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SUMMARY REPORT

HEALTHCOM REGIONAL WORKSHOP — AFRICA

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I. BACKGROUND

Recognizing the benefit of bringing together regional field staff and their counterparts to share technical and managerial information, HEALTHCOM first convened a regional meeting in Latin America in January of 1989. The success of this meeting led to the notion of similar meetings for the African and Asian regions. Accordingly, an Africa Regional Meeting was held in Nairobi, Kenya, April 16-18, 1989, attended by resident advisors and their counterparts from Lesotho, Nigeria, and Zaire. Facilitators were the HEALTHCOM Project deputy director, Elayne Clift, the country program manager for Nigeria, Dr. Clarence Hall, and the Academy's vice president for health, population, and nutrition, Mark Lediard. In addition, representatives from the Africa Regional Health Education Center and the Tulane University/Zaire Program were invited. (A similar meeting is planned in Asia in May 1989.)

The purpose of the meeting in Nairobi was to hold discussions in three important areas:

- (1) project management and implementation;
- (2) refining the methodology for greater sustainability;
- (3) development of academic and training programs through linkages with indigenous institutions.

To facilitate these discussions, a set of questions was developed to guide participants (see Appendix). The following report provides a summary of the dialogue around these questions.

II. INTRODUCTION

The meeting opened with introductory remarks by HEALTHCOM home office staff and introductions by the group. Academy Vice President Mark Lediard shared with the group AED's structure and purpose, pointing out that AED's role is to support the counterpart. "Our effectiveness," he said, "is in our ability to support those who execute our projects and to respond intelligently to the realities in which we work, to share the process of learning together."

Following the introductory remarks, brief country reports were given, highlighting accomplishments and continuing challenges.

A. Lesotho

Mr. Mokuba Petlane pointed out that HEALTHCOM was invited into Lesotho primarily to guide the development of the Health Education Division's (HED) organizational structure. This guidance included upgrading of staff skills and promotion of systematic planning. With the rapid growth and expansion of the division in recent years, planning has become vitally important. The HED has nearly doubled the size of professional staff and has added two staff members with diploma-level qualifications in health education. Other departments have continued to demand an increased volume of services from the HED, and the division has now evolved into a full division responsible for communication in 14 different subject areas. The demands inherent in this growth have underscored the importance of upgrading staff skills in the areas of communication planning, social marketing, qualitative research, materials development, and computer graphics as applied to CDD and EPI activities, as well as to breastfeeding and family

planning. HEALTHCOM has been active in supporting the CDD/ORT program with baseline studies, development of educational material, and other assistance. Mr. Petlane expressed the need for further help from HEALTHCOM in the areas of EPI, breastfeeding, and family planning.

With regard to organizational development, the Health Education Division looks to maximize participatory planning and to facilitate the transfer of skills to the Basotho, with streamlined responsibilities for staff. Under consideration currently is the idea of clustering within the 14 subject areas in the division, with one health education officer assigned to each cluster. To maximize transfer of skills, the idea of multiple counterparts to the resident advisor is being considered. Intersectoral IEC committees for ORT and family planning have been set up to work under the main committees providing support to these projects. (An AIDS IEC committee is forthcoming.)

Ways are being sought to provide adequate staff to meet the myriad demands put on the Department, and to allow for adequate staff development. HEALTHCOM assists in staff development through on-the-job training and workshops. HEALTHCOM has also assisted with equipment and other forms of capacity building.

The division is now in the process of refining a mission statement to provide the division with a definite sense of direction. Such a statement also helps with intergovernmental advocacy and demonstrates the worth of the division.

In summary, Mr. Petlane sees significant achievements in the areas of staff training and personnel growth, equipment acquisition and facility development, and the formation of IEC planning groups which are leading to an integrated approach to health education. Policy formation, KAP studies, and standardized messages are all contributing. Continuing challenges include further organizational development, strengthening staff competency through more training, and increased communication planning.

B. Zaire

In the absence of her counterpart, Resident Advisor Joan Schubert reported on the status of HEALTHCOM/Zaire. There are many challenges in carrying out the work in Zaire, including the size of the country, poor communication links with the U.S., poor communication linkage between the project site in Lubumbashi and Kinshasa, the capital, and the fact that more than 100 languages are spoken in Zaire. In the absence of a local counterpart (who has gone abroad for further study), the resident advisor must relate to a counterpart in Kinshasa (a two-hour flight, or a road journey of nine days).

Current IEC activities are loosely coordinated by FONAMES, and tend to operate rather vertically under nutrition, urban health, family planning, School of Public Health, activities in AIDS prevention, rural health, and CDD. HEALTHCOM tries to coordinate with the different IEC units, but the linkage with most is weak and at present HEALTHCOM works most closely with rural health and CDD. Stronger links are currently being established with the School of Public Health. It is now proposed that a second advisor be resident at the School of Public Health to work in HEALTHCOM activities at the national level in Kinshasa.

To date (the project has been in country for seven months), HEALTHCOM has established a pilot IEC group at the project site. Focus group discussions were conducted in October 1988 during a two-week training session, during which "eye-opening information was gathered." In January 1989 a five-day Project Implementation Workshop

was held, bringing together 23 national and regional IEC technicians and health professionals who collectively planned the major thrusts for the project. In February and March, the baseline survey instrument was pretested and refined, interviewer training took place, and a baseline survey was carried out. Through the use of appropriate computer software, partial analysis of the data was carried out within three days. Emphasis continues to be placed on using community communication channels, with results of the focus group discussions being fed into the baseline survey questionnaire to enrich it.

