PN-ABH-577

The HEALTHCOM Project in Paraguay: A Case Study

Prepared by

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1989

for

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The research reported here was conducted as a part of the HEALTHCOM Project, a program of the Bureau for Science and Technology, Office of Health and Office of Education, United States Agency for International Development. It was supported through a subcontract to Applied Communication Technology from the Academy for Educational Development's prime contract, #DPE-1018-C-00-5063-00.

TABLE OF CONTENTS

I. INTRODUCTION 1

II. DESCRIPTION OF ACTIVITIES 2
- A. Background 2
- B. Social Marketing Activities 3
  - 1. Planning Research and Developmental Investigation 4
  - 2. Project Objectives 4
  - 3. Communication Strategy 5
- C. Training Activities 7
- D. Private Sector Institutions 8
- E. The Effect of the Change in Government 8
- F. Summary 9

III. FINDINGS RELATED TO THIS PROJECT 10
- A. Prerequisites 10
  - 1. Governmental commitment 10
  - 2. Scale of activity 12
- B. Project Design 13
  - 1. Tradeoffs between capacity building and maximizing impact 13
  - 2. Structural issues that affect sustainability 14
    - a. Tradeoffs between paid and volunteer services 14
    - b. Tradeoffs in project design 15
- C. Project Implementation 16
- D. Institutionalization 17
  - 1. Progress prior to the change in government 18
  - 2. Effect of the change in government 20

IV. GENERAL ISSUES RELATED TO HEALTHCOM 22
- A. Intervention Issues 22
- B. Size Issues 24
- C. Summary 25

V. APPENDIX A 26

VI. APPENDIX B 30

I. INTRODUCTION

The HEALTHCOM project activity in Paraguay represents a situation that may be typical of a large number of contexts. It is a small project in a small country, trying to accomplish an ambitious agenda with limited resources. In pursuit of its objectives, it has utilized a structure somewhat different from most of the other HEALTHCOM sites. Its experiences offer some valuable insights for other HEALTHCOM projects, and for social marketing interventions elsewhere.

The purpose of this report is to describe some of the salient features of the project in Paraguay, and to draw from that description lessons and issues that have broader application. The report is not intended to be an exhaustive description of HEALTHCOM's efforts in Paraguay, nor is it intended to pass judgment on the success of the intervention there.

The body of the report is structured in three major sections. The first is primarily descriptive of the project. The second considers findings related to characteristics of this specific intervention, presenting new descriptive information as necessary. The final section raises issues that transcend particular project decisions or circumstances.

II. DESCRIPTION OF ACTIVITIES

A. Background

HEALTHCOM responded to an opportunity to be involved in Paraguay with initial planning visits in 1986, with operations beginning in 1987. The Ministry of Health's interest in diarrheal disease control and oral rehydration therapy had been evident for several years prior to that, but had not resulted in much concentrated effort due to organizational and resource limitations. The mutual interest in cooperating in applying the HEALTHCOM approach led to the creation of a project that included:

- a diarrheal disease program consisting of formative evaluation, development of messages and materials, monitoring and evaluation, and creation of oral rehydration units (ORUs); and

- a training program consisting of training for health workers, community leaders, medical students, and nurses, and materials for health workers and community leaders.[1]

In order to implement these efforts, the project received various inputs funded by the United States Agency for International Development (USAID) through the worldwide HEALTHCOM program, including: a resident advisor; a number of short-term technical assistance missions; financial support for the costs of local

1 HEALTHCOM -- Communication for Child Survival: Implementation Plan for Paraguay, 1987-1988: Academy for Educational Development, Washington, D. C., November, 1988.

research, materials development and production, broadcast expenses, and training costs.

During the period 6-17 March 1989, Dennis Foote traveled to Paraguay to visit the HEALTHCOM project there. While there he interacted with Jose M. Espinola, the Academy for Educational Development's (AED) Resident Advisor, and met with an extensive set of present and past Ministry of Health officials, representatives of USAID, local health care workers and community volunteers, and local firms that had worked on some aspect of the project. In addition to the contacts in Asunción, field trips were taken to the areas around Mingua Guazu and Encarnación. This report draws on those interviews, as well as review of documents and interviews with U.S.-based staff.

B. Social Marketing Activities

One set of social marketing activities involved the creation of media campaign to reach out to mothers, fathers, older siblings, and others with responsibility for taking care of children in order to inform them about oral rehydration therapy (ORT). The project strategy follows the broad outlines of the HEALTHCOM approach, with a research basis for planning, a media production and broadcast component, interpersonal training of health workers, and outreach to individual mothers. The basic plan for intervention is described in the Implementation Plan for 1987-1988, prepared as a part of the initial HEALTHCOM efforts in Paraguay.

1. Planning Research and Developmental Investigation

The use of research to gather information on which project design can be based is an essential element of the HEALTHCOM methodology. The initial research was conducted by a local firm that is no longer actively involved in the project. Both the research firm and the project staff voice disappointment surrounding the interface between the externally conducted research and the programmatic response. The project can improve the manner in which it gathers and/or utilizes research information in planning its activities.

The research included a set of five focus group studies of groups of rural mothers and a knowledge-attitude-practice (KAP) survey of physicians in Asunción and selected interior cities. The project staff cite as the major findings of the research the choice of the dialect "Jopara" as the most appropriate dialect in which to broadcast general population messages, and the general acceptance by the physician community not only of ORT in general, but also of ORT administration in the home.

