projects have been identified as phase 2  
in the implementation of the restated CDD National  
Program for 1988-92.

	<u>Estimated National Average</u>		
	<u>1986</u>	<u>1989</u>	<u>1992</u>
Diarrhea Mortality/ 1,000 children under 5	8.6	6.3	4.5
Diarrhea Morbidity (episodes per child per year)	2.8	2.5	2.0

In order to achieve the mortality reduction  
targets, the program aims to increase ORS  
availability in all health outlets (health  
centers, drugstores, government and private  
hospitals, barangay health stations) as follows:

Estimated National Levels

	<u>1985</u>	<u>1989</u>	<u>1992</u>
ORS Availability		60%	100%

At the same time the program aims to increase the percentage of the population with access to ORS (access is defined as "living" within 5 km. or 1 hour's travel to a health facility or trained ORS provider with adequate ORS supply) as follows:

Estimated National Levels

	<u>1985</u>	<u>1989</u>	<u>1992</u>
ORS Access (% pop.)		80%	85%

It also aims to increase the number of mothers who know about ORS and use it properly as follows:

	<u>1986</u>	<u>1989</u>	<u>1992</u>
Proper ORS Use		30%	35%

The following strategies shall be adopted to operationalize the program:

- education of mothers and caretakers of children on proper diarrhea case management and effective diarrhea prevention measures;
- propagation of ORT as the standard intervention in the management of acute diarrhea;
- increase access of population to ORS through promotion of commercialization of ORS by private manufacturers, with government continuing to produce and distribute free Oresol to patients who cannot afford to pay;
- promotion of preventive interventions like breastfeeding, environmental sanitation and measles immunization;
- training professional health workers in ORT;
- decentralized implementation of the CDD

program;

- phased implementation of the CDD program;
- evaluation and monitoring; and,
- encouragement of research activities which will address technical and operational issues of implementation.

6. Objectives

a) General Objectives of the Test Markets in Regions 6/7 and 10

1. To gain experience in the management of a multifaceted marketing approach for Oral Rehydration Solution and Oral Rehydration Therapy.
2. Evaluate the Pilot Marketing Strategy against specific objectives set for the test markets (below, item B).
3. Fine tune elements of the marketing mix for expansion to a national or multi regional program.
  - Program acceptance/satisfaction
  - Pricing strategy (consumer and trade)
  - Advertising effectiveness
    - \* Message
    - \* Media Mix
  - Promotion/PR Strategy
  - Distribution Strategy
4. Establish marketing goals and projections for the national or multi regional program.
5. Utilize the Test Market experience to develop a National Privatization Plan.
6. To find out the Oresol marketing conversion ratio, i.e., awareness of Oresol with sick child with diarrhea usage/bought Oresol

b) Specific Objectives

Test Market A (Regions 6 and 7)

By the end of the test market duration, the following would be observed:

	<u>Public Sector</u>	<u>Commercial Sector</u>
i) Distribution of Oresol	Available in all RHUs and BHSS	Available as an OT item in at least one major drugstore and one main sari-sari store in each municipality
	<u>Public Sector</u>	<u>Commercial Sector</u>
	No out-of-stock condition at any one time	No out-of-stock condition
ii) Market share	Increased use of Oresol	Increased sales of Oresol in drugstore
iii) Mother's knowledge of diarrhea improved i.e. 50% know that in diarrhea, it is the dehydration to be treated.		
iv) Awareness/Practice Gap - 2 (i.e. of those aware of Oresol and have child with diarrhea, 50% will give Oresol)		
v) Demonstrated to distribution houses/pharmaceuticals that Oresol manufacture and sale can be profitable		

Test Market B (Region 10)

By the end of the test market, the following would be observed:

- i) Distribution of Oresol: Available in all RHUS and BHSS and no out-of-stock condition.
- ii) Mother's knowledge of diarrhea improved i.e. 50% know that in diarrhea, it is the dehydration which is to be treated.
- iii) Mother's awareness of Home-Available Fluids: 85% aided, 60% unaided.