Future plans include follow up to the implementation meeting including a training-of-trainers workshop in information, education, and communication/interpersonal communication, standardization of messages, and writing up and applying current experience as a model for other regions. Zaire will also develop popular communication forms (traditional media such as theater and songs). HEALTHCOM will also be providing technical assistance to PanAfrican IEC organizations and efforts.

C. Nigeria

Nigerian Resident Advisor Tony Agboola presented a comprehensive status report accompanied by a document outlining program objectives, achievements, and challenges. He pointed out that Nigeria is the most populous country in Africa. It has a large land mass and a diversity of cultures, languages, and religions which present formidable challenges to any state or countrywide communication effort.

HEALTHCOM/Nigeria has been operational since May 1987. The staff includes a resident advisor, graphic artist, materials development specialist, and a zonal liaison officer. The latter is posted to Niger State and coordinates HEALTHCOM programs and activities in the focus state and other states in one of two zones in northern Nigeria. A long-term consultant in development communication has been assigned to the resident advisor in Lagos to provide technical assistance and management support to the project.

HEALTHCOM/Nigeria has given high priority to institution building at the national and state levels through the Health Education Division, Federal Ministry of Health, and the Health Education Unit, Niger State Ministry of Health. The project has emphasized strengthening existing structures and staff training in the HEALTHCOM methodology, health communication planning, management, and supervision.

As with all HEALTHCOM projects, formative research preceded project activities. Based on the results of this research, an EPI flipchart, along with a user's manual and handout for parents, have been developed, pretested, produced, and distributed in the focus state and the remaining four states in the health zone. Approximately 400 health personnel have been trained to use the flipchart. An evaluation of the utilization and health staff assessment of the flipchart is now underway in the focus state. A behavioral study is in progress in Niger State to determine the most effective way to use the EPI flipchart in a clinic setting.

Notable achievements of the project include an increase in Niger State Health Education Unit personnel from two to 17; joint training of health and media staff in health communication planning and production; the establishment of child survival units staffed by HEALTHCOM trained producers in six federal and state radio stations; and the formation of child survival technical committees at the federal and state levels to coordinate and provide mutual support for child survival health communication throughout the country.

A major accomplishment, in Mr. Agboola's view, is that health education and media staff jointly produce child survival programs broadcast regularly over state and federal radio stations. These programs are broadcast free of charge in exchange for equipment (high quality portable tape recorder), supplies, and media staff participation in HEALTHCOM-sponsored training programs.

The private sector is involved through an advertising agency that has been contracted to develop, pretest, and produce EPI posters, billboards, and jingles that will be used initially in Niger State--HEALTHCOM's first focus state. Production is scheduled for July 1989.

HEALTHCOM/Nigeria has begun start-up activities in a second focus area in the southern part of Nigeria. A multidisciplinary team of researchers headed by a university professor from each of the five participating states in Zone B have been trained by HEALTHCOM to conduct three types of formative research. CCCD is providing the funds for each team to conduct formative research for child survival in their respective states. This represents a major contribution to institutionalization and an innovative approach to strengthening and using local talent to carry out a key component of the HEALTHCOM methodology.

Mr. Agboola noted that HEALTHCOM will continue a systematic expansion to the remaining two health zones. A change of strategy from concentrating on a single focus state to planning and implementing activities in the entire health zone represents a major shift. However, one state in each zone will continue to receive intensive technical assistance and serve as a model for the other states. Future plans include extending personnel training to traditional birth attendants (TBAs) and school teachers in an attempt to intensify face-to-face communication and reduce the rate of immunization defaulters.

Mr. Agboola indicated that a major challenge to HEALTHCOM is to keep pace with and to become fully integrated into the recently initiated National Primary Health Care Program. Now that HEALTHCOM has successfully demonstrated the value of strengthening and supporting health education and media personnel the requests for assistance have considerably increased. HEALTHCOM is challenged to maintain a high standard of technical assistance and at the same time meet the identified needs with a limited number of HEALTHCOM staff.

III. REFINING AND IMPLEMENTING THE METHODOLOGY

A. Essential Elements

Group consensus was easily achieved with respect to the key components of the HEALTHCOM methodology. These elements include the fact that HEALTHCOM is:

- (1) research driven;
- (2) client centered;
- (3) applying the underlying principles of social science (social marketing, anthropology, behavioral science);
- (4) dynamic, adaptive;
- (5) multi-channeled (mass media, face-to-face, print, traditional);
- (6) seeking behavior change as its outcome;
- (7) including community participation as a goal;

- (8) placing emphasis on planning and strategy development; and
- (9) continually monitoring and evaluating.

The group concurred that to this list should be added an explicit statement of values.