2. Project Objectives

The formal research, coupled with an analysis of the history and institutional context of the situation in Paraguay, resulted in the project setting a number of fundamental objectives for its future work. These included:

- provision of information about diarrheal disease to the different target audiences;

- community education about the dangers of dehydration and about how to identify and treat it;

- instruction to caretakers and health workers about the benefits of oral rehydration solution (ORS) and the methods of preparing and administering it;

- promotion of other child survival behaviors, such as breastfeeding and preventive care;

- development of informed resources among the community leaders and health volunteers who could support local women in the use of ORT;

- training of health care personnel in interpersonal communication skills; and

- development of an environment of cooperation and consistent support from the full range of community and health organizations for ORT.

3. Communication Strategy

The intervention plan focused on the use of consumer-oriented social marketing interventions. The initial research attempted to:

- define the extent to which the population understood the consequences of diarrhea, and the degree to which they were acquainted with ORS;

- learn what attitudes or practices might help or hinder the adoption of ORS within the population;

- understand current practices in response to an episode of diarrheal disease; and

- identify the decision-makers and actors within the family in regards to episodes of diarrhea.

The audience was conceptually segmented into a primary target group, consisting of those who had direct caretaking responsibility for a child, and a secondary group, composed of those who might in some way influence the behavior of the primary group.

The intervention strategy utilized four different approaches:

1. improving the formal health care system's capacity for health education

2. community-level face-to-face communication

3. mass media

4. on-going training of the existing health care personnel in diarrheal disease-related topics.

The execution of the mass media part of the strategy was contracted to a local advertising agency, Biedermann Publicidad, S.A. Working in concert with the government and AED personnel, they developed messages and a distribution plan for an aggressive dissemination of information through the mass media channels. The effort called for about 100 television spots and 12,000 radio spots in 1988, with similar or larger numbers planned for 1989. A list of the media plans for both years is attached as Appendix A.

Much of the approach taken in the messages was derived from a combination of a creative analysis undertaken by the advertising firm and a review of the research conducted previously for the project planning. This resulted in a document on the positioning of the product, in which the messages and their target audiences were spelled out. The part of that document that discusses the positioning of the product and the segmentation of the audience is attached as Appendix B.

The production quality of the materials seems quite professional. There is a difficult linkage between the creation of the materials and the plan for distribution. For example, copies of the radio spots were distributed to the people charged with local implementation responsibility. They were instructed to request local radio stations to air the spots for free. In several cases the stations declined to provide free air time, and the spots went unused, because the local implementers did not have a budget for radio broadcasts. Such circumstances threaten any attempt to engineer an integrated and systematic approach to promoting and maintaining appropriate behavior change.

C. Training Activities

While the advertising firm was preparing the mass media aspects, the Ministry of Health's primary efforts were concentrated on the development of the institutional base for support of the intervention. The majority of this work consisted of training existing health care workers and attempting to galvanize and train a cadre of volunteer community level workers.

Much of the training took place in seminars conducted in the participating regions. Seminars often targeted more than one class of health care worker or community representative. The range of people trained included physicians, public health educators, health workers, community leaders, teachers, and volunteers. According to lists provided by the project, between June of 1987 and December of 1989 a total of 34 seminars were held, training a total of 713 participants.

D. Private Sector Institutions

A salient feature of the project has been the concurrent planning to involve the private sector in the oral rehydration therapy emphasis. The project has been coordinating with a separate effort to create a national capability for production of ORS packets. It is hoped that this strategy will eventually help not only on the supply side of the equation, but also on the demand side, in which the incentives for the private institutions will lead them to promote the widespread utilization of ORT.

E. The Effect of the Change in Government

Shortly before the visit on which this report is based, there was a transition in leadership in Paraguay. At the time of the visit, there was considerable uncertainty about the staffing of the units within the Ministry of Health. Changes were being made in assignments from the top down, and the changes had not been finalized for the Maternal-Child Health Division (MCH), the Health Education Division (HED), or other units that had been involved with the project up to that point.

Ultimately, three of the four principal players in the leadership of the MCH and HED who had been involved with and were supportive of the project were transferred to different assignments. Many of the staff at the lower levels of responsibility within the divisions have remained in their previous assignments.

These outcomes reflect a consistent risk in the attempt to institutionalize such projects. When the substantive leadership of a complex approach is treated as a political rather than a technical appointment, the continuity and commitment to the investment made are vulnerable.

F. Summary

The project has accomplished a great deal under circumstances that have often been difficult. A fruitful collaboration between the divisions of Health Education and Maternal-Child Health have been created where none existed before. Large numbers of people have been trained, awareness about ORT is high, and the

health personnel involved in the project have very positive attitudes about it. A polished media-based campaign has been designed and executed. The participating institutions have accumulated a significant amount of practical experience in social marketing.

Much also remains to be done. The training program needs to be translated into an aggressive outreach effort focused on changing mothers' behaviors. The different pieces of the effort are not yet working in concert. Logistics, such as supply of packets and the dissemination of training materials and broadcasts, continue to be problematic. Institutionalization of the necessary skills and creation of a bureaucratic niche in which this methodology can grow are definite weak points, even prior to the disruption caused by the change of government.