- iv) Mother's Use of Home-Available Fluids: 75% trial, 50% repeat users.
- v) Mother's knowledge of one to two signs of dehydration: 75% aided, 55% unaided.  
Mother's knowledge of more than 2 signs of dehydration: 60% aided, 40% unaided.
- vi) Mother's knowledge of what to do when dehydration appears: 50% bring to health center, 60% continue giving home-available fluids.

7. Components of the Test Market

a) Product

Oresol and other Commercial Brands of ORS

Oresol is a government produced powder sachet for a 1 liter volume of oral rehydration solution.

It follows the WHO formula. Its ingredients per sachet are:

Sodium Chloride	3.5 g.
Trisodium Citrate, dihydrate	2.9 g.
Potassium Chloride	1.5 g.
Glucose	20.0 g.

There are six (6) brands of oral rehydration products in the market. Two new brands (Rohrer's Gastrolyte and Wyeth's Aqualyte) are expected to be launched in April 1988. However, only three brands conform to the WHO formulation of 90 m Eq sodium namely, the pre-mixed solution, PEDIALYTE-90, the Servipharm ORS and the DOH Oresol.

PEDIALYTE, the pioneering brand, was way ahead of other brands, having been introduced in 1972. Glucolyte and Kristlyte, both in powder form, were introduced in 1977.

It was only recently, however, that the PEDIALYTE 90 was introduced. The earlier formulation contained 45 m Eq of sodium. The Servipharm ORS powder is also new; it was launched in April, 1987.

Following is a product profile of the six brands.

TABLE 1

ORS PRODUCTS

BRAND NAME	FORM	SIZE (Volume)	DISTRIBUTOR	MANUFACTURER	TRADE PRICE	PRIC
Glucolyte	Powder	240 ml.	Pharex	Pascual	₱5.50	.022
Kristalyte	Powder	200 ml. 500 ml.	Zuellig Pharma	Squibb		
Pedialyte	Pre-mix	250 ml. 500 ml.	Metro	Abbott	₱27.21 ₱32.66	.109 .065
Pedia- lyte.90	Pre-mix	500 ml.	Metro	Abbott	₱34.43	.068
Servipharm ORS Powder	Powder	1000ml.	Zuellig Pharma	Ciba-Geigy	₱6.86	.006
ORESOL	Powder	1000ml.	DOH	DOH	FREE	

Source: Philippine Index of Medical Specialties  
April 1987 (except for Servipharm ORS Powder and ORESOL)

Amount of Oresol to be Available for Test Markets

Two million sachets of Oresol will be made available for Regions 6,7 and 10. The plan is to allocate all for the public health system (free distribution). Separately, around 600,000 sachets of Oresol will be procured using the DOH-approved Kabalikat-tested package design. These will be allotted for commercial distribution in Regions 6 & 7.

Oresol Packaging and Branding

It is important that the commercial Oresol be distinguishable from the free DOH-distributed product. It is doubtful that the private sector will pick up the manufacture and

marketing of a product which has been distributed for free by the government.

Assuming the test market is successful and the private sector would want to use the brand Oresol, they will be allowed to do so. Or if they so desire, they will be allowed to change the brand name of Oresol.

b) Price

The trade price is the manufacturer's price to drug retail outlets, less a manufacturer's standard wholesale discount. It does not take into consideration any additional discounts, such as quantity and cash discounts, bonus and periodic offers.

The distributor charges 7-9% of the manufacturer's price for handling and distribution.

The retail price of the commercial Oresol will be set competitively against other similar brands. A market study of all ORS brands will be made for this purpose.

c) Distribution of Oresol

The ideal distribution situation is for Oresol to be available in all RHUs and BHSs in the 3 regions and in most drugstores in each municipality and sari-sari stores in each barangay in regions 6 and 7. In the foreseeable future, this is not achievable. However, the two test markets will, hopefully, widen the distribution network of Oresol.

Public Sector Distribution: Regions 6/7 and 10

The distribution objective of the test market is to make the Oresol available all the time - with no out-of-stock condition in all RHUs and BHSs of the three regions.