HEALTHCOM faces a variety of challenges. Among these is resistance from traditional health educators, primarily to social marketing jargon and frequently, to its approach. For this reason, values clarification is a perceived need. This clarification may only require rhetorical or linguistic alteration, or it may demand more substantive self-evaluation. Many factors contribute to resistance, including physicians discrediting of communication, traditional health educators not being exposed to the methods and benefits of mass media, distrust of mass media approaches among ministry and other personnel, and the restricting by higher officials of access to media by lower officials. Ironically, properly applied, traditional health education can offer all of the benefits of health communication and the social marketing approach. However, traditionally, it tends to emphasize promotion alone, shying away from mass media and concentrating on health facilities, thereby reducing its effectiveness. Participants noted that there appears to be an ongoing battle between traditional health education and methodologies which borrow from the private sector. The situation is complicated by physicians who do not give credibility to the effectiveness of either traditional health education or to the HEALTHCOM approach. In addition, many health education officers do not know much about the mass media or how to use them. Senior officials may feel threatened allowing others access to media. Therefore, there is a strong need for advocacy with high officialdom and a need to use nonthreatening language in presenting the HEALTHCOM approach, whether in presentations or in formal documentation.

B. Key Techniques

The group discussed in depth a number of key techniques for overcoming resistance to the HEALTHCOM methodology. These techniques include the following:

1. **Speed Up the Process** -- It should be possible to achieve some level of reportable results in good time. The process is currently somewhat slow because the people applying it are also learning as they go, as well as teaching others. A natural "streamlining" should occur with greater experience and confidence in the process. Nevertheless, a number of things can be done now to refine and simplify the methodology. For example, more rapid assessment techniques should be developed and applied. Functional models for conducting qualitative and quantitative research should be designed. (Several participants noted that the manual, Communication for Child Survival, was an excellent resource, with a variety of checklists and modules to guide communication planners. At the same time, there is still a perceived need for simplified guides, checklists, and modules to assist in various stages of assessment, planning, implementation, and monitoring.)

2. **Use Appropriate Computer Software** -- A plea was made for the "appropriate transfer of technology" vis-a-vis computer analysis. The experience in Zaire in turning around data in three days impressed and excited the group, who felt certain that simplified computer analysis is possible with the right kind of software, both with respect to entry and analysis.

3. **Demystify!** -- This was a continuing "cri de couer" and a re-emerging theme throughout the meeting. There was strong sentiment that it was both possible and necessary for HEALTHCOM to remove the mystique that continues to surround the methodology. Participants felt, along with the notion that the methodology would

streamline itself given adequate time and experience, that allowing for a practical approach, a natural simplification--or demystification--would occur.

4. **Involve The Community In Research and Evaluation** -- The group felt that integrating research at the community level into the total methodology would make an important difference. This approach implies improved training in research and evaluation, but clearly, a sense of ownership and involvement at the community level in these critical functions can only enhance HEALTHCOM's work. Integration of the R&E component helps "players" to understand where their role fits (e.g., health educators need to be involved in research efforts and to see how data are transformed into creative messages).

5. **Improve Collaboration** -- A key technique in reducing resistance is to reach out to others with a vested interest in public health and/or the HEALTHCOM approach. Coordinating bodies such as task forces, committees, and international agencies can help with advocacy at the highest levels, and often, there is much to be learned from those participating in these consensus-building groups.

6. **Show, Don't Tell!** -- Take policy makers and others to the field. Demonstrate that the methodology works.

7. **Use Innovative Training Techniques** -- Try new training techniques such as simulation, role playing, and so forth. Include policy makers and others in training sessions.

8. **Improve Diffusion Tools and Techniques** -- At both the inter- and intra-project levels, the group perceived a need for diffusion methods that reach the right audience and capture their attention in the little time available to them.

C. **Further Challenges**

How do we translate research results into creative messages? (Look at approach/appeal; then brainstorm on creativity aspect. There is no real methodology. Democ tapes may be useful.)

What is the effect on a Health Education Unit of developing a communication strategy? Will restructuring be required?

How does one co-opt, reward, and monitor gatekeepers? Are incentives appropriate, viable? Should they be commodities or something more systemic (e.g., training)? Incentives are a sensitive issue. Are they sustainable?

How can we coordinate our work across ministries?

IV. RESEARCH AND DEVELOPMENT

A. **Integration of Research Methods**

The participants reached a consensus regarding future R&D efforts by HEALTHCOM.

An integration of research methods seems to be called for. In addition, while a literature search may tell us what has been done and what is available in country, we

need to look more closely at cultural resource material in order to understand behavior attached to traditional practices. Communication channels at the community level and social support systems need to be identified and involved more deeply as well. We need a better understanding of what local "networks" exist and how they might function as channels. This knowledge may also help to ensure that technical aspects of the methodology are within the implementation capacity of the target audience, that elements of the methodology are properly "distributed," and that those technologies work.

An important point focused on discrimination with respect to implementation of the methodology and its R&D components. Within the context of "streamlining" and simplification, it is important that implementers of HEALTHCOM grow to trust their own ability to discriminate in terms of methods applied and approaches that work. This is not to suggest deviance from the prescribed methodology, but rather professional judgment about which elements to emphasize, adapt, or in some instances, eliminate in the interest of efficiency as well as effectiveness. This natural tendency towards self-determined parameters within the context of country realities should be encouraged and facilitated through appropriate guidelines, models, and paradigms. The fundamental question is: What works best for telling me what I need to know? This approach can help to eliminate unnecessary overlap and duplication. It is also important to remember that some studies can be carried out simultaneously, and do not require sequencing. There is also a need to go beyond current studies. For example, more research into dietary management of diarrhea during the next phase of HEALTHCOM will be useful. Behavior studies should investigate the philosophies behind local customs.

