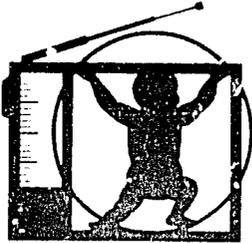


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ISA 70894



Communication for Child Survival
HEALTHCOM

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

SUMMARY REPORT

HEALTHCOM Faculty Workshop

July 11-15, 1988

PN-A13A-653

HEALTHCOM FACULTY WORKSHOP

July 11-15, 1988

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Questionnaire

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I. PURPOSE AND RATIONALE

In accordance with the diffusion mandate in the HEALTHCOM Project contract, a U.S.-based Faculty Workshop of five days duration took place at the Academy for Educational Development in Washington, D.C., July 11 - 15, 1988.

The purpose of the workshop was to bring together senior faculty members of schools of public health both in the U.S. and in LDCs, who, because of their expertise in a discipline relevant to public health communication, could contribute intellectually and practically while learning about a methodology which embraces social marketing, behavior analysis, and anthropology.

The process of selecting participants began with suggestions solicited from various experts involved in the HEALTHCOM Project as managers, collaborators, and subcontractors. In order to develop a "short list," personal interviews were conducted by telephone, and prospective participants were asked to submit CVs and to complete a brief questionnaire aimed at determining their personal and institutional level of involvement in teaching subjects related to public health communication. Consultantships in developing countries were also a factor in selection. Balance was sought between the U.S. and LDC participation.

In order to plan and implement a curriculum for the workshop which would be relevant to the participants and meet the objectives established by HEALTHCOM, a consultant, Dr. Vicki Freimuth of the University of Maryland, Department of Communication Arts and Theatre, was brought in. Experienced both as a senior faculty member and as a development communication consultant specializing in research and evaluation design, Dr. Freimuth worked closely with HEALTHCOM senior staff and with the A.I.D. Project Manager throughout to ensure that the workshop was on target.

The participant selection process resulted in invitations being issued to representatives from the following institutions: Harvard University, Johns Hopkins University, University of North Carolina, Tulane University, UCLA, University of Kinshasa (Zaire), University of Ibadan (Nigeria), University of Jakarta, Asian Institute of Management, and a representative of the Ministry of Health in Brazil, who also teaches at a school of public health. Unfortunately, last minute attrition resulted in the absence of participants from Nigeria, University of Jakarta, Indonesia, and Brazil. A complete list of participants appears in the appendix to this report.

Throughout the planning of the workshop, the notion of a participatory seminar was paramount. It was recognized that participants had a strong set of ideas and experiences to contribute while at the same time learning about the HEALTHCOM methodology. It was determined that each participant would make a case study presentation during the course of the week, and that to the extent possible, presentations by HEALTHCOM and its subcontractors would be engaging, openly encouraging critical comment and thinking. It was also felt that given the level of experience of participants, an approach or structure based on disciplines rather than on process was appropriate to the workshop. Each attendant represented a discipline that clearly contributes to the methodology employed by HEALTHCOM and it was a critical component that while perhaps not fully embracing each other's approach, participants were for the most part positively disposed to the HEALTHCOM methodology, and visa versa. Throughout the planning phase, two questions were continually addressed: How could the material be presented in a way that would engender "creative tension" without creating hostility; and, What could HEALTHCOM offer participants that would be useful and beneficial to them, and to a continuing partnership?

The integrated and participatory structure of the workshop was an attempt to address the former question. Towards the latter, a comprehensive and impressive set of teaching tools was assembled as a handout for use in the classroom. These materials included slides used in presentations during the week, a 12-minute videotape of actual HEALTHCOM broadcast messages from several countries, the newly produced manual, Communication for Child Survival, and a set of various other print materials.

II. OBJECTIVES

The workshop had three clear objectives:

- 1) to integrate the HEALTHCOM methodology into existing or new curricula;
- 2) to develop models for linkages between U.S. and LDC-based institutions;
- 3) to move forward training goals by preliminary planning of regional workshops based on the model presented here.

The first objective was clearly met. Almost unanimously, participants reported in their evaluations (see below) that they planned to incorporate what they had learned into classes they were teaching or designing. The material given as handouts were highly rated, perceived in many cases as the most valuable aspect of the workshop.

A solid beginning was made towards meeting the second objective. A positive group dynamic quickly developed among participants, and it seemed clear at the close that professional linkages spawned at the workshop would continue. Beyond that, each participant eagerly agreed to remain involved with the HEALTHCOM Project in a meaningful way. This involvement might mean participation in a TAG meeting, further involvement in developing regional training workshops, or providing technical assistance on request.

A fruitful discussion was held in relation to the third objective of designing regional workshops. This discussion is summarized below.