Distribution of the free Oresol remains a major concern. A 1983 Kabalikat study revealed that 52% of 81 Rural Health Units sampled (in Regions I, V, VI, and X and Metro Manila) experienced an out-of-stock

condition. More recent anecdotal information from a commercial ORS manufacturer indicated that Oresol availability in the regions is spotty. Some areas have adequate supply while others have severe shortages during peak diarrhea season.

The present DOH distribution system is as follows: Oresol is normally sent from the Manila Warehouse at DOH simultaneously to two points - the regional health offices nationwide and the provincial health offices which, in turn, distribute the products to the district level health centers. It seems that the problem point is the distribution from the districts to the RHUs. This DOH system will be reviewed in order to determine the problem points and, if necessary devise a better distribution system. Regular monitoring of Oresol distribution within the DOH system will be done as well as periodic inventory checks at the RHU and BHS levels.

#### Commercial Distribution: Regions 6 and 7

The present distribution system of commercial drugs is as follows: Most drugs are distributed by major distributor houses (e.g., Metro Drug, Zuellig, Pharma) which have warehouses in all the regions. In these regions, the distributors have salesmen who see to it that the drugs reach the provinces under their assignment. Since there are several cities and municipalities in each province, the salesmen usually go to the large drugstores in these areas. The small municipal drugstores usually procure drugs from the larger drugstores within the vicinity. This is one reason prices of drugs in the smaller drugstores tend to be higher.

The sari-sari stores also procure drugs from the larger drugstores in the municipalities or cities.

Healthcom will negotiate with a commercial drug distributor house or with a commercial distributor of packaged goods with extensive municipal networks in these 2 regions to distribute and market the commercial Oresol. With this network, Oresol is expected to be carried as an over-the-counter (OTC) item by at least one large drugstore in each municipality.

It will be extremely difficult for the

distribution network to immediately reach sari-sari stores. Incentives will be given to sari-sari store owners at the barangay level to encourage them to purchase Oresol from the municipal drugstores and carry the product in their respective stores. The DOH will not visibly manage or handle the commercial distribution effort.

#### Product Positioning

All the six (6) ORS commercial brands are positioned as medicine to correct electrolyte imbalance and prevent dehydration due to diarrhea. The Pedialyte (45 mEq) is meant to prevent dehydration and maintain normal fluid electrolyte balance in mild to moderate diarrhea. Pedialyte 90, on the other hand, restores fluids and electrolytes in moderate to severe diarrhea with dehydration.

For purposes of the test markets, ORESOL will be positioned in Regions 6 and 7 as a product to be given at the onset of diarrhea to treat dehydration.

This positioning has distinct advantages: (1) from a communications point of view, it is a simpler message to transmit through media and, therefore, easier to teach, than to explain the difference between diarrhea with and without dehydration; (2) studies have shown that within a few hours after diarrhea starts, dehydration amounting to 3-4% of body weight can occur, without symptoms; (3) early ORT minimizes symptoms associated with increasing water and electrolyte loss (Population Reports series L no. 2). Field programs that have involved early home use of ORT (e.g. India and Bangladesh) actually reduced mortality and lowered hospitalization incidence.

#### Over-the Counter (OTC) approach

A few months after the May 1 promotions launch, when the commercial product is available, Oresol will be marketed in Regions 6 and 7 as an OTC item in drugstores and sari-sari stores.

Discussions with commercial distributors have confirmed the validity of launching promotional activities before product placement in commercial outlets. This is

because ORS (unlike milk or other household products) is not a familiar product category among consumers. Thus, sari-sari stores/drugstores may not agree to carry Oresol for fear of non-movement of the product.

Competing brands (e.g., Pedialyte and Servipharm ORS powder) are promoted to pharmacists and physicians as ethicals but can be bought from drugstores without prescription. ORESOL will be sold as an OTC to consumers (similar to advertised cough and cold preparations). Alongside this, a heavy product sampling/detailing effort will be made for public and private physicians in the two regions. A corollary effort will be undertaken for drugstores and sari-sari stores.

Competition

Competition to ORESOL includes anti-diarrheals and home remedies. Anti-diarrheals have the highest reported use, as treatment for diarrhea. Home remedies are used in the early stages of the diarrhea episode. Anti-diarrheals act to harden stools, which is perceived by the mother as the desired solution for her child's diarrhea problem. Home remedies are seen as convenient, readily available at home is considered traditional therapy.