III. FINDINGS RELATED TO THIS PROJECT

Two different types of lessons can be distilled from the experience with the Paraguay project. Some of those are lessons that have direct applicability to the country project itself, while others are lessons that guide the investment of resources from the larger HEALTHCOM project. This section discusses those issues that shed light on the way in which this specific project functions. The more global issues of HEALTHCOM as a whole are discussed in the subsequent section.

A. Prerequisites

1. Governmental commitment

In order for the partnership of national effort and USAID resources to be productive, both sides must commit to providing an adequate amount of inputs over a meaningfully long time frame. In this case, the Government of Paraguay committed to a level of effort that represented a moderately intense involvement on their part. While the absolute size of the resources was modest, it represented a major proportion of their effort in the child survival area, and it reflected their sense of priority for the activity.

The national resources offered were primarily manpower and access to the existing institutions. The staffs of the divisions of Health Education and Maternal-Child Health were assigned the responsibility for project development, and the staff in the field units committed time and energy to organizing the training. Oral rehydration units were established in many locations, and staffed from among the existing personnel. The total amount of person-time devoted to the project by the government was not large, but it was a significant fraction of the government's current activity. The effort was assigned to existing personnel, so it seems inescapable that the other activities to which they were previously assigned would suffer.

The USAID commitment consisted of financial resources channeled through the HEALTHCOM program to provide three different types of assistance. It bought the services of a full-time, local-hire advisor, some assistance to the funding of logistical costs for operations related to the project, and technical assistance from

the Washington office of HEALTHCOM. Because the USAID program in Paraguay is small, their budgets for supporting activities like the HEALTHCOM effort are very limited. They seem to have been consistently supportive of the HEALTHCOM efforts, but the funds were never sufficient nor secure enough to mount the scale of activity that HEALTHCOM would normally have.

At the critical juncture for project survival, after the coup had occasioned a major reshuffle of personnel within the Ministry of Health, USAID was caught in the difficult position of having planned to allocate all of its funds for the social services sector to a different project. Because of their other priorities, their small scale of activity in Paraguay, and the long time horizon for programming new commitments, USAID was not able to respond with a significant influx of support at the point that the project was most in need. The inability to respond jeopardized the fulfillment of the institutionalization objective toward which USAID's investment had been oriented.

The most appropriate description of the levels of commitment on both sides might be that each gave moderate priority to the project, but that the project was not uppermost on either's agenda. The government of Paraguay reoriented some existing expenditures, presumably at the cost of other existing work. USAID, for a time, made HEALTHCOM its premiere activity in a sector in which it otherwise had little investment, but planned to virtually abandon the project as its priorities changed. In both cases, the degree of commitment evidenced is not as strong as would be ideal to ensure that the project is successfully implemented and has a good chance of becoming self-sustaining.

2. Scale of activity

The Paraguay HEALTHCOM project implementation generally operated at a small scale of activity, necessitated both by the limited resources available and the small size of the country. The size of the country would necessarily limit the degree to which economies of scale could be realized. Thus the project could never make as large an investment in the development of training materials and supporting broadcast materials as would be feasible if the project were to be amortized across a larger target audience. In addition, there are limits on the range and depth of human resources that can reasonably be expected to be available within an institution the size of the Ministry of Health in a small country.

B. Project Design

1. Tradeoffs between capacity building and maximizing impact

The project followed a pattern of contracting out much of the substantive effort to research firms and advertising agencies, rather than developing such skills internally in the Ministry of Health. Projects in this position must face a strategic choice between creating the actual skills within their institution, versus creating the ability to design and manage this process. This project's choice to contract out has following implications:

- it provides the benefit of professional levels of quality, if those. resources can be harnessed and directed efficiently;

- it has the liability of loss of control or direction if the Ministry of Health does not adequately specify the tasks and manage the contract;

- it does not create a capacity within the Ministry of Health to carry out subsequent work, which may be necessary later if limits on operational funds create difficulties in subcontracting project components; and

- the professional culture of research firms and advertising agencies is not necessarily consistent with the social marketing approach, hence one may encounter conflicts in the short run, and in the long run, the experience accumulated there is less likely to have a long term benefit for the Ministry of Health.

Given the decision to contract out substantive work, projects like this should probably give more explicit emphasis to training on design issues and on management of subcontract efforts. It may still be preferable to equip the Ministry of Health to carry out smaller, less "professional" projects rather than contract out for services if the subcontracting model is not ultimately the one they will follow. It is an open question as to whether turnover within the Ministry of Health will be any less than in advertising agencies and research firms.

2. Structural issues that affect sustainability

a. Tradeoffs between paid and volunteer services

There is a perennial conflict between a larger project built around volunteer services and a smaller one based on utilization of paid staff. This project's choice to make heavy use of community volunteers makes possible much broader reach than otherwise could be accomplished with the available resources. However, it also incurs a risk that sustaining the project in the long run will be more difficult. The local project, or HEALTHCOM centrally, needs to ask whether it is reasonable to design a system of minimally supported community volunteers as a central component of an effort. If it is found to be an attractive strategy, how might the design be revised to ensure the retention of volunteers and to plan for accommodating turnover in their ranks?

b. Tradeoffs in project design

One set of questions that must be asked concerns whether the project design is appropriate to the circumstances of the country. Does it make optimal use of the resources and strengths that the country has available to it? In this instance, the adopted strategy decentralizes much of the implementation to the regional and community level. There is a risk that some resources, either in terms of effort or of skill, will be lower at the regional level than nationally. How might the design be adjusted to make it more closely suited to the health care situation in Paraguay, by supplementing or guiding the local efforts in those areas where the national level has the advantage?