III. THE AGENDA AND ITS COMPONENTS

The workshop began on Monday, July 11, with welcoming remarks by Project Director, Mark Rasmuson. Each participant introduced him or herself, presenting a brief "biodata".

Robert Clay, A.I.D. Project Monitor from the Office of Health, then discussed HEALTHCOM from A.I.D.'s perspective. He pointed out that USAID began to support communication projects when it saw that a set of systematic problems existed with respect to health in the developing world that required active outreach in order to affect change. The primary health care approach endorsed at the Alma Ata Conference in 1978 has led health care professionals to look at people's basic needs and to explore how to capture or harness what the social sciences have to offer. HEALTHCOM's forerunner, The Mass Media and Health Practices Project, or MMHP, demonstrated A.I.D.'s willingness to take risks in supporting the idea that communication is a viable part of primary health care, and USAID continues to experience this learning process. Some of the challenges facing all of us, despite the proven success of the public health communication approach, include the fact that "long term" requires a commitment beyond the two or three year period of technical assistance originally envisaged; integration of agencies, programs, disciplines, etc. is critical and remains difficult; sustainability or institutionalization is ever a difficult objective to ensure and measure. Critical questions must be asked and reassessed. For example, Are we reaching the right target audience? Why does behavior remain unchanged despite new knowledge? What technical information should messages impart?

Mark Rasmuson followed this introduction with an overview of the public health communication methodology practiced by HEALTHCOM. After a brief historical review,

a statement of objectives, and an "introduction" to the four project subcontractors, Rasmuson proceeded to share, through narrative and slides, the work of MMHP and HEALTHCOM in Honduras and The Gambia as illustrative of our programmatic approach. He defined public health communication as "the systematic attempt to positively influence the health practices of large populations, using principles and methods of behavior analysis, medical anthropology, social marketing, and mass communication." The role of public health communication in child survival, he pointed out, is to create demand, teach appropriate use, and strengthen supply. A variety of research and development issues present themselves to the public health communication professional. At the macro level, one needs to ask how best to structure communication programs to support national child survival efforts, and at the micro level, how best to refine and apply our knowledge and technologies of behavior change. MMHP and HEALTHCOM have taught a number of lessons on applying the methodology and answering some of the critical questions.

Following this overview, Dr. Richard Brown asked that the group consider three important relationships:

- 1.) individual behavior and its impact on health status;
- 2.) environmental influences on health behavior which impacts health status;
- 3.) environmental influences which directly impact health status.

Dr. Brown suggested that the first of these traditionally receives the most emphasis, and that perhaps we need to pay greater attention to the physical and social environment as "root causes." He asked that we examine the primary health care (PHC) approach as compared to the child survival (CS) approach, and explore what the appropriate relationship of one to the other is. Child Survival Programs, he felt, are often over-reliant on external technical assistance, rely on vertical interventions, and prove difficult to sustain over time. Advocating a community organizing or community participation approach, which is mindful of resources and political ramifications, Dr. Brown suggested that sustainability can be increased through educational initiatives that raise awareness of these broad and deep issues.

On the afternoon of the first day, three case studies were presented by the participants. Cecilia Verzosa, HEALTHCOM Country Project Manager for the Philippines and Papua New Guinea, presented on the measles campaign in the Philippines, emphasizing that messages were research driven. Erma Wright, of Tulane University,

described training challenges presented by an attempt to transfer lessons learned in three African countries to a health promotion program in three southern states in the U.S. Finally, Francisco Roman, of the Asian Institute of Management, discussed the role of the research user, exploring how program managers can use the results of market research.

The second day of the workshop was devoted to principles and applications of qualitative research. Porter/Novelli, a public relations firm and subcontractor to the HEALTHCOM Project for formative research and creative strategies, took responsibility for explaining audience segmentation, exploring the role and process of focus groups aimed at concept development, and assessing other methods of exploratory qualitative research. Rob Gould, Senior Vice President at Porter/Novelli, using a case study example involving a health education campaign in the U.S. directed at lowering cholesterol, led the participants through a set of exercises including a mock focus group. Michael Ramah, also Vice President at Porter/Novelli, led the group in a discussion of message testing, and through slide presentations, presented the launching of a new ORS product in Mexico as a case study. Presenting as Luncheon Speaker, Porter/Novelli's Senior Vice President, Merrill Rose, spoke on the "Guidelines for Creative Excellence," using U.S.-based commercials as examples. She stressed the importance of agreeing to a strategy statement with the "client."

Two case studies were presented on Tuesday afternoon. Dr. Eugenia Eng, of the University of North Carolina at Chapel Hill, presented outcomes from training health workers to conduct focus groups in the West African country of Togo. Two unanticipated outcomes were observed: "First, the focus group method forced health workers out of exclusive adherence to the helpless villager and learner roles. Second, by stimulating this 'role shift,' focus group findings added legitimacy to the notion of community competence, thereby enhancing the opportunity for collaborative program planning between health workers and target villages." Despite this positive outcome, Dr. Eng raised a critical question: Should health workers be expected to do research (i.e., is that an appropriate expectation)?