Following the DOH policy regarding anti-diarrheals, the campaign in Regions 6, 7 and 10 will not directly discourage the use of anti-diarrheals but rather will focus on promoting Oresol as treatment for dehydration due to diarrhea.

#### Communication Objective

##### i) General

The ultimate objectives of the market tests are:

- a) to increase demand for Oresol among mothers and medical practitioners; and,
- b) to increase correct ORT procedures among mothers and medical practitioners.

Correct ORT procedures include

related practices such as proper feeding and breastfeeding during and after diarrhea.

ii) Specific Objectives

Regions 6 and 7

The specific communications objectives of the market test are:

- to teach mothers and medical practitioners, that in diarrhea, what one treats is dehydration, not the loose stools;
- to generate demand for Oresol as the primary treatment for dehydration due to diarrhea either in addition to or as a replacement for current treatments; and,

Region 10

The specific objectives are:

- to teach mothers and medical practitioners that, in diarrhea, what one treats is dehydration, not the loose stools.
- to encourage home treatment of diarrhea with home available fluids and continue related feeding practices in order to prevent dehydration and nutritional loss;
- to teach mothers to detect major signs of dehydration; and,
- to motivate mothers to immediately bring the child to the health center as soon as dehydration set in at the health center, Oresol will be given.

Each of the above-mentioned objectives will be addressed by different media vehicles, singularly or in combination.

Target Audience

Promotions/communications will be targetted at four audiences: mothers or caretakers of children; public and private physicians; municipal drugstores and sari-sari store owners; and pharmaceutical companies and distributor houses.

i) Promotions to Mothers and Caretakers of

## Young Children:

### Regions 6 and 7

In regions 6 and 7, the objective of public promotion is to improve knowledge on diarrhea management and teach mothers/caretakers of young children to give Oresol at the onset of diarrhea. Television, radio and print materials will be used to disseminate this message. It is expected that the media campaign will improve mothers' knowledge and awareness of diarrhea management and, in complement with other components of the marketing mix, increase demand for Oresol in both the health centers and the commercial network.

### Region 10

In region 10, the objective of public promotion is to improve knowledge on diarrhea management and teach mothers/caretakers of young children to give home available fluids at the onset of diarrhea. They will also be encouraged to continue correct feeding practices during the diarrhea episode. Hopefully, these practices will prevent dehydration. However, if and as soon as dehydration sets in, mothers will be taught to bring the child immediately to the health center (where Oresol will be administered,). It is expected that this campaign will reduce the number of dehydration cases and bring early dehydration cases to the health centers, thus, avoiding deaths.

Television, radio and print materials and other non-traditional media vehicles (e.g. movies at town plazas) will be used to disseminate these messages for Region 10. Since this combination of messages is more complex, paid media spots and print materials may not suffice. Thus, an overlay advertising plan (such as soap operas, launching of a local version of "Kapwa Ko, Mahal Ko") is envisioned.

ii) Promotions to Private Physicians:  
Regions 6 and 7 and 10

### Regions 6 and 7

Samples of and product information on the commercial Oresol will be detailed to public and private physicians in Regions 6 and 7. Scientific meetings on ORT and CDD will be sponsored for the local chapters of the Philippine Pediatric Society (PPS) and the Philippine Academy for Family Physicians (PAFP).

The objectives of these efforts are to:  
a) improve physicians' knowledge on the scientific treatment of diarrhea; and,  
b) encourage them to prescribe Oresol in the treatment of dehydration due to diarrhea.

### Region 10

A scientific meeting on ORT and CDD will be sponsored for the local chapter of PPS and PAFP. The objective of these meetings is to improve their knowledge and appreciation of ORT.

iii) Promotions      Targetting      Municipal  
Drugstores      and Sari-Sari      Stores      in  
Regions 6 and 7

The main question to address as far as municipal drugstores are concerned is: "What is in it for us if we carry Oresol, considering that carrying Oresol entails opportunity costs (loss of space for other drugs, etc.)"