The group also explored ways in which face-to-face communication could be enhanced. Once again, greater use of indigenous social support systems was promoted (e.g., opinion leaders in women's groups, religious leaders, and traditional healers). Training was also seen as vital for anyone involved in health education. In addition, strengthening of the traditional folk media was proposed, ensuring a balance between entertainment and effective messages. Implementers need to be careful about information overload. Also, one's attitude towards women as the target audience is critical. We need to believe in their inherent ability to make good judgments and to carry out sound practices. Also, we must not be threatened by empowering women with information. The group agreed that as health educators, we continue to harbor subliminally the notion that we "own" the information we impart. We therefore have a tendency to "infantalize" women, particularly in clinic settings where they are often treated like obedient schoolchildren. In short, we need to encourage positive attitudes as well as actions with women. Another important suggestion in this category was that health workers should be encouraged to develop their own teaching aids. Finally, HEALTHCOM implementers should look at other potential avenues for face-to-face opportunities. These channels might include the church, traditional healers, and women leaders.

B. Future Research Directions

Continue to explore ways of simplifying methodology through practical approaches (e.g., how small can sample size be to still be reliable?).

Put more emphasis on communication channels at the community level; broaden channels (e.g., traditional media).

Improve audience research methods and techniques for tracking what happens to the information disseminated.

Conduct research reporting barriers to health-promoting behaviors of the target audience.

Explore further the idea of combining interventions under one umbrella theme (e.g., PHC). Integration has benefits but political and donor interests often interfere. Ironically, integration takes place at the village level, but institutionalizing this at the clinic requires decentralization.

While the group felt strongly that a "standardized, streamlined package of formative research" would be a grave error, participants agreed that methods for determining which formative research technique to apply in various circumstances could be further explored.

V. COMMUNITY PARTICIPATION

"The Pig, the Hen, and the Cow: A Parable." Once upon a time, a pig, a hen, and a cow agreed to contribute to breakfast. The cow said she would give milk, which she readily did. The hen was only too happy to contribute an egg. However, when it came to the pig giving bacon, only then did it realize the seriousness of its pledge. The cow and the hen were participating; the pig was involved.

This story helped the group understand the difference between involvement and participation!

Participants defined "community participation" as "having the opportunity to take part in decisions which affect one's life and one's community, being able to transform those decisions into action, and accepting any consequences which might result."

HEALTHCOM should view itself as "broker," facilitator, and negotiator with respect to community systems, according to the group. It must create a marriage of national, regional, local, and community needs. We should think of community participation at the micro level, starting with people ("trickle up" vs. top-down). The challenge is in integrating government interests with those at the community level. HEALTHCOM is perceived by its implementers as inherently community oriented insofar as our methodology is client-centered and applies the findings of its formative research in such a way as to improve outcomes for its target audience. However, information flow must be two-way: We must bring findings back to the community for their verification, and adaptation, rather than ask for a "leap of faith." **DECISION MAKING IS THE KEY TO INVOLVEMENT IN POLICY AND PLANNING WHICH IS AT THE HEART OF COMMUNITY PARTICIPATION.** Involvement needs to occur incrementally, whether from the central level, to the clinic, to the individual, or vice versa. It implies trust, collegiality. Community participation can and should be operationalized through training. This could, in the long term, affect staff or volunteer attrition rates. Once again, health educators, policy makers, and others need to revise their thinking in some instances, and to open up to new approaches if community participation is going to be genuine.

VI. EVALUATION (The Formulation of "Aha!")

The group agreed that there is a distinction between formative, process, and summative evaluation. The difference between formative and process evaluation is in timing and methods used. Process evaluation asks why and how something happened.

Documentation of process helps to explain outcome, or as one participant put it, "the formulation of "Ahas!" Checklists are a useful tool in process evaluation, and perhaps HEALTHCOM needs to develop more in the way of checklists, action guides, and monitoring tools. Participants recommended that HEALTHCOM should look across country experiences to determine what works in what settings with what resources; search out trends and patterns that tell us something in the aggregate, or which are usefully extrapolated. We need a "Lessons Learned" in process evaluation.

Outcome, or summative evaluation, asks what. It seeks to understand results. The group strongly agreed that HEALTHCOM should continue to look to behavior change as an outcome measure; that is what makes us unique in comparison to the epidemiological approach. While behavior change takes a long time, we nevertheless need to demonstrate relatively quickly and credibly that we have made a difference. Also, outcome evaluation must take into consideration what nonprogrammatic activities are taking place in the community that may have an influence on outcome. Projects/methodologies such as PRICOR may have formats which HEALTHCOM should consider adopting.

Local resources should be used more in the collection of data. Also, we must remember that "ministries are in the business of programs not projects." Outcome results shouldn't bog them down, as one resident advisor put it. The question was raised whether appropriate measures could, in some ways, drive institutionalization (e.g., distribution checks, media monitoring). In any case, indicators need to be expressed operationally. They need to aim for efficiency as well as effectiveness, as long as limitations are understood. We need to be clear about whether we are gathering information or data. Do we want knowledge for the sake of knowledge, or information for decision making? We need to be certain that people are driving computer applications, and not vice versa.