Dr. Debra Roter, of Johns Hopkins University, presented a case study on a photonovella developed in Baltimore using a community participation approach. Union construction workers designed and produced the photonovella, which discusses asbestos risks. Roter reported that the workers' sense of self-confidence and competence was enhanced by their participation in the project. Client produced materials reaffirm for the target audience that they know (i.e., are "expert"), and can inform and guide their peers.

Wednesday morning's activities built on the presentations by Porter/Novelli. Acting as the "Creative Department," the group designed a creative strategy for the cholesterol campaign discussed on Tuesday.

After the group presented their strategy and rationale, Gould shared with the group the actual TV campaign clips. The group was amazed and gratified to see many of its creative strategies had actually been employed!

Wednesday afternoon was dedicated to an introduction and discussion of the role of behavior analysis within the HEALTHCOM methodology. Presented by Drs. Judith Graeff, HEALTHCOM's Behavior Task Force Director, and John Elder, of San Diego State University, the presentations looked at principles of behavior analysis for health promotion and implications for programmatic research. Antecedents and consequences of behavior were defined, and Dr. Graeff pointed out that consequences are of prime importance in the HEALTHCOM methodology. Intervention phases and target levels were outlined by Dr. Graeff (see Fig. 1). Behavior inputs to materials development were illustrated through a discussion of print materials from Honduras, Nigeria, and Ecuador. Key terms such as behavioral excess, behavioral deficit, and behavioral asset (Fig. 2) were defined. Methodologies for behavior research were outlined including ABC Recording (keeping a record of antecedent/behavior/consequence); Direct Observation; and Time Series Design (taking measures over time, with possible multiple base-line studies). Following a role play exercise, in which a health worker's behavior was simulated and analyzed, Dr. Elder discussed integrating behavioral research into a health promotion curriculum, using the course offerings at San Diego State University as an example (see Fig. 3 & 4).

On Thursday morning, Dr. Stan Yoder, a medical anthropologist from the Annenberg School of Communications in Philadelphia (one of HEALTHCOM's four subcontractors, with responsibility for evaluation), presented on the uses of ethnomedical research for formative purposes. Drawing on his experience with HEALTHCOM in Nigeria and Lesotho, Dr. Yoder discussed development of salient survey instruments, including questionnaire design. Cultural implications and the relevance of certain beliefs were explored.

Following Dr. Yoder's presentation, Dr. Vicki Freimuth, of the University of Maryland's Department of Theatre Arts & Communication, presented a case study on evaluating educational radio in Swaziland. Based on a consultancy for HEALTHCOM conducted in 1986 to evaluate the use of school-based radio messages designed to target children as change agents in the home, Dr. Freimuth asked the group to address key