An incentives program will be devised to encourage drugstore owners and personnel to carry the commercial Oresol and push the product to consumers. The program could include rebates, consignment terms and/or rewards.

Similar incentives will be given to sari-sari owners in the barangay level to encourage them to purchase Oresol at the municipal drugstores and carry this item in their respective stores.

iv). Promotions      Targetting      Pharmaceutical

### Houses/Distributor

The main question to address is: Will Oresol be profitable enough to manufacture and market? The objective of these promotions is to motivate distributors and pharmaceutical companies to carry/distribute Oresol. Presentations on Oresol will be made to these companies. An incentives program will also be devised.

8. Researches

a) Regions 6 and 7

i) Comparative Study of Oral Rehydration Brands (National-level)

Objectives

- i) to identify market size and growth patterns (1985 to 1987) of oral rehydration products market vis-a-vis anti-diarrheals.
  - ii) to determine market share of various commercial brands of ORS.
  - iii) to identify physicians' prescription practices re management of diarrhea (whether ORS prescribed; if prescribed, whether prescribed alone or in combination with anti-diarrheals).
- ii) Tracking Study of Drugstore Sales/Physicians' Prescriptions - Regions 6 & 7

Objectives:

- i) to determine drugstore sales of Oresol before the launch of the market test, 6 months after launch of the commercial product after the market test.
  - ii) to identify changes in physicians' practices re ORS and Oresol before the launch, 6 months after launch of commercial product and after the market test.
- iii) Tracking Study of Mothers' KAP - Regions 6 & 7 (Mid and Post)

Objectives:

- i) to identify changes in mothers' awareness and use of Oresol.
- ii) to identify changes in mothers' management practices re diarrhea.

iv) Distribution Channel Study: Regions 6 and 7

Objectives:

- i) to identify present distribution of drugs.
- ii) to identify most effective distribution channel for Oresol

b) Region 10

i) In-Depth Study of Home-Available Fluids

Objectives:

To identify what are the different home-available fluids used in the home treatment of diarrhea and their composition, duration of use, etc.

ii) Mid-Assessment and Evaluation

Objectives:

- i) to identify changes in mothers' awareness and use of home-available fluids.
- ii) to identify changes in mothers' knowledge of major signs of dehydration.
- iii) to determine changes in nature or number of dehydration cases brought to RHU/BHS.

c) For the 3 Regions

Researches for communication materials development similar to those planned for EPI will also be undertaken.

#### IV. INSTITUTIONALIZATION

The institutionalization of a capacity for strategic thinking, communication planning, research and subject management within the Department of Health and various collaborating institutions involved in HEALTHCOM in the next two year program is seen as a specific objective for HEALTHCOM in the Philippines. Therefore a tangible output is seen as necessary. In discussions with Undersecretary Mario Taguiwalo and AID Manila, a need was voiced for providing a specific workplan that will demonstrate how institutionalization will be achieved over the next two years. Towards this end, the following mechanisms are being proposed:

##### a. Process Documentation

Technical assistance activities in the Philippines will be documented in terms of the technical assistance process and the technical procedures in communication planning, research and management. There will also be a documentation of the organizational dynamics and decision-making patterns involved in the process, and the outcome of such organizational decisions and technical processes. A project documentation report will be submitted on a quarterly basis to HEALTHCOM.

- b. All consultants sent by HEALTHCOM in the Philippines will make it an explicit task during their trip to train and orient the Department of Health, PIHES and the actual counterpart team on the activities that are being undertaken during the trip. For example, an advertising agency consultant who will be in the country to provide technical assistance in media planning and development of a creative brief would be asked to conduct an orientation session for relevant groups on the topic of media planning and the preparation of a creative brief.
- c. HEALTHCOM will prepare manuals documenting the substantive elements in the technical assistance activities provided to the Philippines during the next two years. The purpose of this manual is to enable the Department of Health to replicate the process involved in communication planning, research and management used in the CDD and EPI program to its other programs, even as the HEALTHCOM Project is still ongoing. Secondly, the manuals can be used in the training of new staff who may become involved in the work of PIHES in the coming years.
- d. The preparation of articles for the HEALTHCOM publication entitled "Field Notes" will be prepared in collaboration with various Department of Health officers involved in the HEALTHCOM activities.