Participants strongly felt that we need a "research mix" which is integrated with other activities. Qualitative and quantitative approaches can be used together. Also, anecdotal and self-reported data do have value in the proper context. Feedback is critical. All of this suggests that we need to "desegregate" skills. Health educators can and should conduct research and evaluation. HEU professionals need to be integrated into the research process and to receive immediate feedback which assists in the processing and development of skills. HEALTHCOM needs to ask for inputs regarding research design and data collection at the community level more often. One participant suggested that HEALTHCOM propose ways of doing this, keeping in mind that methods must be affordable and easily taught. One participant suggested that evaluation data collection may be efficiently combined with monitoring and supervision visits. Inherent in this approach is the importance of giving the community feedback on the results of evaluation efforts.

Improving project indicators remains a challenge. We can look at levels (e.g., were pamphlets printed; distributed; what was impact?) and skills (can the health worker/mother do what was taught?). Is the HEU working any differently than when we started? Is a unit now producing more? Again, we need to seek inputs from health workers and the community. The group agreed that they did not want to resemble program planners who "sit in capital cities trying to guess what is best." Rather, we need to "practice what we preach" by going to the people and asking them for input--this is true community participation.

VII. SUSTAINABILITY AND INSTITUTIONALIZATION

There is a difference! Institutionalization occurs at the level of policy, planning, and resources. Sustainability happens at the community level, and is of course, directly linked to institutionalization. The group liked the differentiation made by Buzzard: Institutionalization refers to programs while sustainability refers to benefits. Paramount in program or project sustainability is resource allocation. But HEALTHCOM is a labor intensive methodology. We know it is effective, but is it sustainable?

What is it we wish to sustain--methodology, behavior, or both? The methodology in its purest form may not be sustainable, but perhaps behavior change is. Also, we must recognize that in its early days, HEALTHCOM is conducting much research. Adaptation of the methodology is not a bad thing. We want to position the methodology so that it continues to be applied. Skill development is a form of institutionalization. Perhaps this needs to be separated from institutional issues at the policy (i.e., government) level. In terms of training, it is important that we introduce the methodology into institutions of higher learning; this is critical to institutionalization and requires that we learn more about methods of adult learning.

We also need to institutionalize confidence in the methodology. This approach should be directed to the field level, as well as the headquarter level, and speaks to the importance of decentralization.

It may also be possible to institutionalize involvement of the private sector; this must be considered with caution. Health education units must know how to contract for services and how to work with private sector partners. HEALTHCOM already has several models to look to, including those in Zaire and Nigeria. Innovative models of private/public sector cooperation will also be useful in the area of training. For example, an ad agency may be willing to offer an internship to a health education unit employee. Or, if someone in the public sector has been trained by HEALTHCOM and then moves into private sector employment, perhaps the company would be willing to commit some time to pro bono activity for HEALTHCOM. Other similar opportunities might well be explored.

A. Measuring Success

How can we "measure success" in the institutionalization process? We can measure the investment in human and financial resources being committed. We may want to see to what extent the methodology is being taught at various institutions by people not involved in HEALTHCOM initially. Is training at the community level continuing? What other kinds of knowledge transfer are taking place? Has information seeking behavior increased? What policies are being put in place? (In Lesotho, the Health Education Division has a written mission statement). Is the methodology being applied to other problem areas? These questions all serve as indicators of institutionalization and/or sustainability, but clearly, indicators still need to be refined and standardized.

B. Strengthening Commitments

First, it is necessary to demonstrate that the methodology works. In addition, it is critical that counterparts, the community, and others are engaged from the earliest planning stages. Further, government at all levels must be integrated from the start. Training is essential at all levels. Top ministry officials should be involved as well

as schools and other relevant institutions. The notion of peer support is also important in the exchange of ideas, information, and opportunities.

"Conditions Precedent" to a HEALTHCOM project should be considered. Counterparts, and access to staff, are essential. Different levels of community participation must be assured. Obviously, facilities, equipment, and work space are required. Many conditions are already expressed in the Letter of Agreement HEALTHCOM requires (e.g., permission to publish, access to community for formative research, commitment to training) but enforcing the letter as a "contract" might be better. Changes in government and/or personnel obviously present the biggest challenge and drain to training resources.

C. Collaboration Possibilities

Collaboration can be enhanced by training health and media staff together. (This has been done in Nigeria, Jordan, and elsewhere.) Training and technical assistance can also be extended to collaborating agency personnel (e.g., Zaire/UNICEF). Collaboration with NGOs can provide access to the community (Lesotho). In general, increased networking and the sharing of information, research findings, materials, documents, and so forth, can only help collaborative efforts. Mutual development of research tools, indicator lists, and so forth, is also of benefit. Demonstrations of "public commitment" can be useful (e.g., panel discussions among noted leaders, perhaps even broadcast). It is important to identify and include the powerbrokers as well as the gatekeepers.

Motivation for increased collaboration includes "fame" or recognition, association with positive and visible activity, and credibility building. For some participants in HEALTHCOM projects, this could lead to overseas opportunities (training, presentations), or other educational or field opportunities. A note of caution, however: we need to exercise care in terms of rewards, insuring that they are distributed fairly so they do not become a "demotivator." Donors need to be involved in selecting recipients.

VIII. TRAINING AND CURRICULUM DEVELOPMENT

A. The Africa Regional Health Education Centre (ARHEC)

ARHEC presents an interesting model around which to discuss future training activities for HEALTHCOM in Africa.