Another set of questions has to do with the degree to which the project has taken advantage of what is known about HEALTHCOM-like interventions. Has the design incorporated elements of the accumulated wisdom of the HEALTHCOM projects? For example, in this particular case, the elements of the HEALTHCOM methodology are all present in some form. Yet the participants report a process that is not highly integrated -- the elements seem to operate independently. How could the components be better articulated with one another?

Similarly, there are tradeoffs between vertical and integrated programs; there is an as yet unresolved question of whether it is more productive to view this as a process -- as a health communication/education activity -- or as a sectoral program such as a maternal-child health program. On the one hand, greater diffusion of the methodology is possible if the responsibility is assigned to the Health Education Office, as skills can easily be transferred from one project to the next. On the other hand, there is a greater likelihood of something happening and enduring if a unit with line responsibilities such as the Maternal-Child Health Division initiates the approach. There is no correct answer to these questions; they should be considered in light of the objectives and resources available and a decision made that is specific to the context.

C. Project Implementation

Brief mention has already been made of the issues of planning for staff and volunteer turnover and continued training inputs. There are other concerns as well once a project is ongoing. It is necessary to have a plan for revision and

replacement of messages in order to keep them "fresh" for the target audience, and some plan for supporting the continuing expenses of media production and broadcast. The project will have to determine the level of emphasis required to maintain a changed behavior once it is established, so that it can rationally assign its resources between new priorities and the protection of previous gains.

A major area in which the project needs to focus, especially if it begins to expand its range of goals, is the analysis of the problem and the development of an intervention design that is responsive to the analysis. The relationship between the collection of information and the use of that information, both in selecting goals and in crafting a strategy to attain them, is a major hurdle. The planning which is currently under way for the application of the HEALTHCOM methodology to immunization and breastfeeding objectives shows considerable advancement in the systematic use of planning techniques. If the project's subcontracting strategy for the media component can continue to be afforded, there may be a good synergy for the delivery of a solid base of information for the development of the media plans.

Ultimately, questions of implementation and logistics -- e.g., were sufficient packets delivered in timely fashion, was adequate training and support provided, were project activities well coordinated, etc. -- will be central to determining long term success. The project has been able to coordinate ambitious levels of effort, but it has relied in part on its external resources and special status to achieve that. What are realistic goals if one operates within the Ministry of Health's infrastructure? What are ways of minimizing the inevitable problems? These questions have not yet been seriously addressed.

The provision of technical support from the central HEALTHCOM offices has contributed much to the accomplishments that have been achieved. The identification of needs for technical assistance and the supply of external input will continue to be necessary for the near term. Attention should also be paid to increasing the utilization of provided inputs by the Ministry of Health staff.

D. Institutionalization

The current situation with respect to institutionalization is ambiguous. In part, this reflects the way the project was carried out, and in part the effects of the recent change in government.

1. Progress prior to the change in government

The staff of the relevant offices were very positively disposed toward the HEALTHCOM activity. However, the activity had been conducted largely outside of the Ministry of Health, through local contractors and by the Academy for Educational Development, through the Resident Advisor and short term technical assistance visits. Given the short duration of project support and the tendency to operate outside of the normal bureaucratic structure (intentional, in many ways) , the Ministry of Health would not have been very well prepared to begin acting autonomously.

The specific situation under which the HEALTHCOM inputs were provided contributed to the accomplishments of the project but probably hinder the institutionalization. The AED Resident Advisor is deliberately placed outside the

Ministry of Health and given control of a modest budget for project tasks. The advisor's personality and this role merge well -- he is a sophisticated and congenial person, and has put these characteristics to good use in assessing the bureaucratic situation within the Ministry and in facilitating cooperation among the different players. The fact that the funds are outside of Ministry control and do not have to be handled through normal bureaucratic channels has made it possible for them to be quickly and effectively deployed in support of project efforts. However, the very advantages of this type of operation impede the longer-term goal of institutionalization, because sooner or later the Ministry of Health will have to allocate funds through normal channels and the collaboration between different pieces of the institution will have to take place without the support of an external facilitator.

If the change in government had not taken place, what would have been the best response if the objective were to maximize institutionalization? The following points seem important:

- A consistent period of external support far longer than has been possible to date would have a positive impact on institutionalization.

- The Ministry of Health would have to make a clearer commitment to dedicating staff and budget to the activity. Ideally, something structural would be done to increase the status of the Health Education Unit in the Ministry.

- Activities would have to be moved inside the Ministry of Health structure and specific training given in performance of the new tasks. If the strategy of contracting out major portions of the effort were still followed, the staff would have to learn how to direct the work of outside professionals in order to retain substantive control and to utilize the results in a productive manner. It goes without saying that an operating budget would have to be allocated, regardless of whether the work were undertaken by in-house staff or contracted out.

It is difficult to consider this issue without facing up to the question of whether the HEALTHCOM approach is appropriate in the Paraguayan context, and whether the support of a locally appropriate project is consistent with HEALTHCOM's mandate. Ultimately the issues have to be considered in tandem.