## Institutionalization Activities

Objectives: To develop capability within selected PIHES Central and Regional staff for planning and managing health communication/social marketing projects.

### A. Workshop on Program Planning and Management and Needs Assessment for Training

1. Specific Objectives: By the end of the workshop, PIHES staff would:

a) understand and appreciate their role in communication planning and program management for health

b) understand and appreciate Healthcom activities for 1987-90

c) identify their own needs for training or skills enhancement relative to their role (per a & b above).

### B. Seminar on Social Marketing

1. Specific Objectives: By the end of the seminar, PIHES staff would:

a) understand the principles of social marketing

b) be able to apply these principles to planning health communication programs

2. Schedule: for PIHES Central and regional staff - 3rd quarter 1988

C. Seminar/Workshop on Research Needs Identification and Research Management for Health Communication

Specific Objectives: By the end of the workshop, PIHES staff would be able to:

a) identify research requirements of Health communication projects for child survival

b) manage research project implementation

D. Assessment Workshop

Specific Objectives: These are planned so that PIHES staff would be able to participate and learn skills in project evaluation.

E. Project Evaluation Workshop

Specific Objectives: To enable PIHES staff to plan and manage evaluation of Healthcom projects: PIHES staff will be included in planning and managing this workshop.

Workshop schedules will be drawn in collaboration with PIHES and submitted separately.

F. On-the-Job Training of Key PIHES Staff with Healthcom

Key PIHES staff will be assigned to the Measles-NCR, EPI nationwide, CDD Pilot and CDD Nationwide projects to gain actual experience in planning and managing health communications projects.

V. IMPLEMENTATION SCHEDULE

Measles/NCR	February - May 1988
EPI Nationwide	June 1988 to May 1989
CDD Test Markets	May 1988 to April 1989
CDD Nationwide	May 1990

## VI. MANAGEMENT PLAN/RESPONSIBILITIES

### Scope of Work for HEALTHCOM Activities in the Philippines

#### A. Objective

Healthcom/AED will provide technical assistance and project management services to the Department of Health (DOH) of the Philippines.

Healthcom/AED will provide a resident advisor to the DOH for two years to undertake training and institutionalization of a communications/marketing planning and program management capability within the Department of Health.

#### B. Description of tasks and services to be provided

The contractor shall:

1. Undertake a Plan Formulation Workshop in Manila to develop a master plan for communications and Social Marketing in support of the Department of Health's Child survival Program with initial emphasis on immunization and oral rehydration therapy.
2. With PIHES, manage the communications/marketing program in support of EPI & CDD.
3. Provide a resident HEALTHCOM advisor for two years to assist in managing the communication/marketing component of the Department's Child Survival Program and train a designated DOH team of communications specialists in communications and social marketing planning and program management.
4. Provide specialized short term technical assistance on communications and social marketing issues, as well as communication research methodology, as needed in the course of program implementation.
5. Develop a research methodology and manage a research program, including the data gathering instruments and data analysis plan to evaluate the impact of the communications program on levels of awareness and health behavior change relevant to child survival program concerns.
6. Arrange for two supervisory visits of HEALTHCOM

Home Office supervisor every year for two years to:

- a. monitor progress of communication/marketing program;
  - b. provide a forum for a continuing dialogue with DOH officials, donor agency representatives, key contractor organizations involved in the communications program, non-governmental organizations involved in child survival programs regarding technical and medical issues as well as health policy and program implementation problems and how all these affect the implementation of a communications program;
  - c. recommend solution strategies on implementation problems.
7. Provide technical and management support to the DOH Communications and Social Marketing Program, including:
- a. arranging for locally subcontracted technical services and goods in support of the national ORT communications plan;
  - b. providing funding for and supervision of local subcontracts to conduct consumer (market) research; developing prototype messages and print materials on ORT, pilot test these messages in different media; and carry out other local contracting needs as may be needed by the ORT promotion program;
  - c. during the first quarter of this project, developing a detailed budget and work plan for carrying out the local subcontracting cited above for the approval of U.S.A.I.D. and the Department of Health/PIHES;
  - d. development of Communications and Social Marketing data bank which includes medical guidelines on child survival technologies; policy studies and communications intervention programs in other developing countries particularly other countries where HEALTHCOM operates and a core collection of technical literature on communications and social marketing.
8. Provide training in the use of microcomputers for

communications planning and program implementation. Applications may include:

- a. communications research such as tracking and preparation of radio/TV/print audience profiles; studies, media analysis;
  - b. preparation of a media activity calendar and an over-all media plan;
  - c. financial planning and management.
9. Provide training in the use of various research techniques to improve the overall effectiveness of the communications and social marketing program. Some of these techniques have been used largely in the commercial sector's marketing and advertising programs but in which there has been experience in its effective adaptation to the marketing of socially-beneficial products and services. These may include: behavioral psychology/behavior analysis, anthropology and market research.
10. Provide training in the utilization and dissemination of research findings.

VII. FINANCIAL PLAN/BUDGET

A. Budget Summary - Healthcom Implementation Plan

	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>
1. <u>CDD</u>				
1.1 Oresol Market Test: Regions 6, 7 & 10		P12,158,000 (\$ 607,900)		
1.2 CDD Nationwide			P30,400,000 (\$1,520,000)	
2. <u>EPI</u>				
2.1 Measles-NCR	P1,225,000 (\$ 61,250)	P 2,300,000 (\$ 115,000)		
2.2 EPI Nationwide		P16,760,000 (\$ 838,000)		
3. <u>Institutionalization     Activities</u>		P 640,000 (\$ 32,000)	P 150,000 (\$ 7,500)	P 250,000 (\$ 12,500)
4. <u>ARI</u>		P 200,000 (\$ 10,000)	P 60,000 (\$ 3,000)	
TOTAL = P64,143,000 =	<u>P1,225,000</u>	<u>P32,058,000</u>	<u>P30,610,000</u>	<u>P 250,000</u>
\$ 3,207,150	<u>(\$ 61,250)</u>	<u>(\$ 1,602,900)</u>	<u>(\$ 1,530,500)</u>	<u>(\$ 12,500)</u>

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B. Detailed Budget

	<u>1988</u>	<u>1989</u>	<u>1990</u>
1. <u>Control of Communicable Diseases (CDD)</u>			
1.1 <u>Oresol Market Test: Regions 6, 7 &amp; 10</u>			
a. <u>Campaign Materials Development &amp; Campaign Implementation</u>	P 10,400,000		
	(\$ 520,000)		
Regions 6 & 7 = P8,000,000			
Region 10 = 2,400,000			
b. <u>Research (Regions 6 &amp; 7)</u>	P 1,168,000		
	(\$ 58,400)		
- Comparative Study of ORS Brands/Physicians' Prescription Practices	P 132,000		
	(\$ 6,600)		
- Campaign Tracking/Evaluation (Mothers)	P 250,000		
	(\$ 12,500)		
- Distribution Check (one time)	P 40,000		
	(\$ 2,000)		
- Drugstore Audits/Sales (mid & post)	P 110,000		
	(\$ 5,500)		
- Child Care Practices Study	P 200,000		
	(\$ 10,000)		
- Distribution Channel Study	P 40,000		
	(\$ 2,000)		
- Physicians' Study (Prescriptions/KAP) includes Region 10	P 396,000		
	(\$ 19,800)		
c. <u>Research (Region 10)</u>	P 190,000		
	(\$ 9,500)		
- In-depth Study of Home-Available Fluids	P 100,000		
	(\$ 5,000)		
- Child Care Practices	P 50,000		
	(\$ 2,500)		
- Mid-Assessment/Evaluation	P 40,000		
	(\$ 2,000)		