ARHEC offers programs for an Advanced Diploma in Health Education (ADHE), M.P.H. degree, and a Ph.D. degree. The program is run by three organizations: WHO (technical assistance and staff), University of Ibadan (space and faculty), and the Federal Government of Nigeria (funding). In order to enter the ADHE program, applicants must have a minimum of five years experience. (These are usually nurses and health inspectors.) Courses are taught in such subjects as communication theory, group dynamics, introduction to health education, planning and evaluation, community organization, patient education, and school health. Training includes a field practicum. ARHEC has expressed a need for linkage with groups such as HEALTHCOM to provide a media component. (At present, the ARHEC graphics unit is not functioning because of staff attrition.)

Each diploma-level course is provided 24 hours/week for two semesters of 14-15 weeks each. Courses are designed to provide theory three days per week, and field work

the other two. Students operate in groups of five or six, supervised by the six faculty members. Students are required to pass all subjects at the 50 percent level as a minimum, and to produce a variety of reports. (Of 34 students this year, approximately one-third of them are non-Nigerian.) An internship program is also designed to give students confidence in working outside the school setting. These internships must be supervised by someone with at least an ADHE or the equivalent, and require progress reports.

The M.P.H. level involves the same course structure but makes greater academic demands on the students, who are usually drawn from medicine or the physical or social sciences. To qualify, applicants must have a first degree and must have placed in the upper half of their class. Plans are underway for a B.A. degree program in Health Education so that ADHE's can move into the M.P.H. program.

ARHEC would like to see HEALTHCOM assistance in providing graphics and media aspects to the training program offered at Ibadan. Specifically, they would like HEALTHCOM to help the university by providing materials development and other HEALTHCOM-related courses once or twice a month. Funding is also needed for the supervision of students outside of Nigeria, and perhaps there will be a grant mechanism through which we can help in the future. Finally, ARHEC expressed the need for HEALTHCOM to provide training support/facilities in other African countries. It was proposed that HEALTHCOM explore the possibility of placing someone at ARHEC for a year to carry out these kinds of duties.

B. The Tulane/ZAIRES Program

The development of the Zaire School of Public Health (ZSPH) is being directed by the School of Public Health and Tropical Medicine at Tulane University. Modeled on the American system, it has the basic courses of a school of public health: epidemiology, biostatistics, environmental health, planning, and management. Other offerings essential to the HEALTHCOM approach are not in place. The courses are delivered in a modular format. Although there is a module on health education, a large portion of this content is subsumed in other topical areas and is not prominent. Health education, as we know it, does not exist, but is an area targeted for improvement.

Parenthetically, there is neither a division nor department of health education within the Ministry of Health. Instead, health education is distributed throughout other training activities.

Under the auspices of the CCCD Program, ZSPH is in the process of consolidating its health education-related content and organizing an intensive short course on health education. It is based on the ARHEC/HEALTHCOM model but will target francophone Africa. ZSPH will work closely with HEALTHCOM and other institutions to form a faculty team. Negotiations are already underway with other francophone countries to recruit CCCD personnel as participants. Initially, the course will be offered once a year; later, working with Tulane, it may be offered more frequently.

An M.P.H. program is already in place in Zaire. Expatriate faculty will gradually be replaced as Zairians return from their Ph.D. programs in the U.S. The majority of M.P.H. candidates in this program are from Zaire. The French have also opened a School of Public Health in the Congo, but it is felt that even two schools will not be able to meet the demand for such training.

HEALTHCOM has a good opportunity now to help the School of Public Health in Zaire evolve in terms of its health communication department. The second advisor proposed for HEALTHCOM would most likely be based at the School and could provide support to training and curriculum development.

C. HEALTHCOM's Contributions To Date

HEALTHCOM has already contributed in a number of ways to training efforts in Africa. The project is working with the University of Lubumbashi in Zaire to provide field work opportunities for students. In Nigeria, we are collaborating in research and baseline studies. This collaboration is limited by the fact that the University doesn't have health/graphics expertise. HEALTHCOM has, in fact, been asked to provide this talent in order to increase collaborative efforts. HEALTHCOM's presence in Nigeria has influenced health education in many ways. In Niger state, we now have facilities in place. Further, in Malawi and Lesotho, HEALTHCOM's presence has enhanced health education in measurable and visible ways. The potential for increased influence is enormous.

D. Necessary Skills

Workshop participants suggested a long list of skills and areas of knowledge germane to health communication. These can be placed broadly under the categories of management and organizational skills, program planning and management; implementation, monitoring and evaluation skills; and public relations (negotiating) skills. In its entirety, the list is formidable and includes:

E. Media

The ability to discriminate with respect to applications of the methodology;

- (1) understanding of the basic language of mass media;
- (2) understanding how to contract for services;
- (3) understanding radio/TV spots and program production;
- (4) knowledge of media formats and which work best for what;
- (5) sophistication in media scheduling;
- (6) knowledge of editing concepts;
- (7) understanding of audiences;
- (8) knowledge of pretesting and impact evaluation techniques;
- (9) knowledge of media monitoring techniques;
- (10) ability to work with gatekeepers and powerbrokers;
- (11) ability to conceptualize programmatically;
- (12) understanding of visual concepts, uses of various media, and actuality vs. scripting;
- (13) facility in scriptwriting;
- (14) facility in writing creative briefs;
- (15) ability to prepare resource people;
- (16) grasp of the basics of good journalism (print);
- (17) grasp of the basics of graphics;
- (18) facility with print pretesting components (visuals, print, colors, etc.);
- (19) understanding of print media options;
- (20) ability to provide production guidance;
- (21) basic understanding of photojournalism;
- (22) grasp of visual literacy techniques;
- (23) knowledge in the area of distribution and use;

- (24) understanding of the problem of information overload;
- (25) facility in face-to-face training;
- (26) basic grasp of adult education theory and methods;
- (27) grasp of principles of counseling at various levels;
- (28) facility in planning, community organizing, community participation;
- (29) grasp of process skills;
- (30) grasp of communication skills (including feedback mechanisms); and
- (31) grasp of folk media applications.