2. Effect of the change in government

In assessing the situation the HEALTHCOM project now faces, one needs to ask what is required at this point if the project is to continue and progress. The answer is necessarily speculative.

The abrupt changes in personnel have done considerable damage to the institutional memory that would normally allow for cumulative gains. One should assume that in terms of staff who are familiar with the HEALTHCOM approach and trained in its application, the project has suffered a major setback. Because of the finite pool of skilled health professionals in Paraguay, many of those who were previously involved will assume roles that bring them into contact with

HEALTHCOM efforts, if the project continues. This would undoubtedly be a benefit. However, in terms of individuals who could relatively independently design and execute a HEALTHCOM-like intervention, the situation would necessitate an essentially fresh effort to educate the new leadership.

The Ministry of Health is in a period of flux in terms of priorities and programs. This may represent an opportunity that would be difficult to match. If USAID and HEALTHCOM were to make a strong commitment to continuing, they might possibly command the required reciprocal commitment from the government, and they might assume a more central role in Ministry of Health priorities. USAID and HEALTHCOM should probably only consider going forward if the Ministry of Health were willing to make stronger commitments than it has in the past to the emphasis put on health education and to the eventual provision of an operating budget.

If a renewed start were made, USAID's and HEALTHCOM's commitments should also be stronger. Running the effort at a small scale may seem attractive, but it has definite costs. From the HEALTHCOM point of view, it consumes energy from the larger project without necessarily providing a proportionate return. From the USAID point of view, it incurs the costs of a full time Resident Advisor without accruing the benefits that a more intense level of activity could generate.

If a renewed start were made, HEALTHCOM should also be more directive about the process of the effort. It will have to offer more substantial levels of technical assistance if it chooses the model of a local facilitator rather than a health communication professional. It should explicitly plan for intense early involvement to set the agenda and the workplan, and it should continue to push technical

assistance in order to thoroughly imbed an alien idea and procedure into the bureaucracy.

IV. GENERAL ISSUES RELATED TO HEALTHCOM

The preceding discussion of the project in Paraguay has brought some project-specific issues into sharper focus than before. However, there is also a set of issues related to the wider, multi-country perspective of the HEALTHCOM program. The conditions in Paraguay are only one example of the circumstances that the program faces. The consideration of these questions needs to be undertaken at the level of the worldwide HEALTHCOM program in order to draw on the wider experience in a range of different countries. Therefore, this section will only attempt to set forth the issues for the program to consider, rather than attempting to provide the answers.

A. Intervention Issues

HEALTHCOM has been involved in a wide variety of project types and structures. The project in Paraguay represents one end of the size spectrum and one model for how to organize the inputs and support from the central program office. The general orientation within HEALTHCOM I has been very accepting of diversity. Now may be the time to consider whether HEALTHCOM II should take different stances on any of these issues than did HEALTHCOM I. Two issues seem to be crucial at the program level:

- there is a risk of reduced quality of support and supervision of interventions due to fragmentation of effort from HEALTHCOM's central resources; and

- there may be a risk to HEALTHCOM's or social marketing's reputation generally if major omissions and modifications of components of the HEALTHCOM methodology are tolerated.

The first issue, concerning the acceptable levels of demand on the limited central office resources of the HEALTHCOM project, is an open question. There are advantages to maximizing the reach of the project, if it can be done without compromising quality. It remains for the participants and the contract monitors to ask, "Is there an issue for the central HEALTHCOM project of fragmentation of effort?" It takes a certain minimum amount of time to backstop any country effort, no matter how small. Should HEALTHCOM strive to serve as many countries as wish to participate, or should it be more selective? If it should limit participation, on what criteria should it make the selections?

The second issue is, at the core, an issue of quality control. What are the essential elements of the HEALTHCOM approach? Should a project which does not apply all the components of the approach be supported? If some components might be excluded or receive minimal emphasis in supported projects, which components might be omitted and under what circumstances? Would HEALTHCOM be willing to support a project that did not at least include some level of involvement of the following?

- Developmental investigation
- Formative evaluation for materials development
- Use of mass media
- Monitoring and feedback

Are there other items that should be explicitly considered optional or mandatory? How flexible should HEALTHCOM be about modifications of the overall approach? Should projects that focus on one aspect to the virtual exclusion of others be excluded? In particular, should projects that concentrate on relatively conventional training be considered HEALTHCOM candidates? Is HEALTHCOM trying to explore the range of circumstances in which components of its methodology can contribute something to a country, or is it trying to set a standard and offer a model for other countries to follow?

B. Size Issues

Earlier, the issue was raised as to whether HEALTHCOM should concentrate its efforts on large projects in order to preserve the scarce resources of central level technical assistance. There is a related question about the size of projects that has to do not with HEALTHCOM's fragmentation of effort, but with the natural scope of the efforts within countries. This might be thought of as an "economy of scale"

issue. The basic question for HEALTHCOM to consider is, "Do some or all of the components of the HEALTHCOM methodology make sense only if they are above a minimum level of effort?"

In practice, this would find expression in several ways. Are there some countries which, by virtue of the size of the country or the magnitude of the diarrheal disease problem, should not be considered for HEALTHCOM interventions? Is there a minimum level of commitment from the government that HEALTHCOM should insist on before providing resources to a country? What kinds of things must a country commit? Is it a question of resources (money or manpower) or of resolve?