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	<u>1988</u>	<u>1989</u>	<u>1990</u>
d. <u>Communication Materials for Medical Professionals: Development &amp; Implementation</u>	P 400,000 (\$ 20,000)		
e. <u>Detailing to Physicians</u>		<u>for discussion</u>	
Subtotal#1.1 =	<u>P12,158,000</u> <u>(\$ 607,900)</u>		
1.2. <u>CDD Nationwide (Year 1)</u>			
a. <u>Campaign Materials Develop- ment &amp; Campaign Implementation</u>		P27,400,000 (\$ 1,370,000)	
b. <u>Research</u>		<u>P 3,000,000</u> <u>(\$ 150,000)</u>	
Subtotal#1.2 =		<u>P30,400,000</u> <u>(\$ 1,520,000)</u>	
TOTAL CDD (Nos. 1.1 & 1.2)		<u><u>P42,558,000</u></u> <u><u>(\$ 2,127,900)</u></u>	

	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>
2. <u>Expanded Program on Immunization</u> <u>(EPI)</u>				
2.1. <u>Measles - NCR Campaign</u>				
a. <u>Campaign Materials &amp; Campaign Implementation</u>	₱1,000,000 (\$50,000)			
b. Additional Media Placements		₱2,000,000 (\$100,000)		
c. <u>PR Component</u>				
- to mediamen & civic organizations		₱ 100,000 (\$5,000)		
- to physicians & family physicians		₱ 100,000 (\$5,000)		
d. <u>Research</u>				
- Tracking	₱ 225,000 (\$11,250)			
- Pre-campaign Distribution Check/MIS		₱ 60,000 (\$3,000)		
- Child Care Practices Study: Additional Analysis		₱ 40,000 (\$2,000)		
	Subtotal # 2.1 =	<u>₱3,525,000</u> <u>(\$176,250)</u>		
2.2. <u>EPI Nationwide</u>				
a. <u>Campaign Materials Development &amp; Campaign Implementation</u>		₱15,000,000 (\$750,000)		
b. <u>PR Component</u>		₱ 400,000 (\$20,000)		
- to mediamen & civic organizations		₱ 200,000 (\$10,000)		
- to pediatricians & family physicians		₱ 200,000 (\$10,000)		

	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>
c. <u>Research</u>		₱1,360,000 (\$68,000)		
- Tracking (Pre, Day- After Recall, 3 months after & Post-Studies)		₱1,000,000 (\$50,000)		
- Pre-Campaign Distri- bution Check		₱ 100,000 (\$5,000)		
- Tactical Research (as needed)		₱ 160,000 (\$8,000)		
- MIS		₱ 100,000 (\$5,000)		
Subtotal #2.2 =		₱16,760,000 <u>(\$838,000)</u>		
Total EPI (Nos. 2.1 & 2.2)		= <u>₱20,285,000</u> <u>(\$1,014,250)</u>		

### 3. Institutionalization within PIHES

3. 1. <u>Workshop on Program Planning Management &amp; Needs Assessment for Training</u>				
- PIHES Central, NCR, Regions 6, 7 & 10		₱ 60,000 (\$3,000)		
- PIHES Regions 1, 2, 3, 4, 5, 8, 9, 11, 12		₱ 120,000 (\$6,000)		
3. 2. <u>Seminar on Social Marketing (PIHES Central + all regions)</u>		₱ 200,000 (\$10,000)		
3. 3. <u>Seminar on Research Needs Identification &amp; Research Management for Health Communications (PIHES Central + all regions)</u>		₱ 200,000 (\$10,000)		

	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>
4. <u>Assessment Workshops</u>				
- PIHES Central, NCR, Regions 6,7 & 10		P 60,000 (\$3,000)		
- PIHES Central + all regions			P 150,000 (\$7,500)	
5. Healthcom Evaluation Workshop				
- PIHES, other DOH divisions + collaborating agencies				P 250,000 (\$12,500)
		Subtotal #3 = P1,040,000 =====		
		(\$52,000) =====		
<u>Acute Respiratory Infection (ARI)</u>				
Research for Inputs to Commu- nication Planning		P 200,000 (\$10,000)		
Communication Planning Workshop			P 60,000 (\$3,000)	
		Subtotal #4 = P 260,000 =====		
		(\$13,000) =====		
		GRAND TOTAL (1-4) = P34,143,000 =====		
		(\$ 3,207,150) =====		