F. Research

Understanding the difference between technologies (e.g., qualitative, quantitative) and what each can/cannot do;

- (1) facility with analytical skills and an understanding of how to apply them;
- (2) facility in protocol writing;
- (3) facility in instrument design;
- (4) facility in conducting focus group discussions and grasp of when they are appropriate;
- (5) understanding of empirical methods; research designs, vocabulary;
- (6) computer literacy;
- (7) understanding of research development and design (and adaptations); and
- (8) presentation skills (to whom/how).

G. Social Marketing

- (1) understanding of the marketing mix;
- (2) understanding of integrated media;
- (3) understanding of the history and context of social marketing;
- (4) understanding of the iterative process;
- (5) understanding of audience segmentation and client-centeredness;
- (6) understanding of the inputs of other disciplines;
- (7) understanding of action orientation aimed at behavior change;
- (8) understanding of readiness states--the "teachable moment"; and
- (9) understanding of diffusion theory.

H. Working with Community

- (1) facility in problem diagnosis and analysis and goal setting;
- (2) facility in education/motivation skills;
- (3) facility in community mobilization;
- (4) understanding of the influence of individuals and collective groups;
- (5) ability to work with influentials;
- (6) ability to work with institutions; and
- (7) facility in problem solving.

I. Monitoring and Evaluation

- (1) facility in setting objectives (with measurable/feasible milestones);

- (2) facility in developing monitoring mechanisms (checklists/guidelines);
- (3) research-related skills;
- (4) understanding of the elements of supervision (adult theory);
- (5) facility in reporting/tracking; and
- (6) understanding of elements of communication/psychology.

Clearly, no one individual can have all these skills. The exercise was useful, however, in clarifying the many roles one must assume in carrying out a health communication intervention. Training must occur at various levels for a wide assortment of people. The group was unified in its belief that many types of people must be trained to some degree in the above elements. These people include:

- (1) program managers;
- (2) health educators and other public health professionals;
- (3) policy makers;
- (4) university faculty;
- (5) NGO representatives;
- (6) community leaders;
- (7) media professionals; and
- (8) teachers.

All of these professionals and semiprofessionals must be trained, but in programs adapted to differing needs, country realities, and inherent skills. A tiered curriculum needs to be devised so that each category of worker gets an appropriate level of training.

J. Strategies to Institutionalize Training

A number of suggestions were offered on how training could be institutionalized.

Linkages to academic institutions need to be formalized through workshops and seminars, regular publications (e.g. newsletters), and other diffusion mechanisms. Diffusion should perhaps be regionalized.

Study tours offer another avenue for training commitments to be made. Exchange programs and internships fall into this category of "cross-fertilized learning."

Training should be phased so that skills are tested. A sort of pre- and post-check-up would involve a practicum followed by more classroom didactics.

"Itinerant professorships" would allow for team teaching opportunities.

Programmed learning (auto-teaching mechanisms) should be explored and developed.

K. Sustainability of Training

It will be important to chart expectations as training agreements are made. "Contracts" should involve a mandate for continued measurable activity. Further, individual and institutional criteria should be developed and enforced for participation in training programs.

Private sector involvement should be explored. There may be a variety of training opportunities which can be designed or housed within the domain of private sector partnerships.

Peer tutorials should be considered. HEALTHCOM might well be able to design a PEP Program (Peer Expert Program), in which it can support indigenous learning opportunities. Degree or certification would be anchored in a home-based institution.

It will be extremely important for governments to provide guarantees of employment following training. Too often, professionals go abroad for advanced educational programs only to find on their return that they no longer have a place. Career structures must be established where they do not exist, and enforced, where they do.

HEALTHCOM will need to broaden its linkages to include NGOs, multinational and bilateral donors, and others as appropriate. The World Bank, for example, might well be interested in joint IEC training activities, particularly where it is already funding related commodities or training. The same might be true for other EEC donors. The USAID PVO office might be in a position to work with HEALTHCOM on training grants. This sort of option needs greater exploration and more visionary thinking.

L. Operationalizing/Proposed Next Steps

Participants proposed a series of important next steps to be considered in furthering the HEALTHCOM methodology within the Africa region. Among these were the following:

- (1) Send a HEALTHCOM person to ARHEC for one or two years to establish a materials development training program and organize in-service training workshops on materials development at national and state levels;
- (2) Detail a HEALTHCOM person to Zaire to help in further developing the program (second resident advisor);
- (3) Develop and conduct joint training in HEALTHCOM sites for mass media and public health people. Seminars should be combined with practicum experiences;
- (4) Develop model curricula to showcase;
- (5) Formally explore potential linkages;
- (6) Develop training linkages with Peace Corps (others?);
- (7) Share resource materials more widely and appropriately. Develop local libraries in country. Allow for translations in budgeting. (Could WHO or UNICEF assist?); and
- (8) Develop more resource materials such as demo tapes, checklists and action guides, training materials, research models, sample scripts, slides, illustrated field notes, and so forth.