C. Summary

From the perspective of the global HEALTHCOM program, different issues emerge as important questions that might be learned from the experience in Paraguay. They have to do with the magnitude of the effort, and with ways of ensuring some form of consistency and quality control over projects supported by HEALTHCOM resources. There is no correct answer to these questions; the Paraguay project simply provides a backdrop against which the issues can be considered.

APPENDIX A

A.E.D.

CAMPAÑA T.R.O.

AGENCIA:BIEDERMANN PUBLICIDAD S.A.

ASUNCION-PARAGUAY

AÑO:1988

RESUMEN PRESENCIA EN TELEVISION

1ERA.ETAPA

CANAL	MES	CANT.SPOTS	TOTAL DE SPOTS
9 y Sistema Nacional de TV	FEBRERO	12 x 70" 3 x 55" 6 x 46" 3 x 36"	24
13 y Red Privada de Comunic.	FEBRERO	8 x 70" 7 x 55" 3 x 46" 5 x 36"	23
9 y Sistema Nacional de TV	MARZO	4 x 70" 11 x 55" 15 x 46" 8 x 36"	
13 y Red Privada de Comunic.	MARZO	2 x 70" 6 x 55" 6 x 46" 8 x 36"	22
TOTAL DE SPOTS EN EL TRANSCURSO DE LA CAMPAÑA			107

A.E.D.

CAMPAÑA T.R.O.

AGENCIA: BIEDERMANN PUBLI[illegible] S.A.

ASUNCION-PARAGUAY

AÑO: 1988

RESUMEN PRESENCIA EN RADIOS

1ERA.ETAPA

EMISORA	PERIODO	CANT.SPOTS	TOTAL DE SPOTS
1° DE MARZO AM	12-II al 31-III	714	
CARDINAL	12-II al 31-III	721	
CARITAS	19-II al 31-III	672	
ENCARNACION	12-II al 31-III	1.092	
CARLOS A.LOPEZ	12-II al 31-III	1.302	
CONCEPCION	12-II al 31-III	1.092	
MBURUCUYA	12-II al 31-III	672	
CENTENARIO	12-II al 31-III	1.512	
LA VOZ DE LA CORDILLERA	12-II al 31-III	1.092	
ITA PIRU	12-II al 31-III	2.184	
CAAGUAZU	12-II al 31-III	1.512	
TOTAL DE SPOTS EN EL TRANSCURSO DE LA CAMPAÑA			12.565

A.E.D.

CAMPAÑA T.R.O.

AGENCIA: RIEDERMANN PUBLICIDAD S.A.

ASUNCION-PARAGUAY

AÑO: 1989

RESUMEN PRESENCIA EN TELEVISION

2DA.ETAPA

CANAL	MES	CANT.SPOTS	TOTAL DE SPOTS
9 y Sistema Nacional de TV	ENERO	13 x 30"	
13 y Red Privada de Comunic.	ENERO	17 x 30"	30
9 y Sistema Nacional de TV	FEBRERO	14 x 30"	
13 y Red Privada de Comunic.	FEBRERO	19 x 30"	33
9 y Sistema Nacional de TV	MARZO	13 x 30"	
13 y Red Privada de Comunic.	MARZO	18 x 30"	31
TOTAL DE SPOTS EN EL TRANSCURSO DE LA CAMPAÑA			94

A.E.D.

CAMPAÑA T.R.O.

AGENCIA:BIEDERMANN PUBLICIDAD S.A.

ASUNCION-PARAGUAY

AÑO:1989

RESUMEN PRESENCIA EN RADIOS

2DA. ETAPA

EMISORA	PEDIODO	CANT.SPOTS	TOTAL DE SPOTS
1° DE MARZO AM	5-I al 14-III	739	
CARDINAL	5-I al 14-III	637	
CARITAS	5-I al 14-III	637	
CARLOS A.LOPEZ	5-I al 14-III	2.070	
CONCEPCION	5-I al 14-III	2.070	
MBURUCUYA	5-I al 14-III	1.656	
CENTENARIO	5-I al 14-III	2.070	
CAAGUAZU	5-I al 14-III	1.587	
ENCARNACION	5-I al 14-III	2.070	
LA VOZ DE LA CORDILLERA	5-I al 14-III	2.415	
ITA PIRU	5-I al 14-III	1.242	
TOTAL DE SPOTS EN EL TRANSCURSO DE LA CAMPAÑA			17.193

APPENDIX B

PERSONALIDAD DE MARCA PARA LA CAMPAÑA DEL TRATAMIENTO REHIDRATANTE ORAL

PROPOSITOS DE MARKETING

a) Dar a conocer el S.O. y sus beneficios. Identificación.

b) Concientizar a la población de los peligros de la DESHIDRATACION causada por la DIARREA, y de sus posibles fatales consecuencias que se pueden evitar.

c) Entregar a las familias las indicaciones y enfrentar el problema de forma fácil y práctica.

d) Crear agentes multiplicadores a través de la concientización y capacitación de mamás con hijos con el problema (diarrea).

e) Disminuir la mortalidad infantil por diarrea.

PROBLEMAS CLAVES QUE LA PUBLICIDAD DEBE RESOLVER

a) Convencer a los padres de que el S.O. es el tratamiento para evitar y curar la deshidratación causada por la diarrea.

b) Que su preparación es fácil y que sus beneficios son invalorables e inmediatos.

c) Enseñar como se prepara el S.O., concientizar a las mamás y capacitarlas para que ellas actuen como agentes multiplicadores en sus comunidades.

d) Aproximar los padres a los médicos y fomentar la utilización más frecuente de los servicios de salud, actitud que mucho contribuirá para salvar vidas infantiles.

EL PRODUCTO

¿CUALES SON LAS CARACTERISTICAS CLAVES DEL PRODUCTO?

El suero oral es un compuesto de sales, de bajo costo que devuelve al niño en fase de deshidratación, las sales y líquidos perdidos, ocasionados

.///

EL PRODUCTO

///... por la DIARREA, evitando una muerte segura. Viene en sobres fáciles de preparar, se encuentra en Puestos, Centros de Salud y Farmacias, y su utilización y beneficios están muy bien comprobados en muchos otros países.

El perfil del Target nos demuestra la necesidad de romper barreras con la publicidad, mostrando la indispensable aproximación de padres, médicos y establecimientos de Salud.

POSICIONAMIENTO

¿POR QUE ES USTED CREIBLEMENTE MEJOR?

El suero oral es para la rehidratación del niño con DIARREA. Su fácil aplicación y beneficios inmediatos puede salvar la vida del niño.

PERSONALIDAD : ¿QUIEN ES USTED? ¿QUE HACE SU PERSONALIDAD DIFERENCIADORA?

Somos las sales rehidratantes, los científicos, los profesionales, los químicos, los médicos, los especialistas en la materia.
El remedio eficaz e inmediato y fácil de preparar, la solución salvadora de la vida de niños. Somos el S.O. la fórmula correcta al alcance de todos. Mi utilización está comprobada en muchas partes del mundo y me caracterizo por ayudar a salvar vidas y devolver sonrisas a niños y a sus padres.

¿COMO QUISIERA SER EL TARGET AL UTILIZAR ESTE PRODUCTO?

Responsable, conocedor, capaz, amoroso de su familia, solucionador de problemas agudos, inteligente, etc.

¿QUE NECESIDADES EMOCIONALES PUEDE SATISFACER EL PRODUCTO?

...///

///... [illegible]tuar la salud a los niños con deshidratación, devolverles el ánimo perdido, así como la tranquilidad a los señores padres y la alegría al hogar amenazado, por la enfermedad de unos de sus integrantes.

¿QUE SENTIMIENTOS DEBE DESPERTAR EL PRODUCTO?

De confianza, de bienestar.

¿QUE PAPEL DESEMPEÑA EL PRODUCTO EN LA VIDA DEL CONSUMIDOR?

Evita la deshidratación, rehidrata, restituye el ánimo, el apetito y líquidos perdidos al niño en proceso de deshidratación por la DIARREA.
Salva vidas de indefensas criaturas y devuelve a hogares la alegria por el restablecimiento de su hijo enfermo.

¿CUALES SON LAS IMAGENES Y LAS PALABRAS CLAVES QUE COMUNICAN LA ESENCIA DE LA PERSONALIDAD DE LA MARCA?

Imagenes : el sobrecito de suero oral, madre amamantando, preparación de las sales, niños, médicos, enfermeras, U.R.O.S., Centros de Salud, madres, padres, educadoras sanitarias, etc.

Palabras : Diarrea, deshidratación, sales, niños, papás, mamás, amamantar, médicos, servicios de salud, suero oral, comidas, cucharita, litro, agua, revolver, beber, medicamentos, U.R.O.S., etc.

¿SI EL PRODUCTO FUERA UNA PERSONA COMO SERIA EN TERMINOS DE? : Actitudes.

¿CUALES SERIAN LAS ACTITUDES EN LOS VALORES DE LA MARCA?
Saludable, líquido, rápido, solucionador de problemas, amigo, fuerte, confiable, etc.

¿QUE BENEFICIOS DA A ENTENDER?

...///

[illegible] DE MARCA PAG. 4

/[illegible] y cura la deshidratación del niño, termina con la angustia de [illegible], devuelve la alegria a los hogares, ayuda a salvar vidas de [illegible] diarrea.

¿[illegible]A? ¿COMO SE SIENTE? ¿COMO ACTUA? ¿COMO LE [illegible] EL PRODUCTO?

[illegible] confiable, a medicamento, se siente actuante, benéfico, actua [illegible] devolviendo el ánimo a niños con diarrea, devolviendo el apetito, restituyendo la vida, se hace sentir confiado y optimista a los p[illegible] niños con diarrea, animados, con apetito, bien.

[illegible] DE MARCA

[illegible] REHIDRATANTE ORAL (con las sales de rehidratación ora[illegible] oral) es el tratamiento más eficaz conocido para evitar y [illegible] DESHIDRATACION por DIARREA en las criaturas. Barato, fácil de preparar, suministrar, de transportar y guardar, el SUERO ORAL el [illegible] oportuno del niño, amigo de los padres, la ayuda indispensable en [illegible] difíciles a causa de la enfermedad.

[illegible]

Para [illegible]

[illegible] la sal de la vida.

TO[illegible] LOS MENSAJES

Série, didáctico, paternal, amigable, memorable y recordado.