IN SHORT, DEVELOP/FEED AN APPETITE; CREATE A READINESS STATE!

IX. SUMMARY AND CONCLUSIONS

It can be said with full confidence that the Africa Regional Workshop was highly successful and that it contributed significantly to the forward direction of HEALTHCOM

as it continues to refine its methodology. Discussions were both practical and substantive. The recommendations reflected above emanate from the realities of the field and represent the considered opinion of a group of experts increasingly comfortable with their ability to apply the HEALTHCOM methodology with discretion as regards its demands and its options.

If there was one message which came through loud and clear, it was this: There is a natural evolution to "streamlining" of the methodology. This evolution can be trusted so long as we take a practical approach to the task before us and allow for the demystification of our process. Adaptation is a natural, and usually desirable, phenomenon. Allowing for genuine community participation will serve to facilitate this process.

As HEALTHCOM moves forward, it needs to attend to the simplification of its research and evaluation methods; timely, appropriate and tiered training; an innovative "potpourri" of communication channels; new and exciting resource materials; and new partnerships. Political realities will not always lend themselves to this agenda. But in the African context, there are strong and exciting possibilities.

As communicators, our job is to watch and listen for these opportunities and to respond to them with action-oriented support and with creative energy.

APPENDICES

AGENDA
HEALTHCOM AFRICA REGIONAL MEETING

April 16-18, 1989
 Nairobi, Kenya

Sunday, April 16

8:30am	Welcome and Introductions	Elayne Clift/Clarence Hall Group
9:00am - Noon	Country Team Presentations Status Update	Lesotho Mokuba Petlane Ed Douglass
	Significant Achievements	Nigeria Felicia Henshaw Tony Agboola
	Continuing Challenges	
	Management Issues	Zaire Musinde Sangwa Joan Schubert
	Discussion	Group
Noon	LUNCH	
1:30pm - 5:00pm	Refining and Implementing the Methodology	Group
	Essential Elements Skills Interventions Community Participation	
	(See Discussion Questions)	

Monday, April 17.

8:30am - Noon	Refining and Implementing the Methodology (Continued)	Group
	Research and Development Integrating Methods Essential Elements Improving Face to Face Techniques Future Focus	
	Evaluation Summative/Formative Indicators Methods Monitoring	
	(See Discussion Questions)	

Noon	L U N C H	
1:30pm - 5:00pm	Sustainability and Institutionalization	Group
	<ul style="list-style-type: none"> Definitions Models Indicators Strengthening Strategies Collaboration 	
	(See Discussion Questions)	
7:30pm	DINNER	
Tuesday, April 18		
8:30am - Noon	HEALTHCOM Training/Curriculum Development	
	<ul style="list-style-type: none"> The Context and Objectives Faculty Workshop Mid-term Evaluation TAG Meeting 	Clarence Hall/Elayne Clift
	<ul style="list-style-type: none"> Training Models Africa Regional Health Education Center (ARHEC) Tulane/Zaire Program 	<ul style="list-style-type: none"> Z.A. Ademuwagum Erma Wright
	Questions and Discussion	
Noon	L U N C H	
1:30 - 5:00pm	Conceptualization of HEALTHCOM Curriculum/Training	Group
	<ul style="list-style-type: none"> HEALTHCOM Contributions to Date Skills Key Elements Methods Participants Strategies to Institutionalize Academic vs. Applied Approaches 	
	(See Discussion Questions)	
5:00 - 5:30pm	Closure	

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DISCUSSION QUESTIONS

Methodology Development

1. What are the essential elements of the methodology? How can it be refined, "streamlined"; simplified while maintaining quality and impact?



2. What major challenges are presented by the methodology? Which are the more difficult elements to implement, teach, monitor, evaluate?
3. Can/should HEALTHCOM use other methodological concepts?
4. What skills are key to implementing the methodology? Is the methodology truly transferable?

C. Evaluation

1. What is the relationship of summative to formative evaluation? Can/Should HEALTHCOM shift from outcome to process focus? What is the nature and implication of such a shift?

2. Are other outcome measures more appropriate than those now used? (eg. case fatality rates vs. behavior change).

3. What level of evaluation capacity should HEALTHCOM try to institutionalize in its country sites? How can this best be accomplished?

4. What methods of data collection are most affordable and easily taught?

5. How can HEALTHCOM improve the systematic monitoring of communication interventions? What indicators and methods should be highest priority?

D. Sustainability and Institutionalization

1. What is the difference between the two? (Definitions)

2. What is most important to institutionalize?

3. What models can we look to?

4. How do we measure success? What are indicators?

public sector > < health education system
private sector > < individual and community

5. How can HEALTHCOM strengthen the commitment of host governments to permanent health communication programs?

Should HEALTHCOM develop "conditions precedent" so institutionalization begins with project start-up? If so, what should these conditions be?

6. What kinds of collaboration contribute to institutionalization? (e.g. non-governmental organizations, private sector) How can we facilitate greater cooperative action?

Please note:

Questions concerning Training as it relates to institutionalization will be discussed on Day 3.)

5. What strategies should be used to institutionalize HEALTHCOM training? How can sustainability be ensured?

6. Are several "tracks" necessary?

- Formal
- Non-Formal
- Informal

7. What are the next steps to operationalize HEALTHCOM training objectives?