SL[illegible]

[illegible] LOS NIÑOS.

35

ESTRATEGIA CREATIVA

1. AMBIENTE

El mundo exterior, este universo de conflictos y necesidades, hierve ahí afuera, donde reside nuestro TARGET OBJETIVO, chocando con los variados problemas y consecuentemente, corriendo en busca de las más diversas soluciones.

2. COMPORTAMIENTO DEL MERCADO

En la mezcla de encuentros y desencuentros, muchos padres de un grupo social plenamente identificados, con disponibilidades financieras muy limitadas y conocidas, con niveles culturales bajísimos y agudos problemas de ignorancia, se debate en la busqueda de la solución del problema : SALVAR A (POR LO MENOS) UNO DE SUS HIJOS DEL FLAGELO DE LA DESHIDRATACION CAUSADA POR LA DIARREA. Este grupo humano, lleno de necesidades y problemas, es nuestro Target Objetivo.

Se caracteriza por ser tímido, desconfiado y en muchos casos sus escalas de valores son confundidas, invertidas o simplemente no existe.

3. BENEFICIOS

Necesitamos llegar a este segmento social para ofrecer un gran beneficio. Tan simple cuanto su nivel de comprensión y tan barato cuanto requiere sus bajos recursos. Estaremos lo más cerca posible del problema, para dar una atención rápida y eficiente a la urgencia. Disponemos de los equipos técnicos necesarios y contamos con un equipo humano, conciente del problema y capacitado para resolverlo.

...///

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[illegible] BISA

4. EVALUACION DE RIESGOS

Los riesgos casi no existen. No hay competencia, la calidad del producto es buena y uniforme, y la distribución será efectiva y anticipada a la campaña. Nos queda el peligro del RIESGO SOCIAL que crece a la medida que crece la ignorancia y la falta de interés del público objetivo.

En el riesgo social se resaltan tres puntos básicos :

a) LOS QUE LLEGAN A CONSIDERAR LA PROPUESTA.
b) LOS QUE SE MUESTRAN INDIFERENTES A LA PROPUESTA.
c) LOS QUE RECHAZAN LA PROPUESTA.

LA CAMPAÑA

Está estudiada y desarrollada con la finalidad de minimizar los riesgos (indiferencias y rechazos) y para convencer a los que aceptan la propuesta, transformándolos en agentes multiplicadores.

5. OBJETIVOS BASICOS DE LA COMUNICACION

a) Conquistar la concientización de la población a los beneficios del programa.
b) Lograr la utilización masiva del público objetivo de los beneficios del programa.
c) Crear agentes multiplicadores para el programa utilizando, para eso la intervención interpersonal, cara a cara, por parte del personal (educadores sanitarios, médicos, enfermeras y líderes de capacitación y de opinión), que tendrán un papel definitivo en el desarrollo de la campaña.

...///

5. RIESGO SOCIAL DE LA COMUNICACION

a) Temor y rechazo de la población por sus escasos conocimientos sobre las ventajas del producto.

b) Dificultades para acceder a puestos de salud. En el caso, la distancia aumenta los riesgos de comunicación.

RESOLUCION : Ya eramos concientes de estos riesgos mucho antes de la preparación de la campaña. Somos sabedores de que la comunicación no puede acortar la distancia en kilómetros entre el Target y los U.R.O.S.. Pero esto es problema de distribución y no de comunicación. De todas las formas, los 8 UROS establecidos para la atención al público fueron estudiados y aproxima en mucho la presencia de las sales al problema. Que la un pequeño esfuerzo que debe ser realizado por el Target, a nuestro criterio ese pequeño esfuerzo da importancia a los padres que buscan los centros de salud, educadores sanitarios, enfermeras, para la atención a sus criaturas necesitadas, y puede ser argumento de importancia para transformar a sus padres en AGENTES MULTIPLICADORES.

Aquí se genera una pregunta ¿cómo?. Respuesta : la distancia recorrida por los padres, donde vive, como llegaron hasta el U.R.O., que medio de transporte utilizaron, debe ser parte de la conversación que mantendrá el médico, la enfermera o la educadora sanitaria.

Es importante que se les diga a los padres el bien que hicieron a su hijo, transportándole hasta el centro de salud, buscando la salvación o la cura para su problema, dejando bien claro la importancia del esfuerzo que ellos hicieron. Que es asi que actuan padres amorosos, que saben apreciar la familia, que aman a sus hijos. No cuesta nada felicitarlos y valorar sus actitudes y eso convertirá automáticamente a los padres en aliados de nuestra campaña.

...////

[illegible] TARGET OBJETIVO

Directo : Padres de clase social baja y media baja, campesinos.
Indirecto : Personas en general, personal de salud.

[illegible] DE LA PERSONALIDAD DEL TARGET Y SU ESTILO DE VIDA

Pocos o casi ningún conocimiento cultural y educativo, bajísimos recursos financieros, ignorantes de su responsabilidad de padres, huérfanos de sus conocimientos preventivos y de la higiene.

PERSONALIDAD DE LA MARCA

[illegible] en el documento anterior.

[illegible]

[illegible], la sal de la vida.

[illegible] LOS MENSAJES

Sério, [illegible]tico, paternal, amigable.

[illegible]

[illegible] LOS NIÑOS.