INTERVENTION PHASES AND TARGET LEVELS

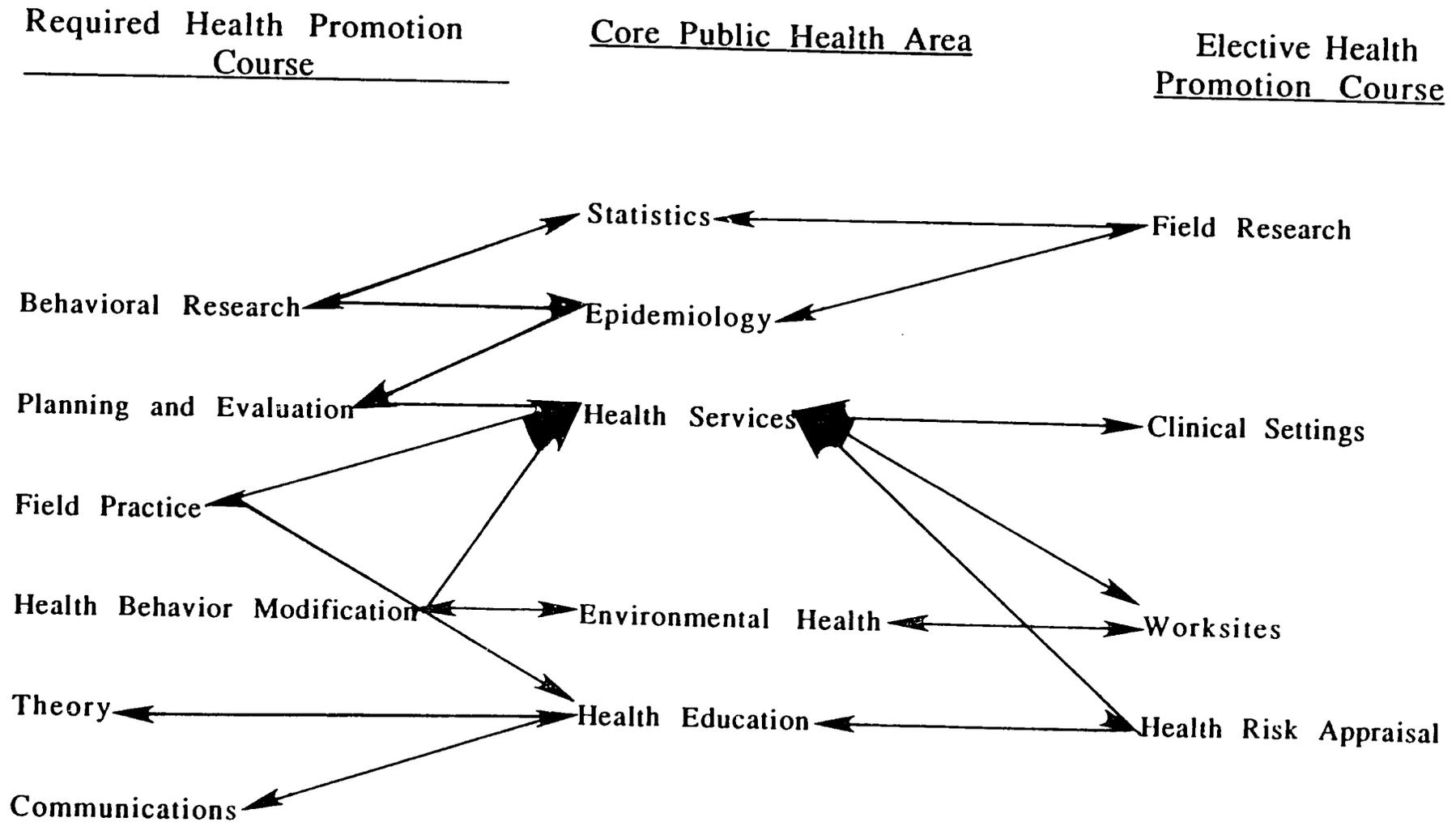
LEVEL \ PHASE	PROMOTION	BEHAVIOR CHANGE	MAINTENANCE/ GENERALIZATION
INDIVIDUAL			
SOCIAL NETWORK (e.g., family, peers)			
ORGANIZATION (e.g., school, health prof.)			
COMMUNITY/REGIONAL			

Figure 1

- A. Behavioral excess. A class of related behaviors occurs described as problematic by the client or an informant because of excess in 1) frequency, 2) intensity, 3) duration, or 4) occurrence in inappropriate situations. Smoking, drinking polluted water, or having unprotected sex are examples of behavioral excesses along one or another of these dimensions.
- B. Behavioral deficit. A class of responses is described as problematic by someone because it fails to occur (1) with sufficient frequency, (2) with adequate intensity, (3) in appropriate form, or (4) under socially expected situations. Examples are reduced social responsiveness, fatigue, and other restrictions in function. Examples of behavioral deficits can include inadequate breastfeeding, poor clinic attendance, or non-recognition of life-threatening illnesses.
- C. Behavioral asset. Behavioral assets are nonproblematic behaviors. What does the client do well? What are his/her adequate social behaviors? What resources does the community have? Any segment of a person's activities can be used as an arena for building up new behaviors. In fact, work and community activities provide a better starting point for behavior change than can be provided in a clinical setting. For example, an ill person who resides in a neighborhood with several motivated and health-oriented residents can be linked with them to insure appropriate compliance to a treatment regimen (2).

Figure 2

INTEGRATION OF HEALTH PROMOTION CURRICULUM INTO PUBLIC HEALTH CURRICULUM AT SAN DIEGO STATE UNIVERSITY



-6c-

Figure 3

BREAK-DOWN OF HEALTH
PROMOTION COURSE CONTENT
SAN DIEGO STATE UNIVERSITY

<u>Health Promotion Course Title</u>	<u>Subject Matter</u>
1. Behavioral Research	1a. direct observation b. reversal designs c. "a-b-c" measurements
2. Theory	2a. operant b. social learning c. communications-persuasion
3. Health Behavior Modification	3a. relationship between health and behavior b. contingency management c. levels of intervention

Figure 4

questions regarding the evaluation design (e.g., What questions need to be answered by the evaluation? What research design should be used? What measurement instruments are needed? What problems can be anticipated)?

Dr. Steven Gortmaker, of Harvard University, then addressed the group on evaluation issues. His critique of the HEALTHCOM evaluation methodology and design pointed out that in the cases of Honduras and The Gambia, no control group existed in the pure research sense. He questioned what outcome measures were really telling us, and pointed to the difficulties with mortality data in terms of assessing the impact of other variables. He noted the absence of a critical review of the clinical literature and challenged HEALTHCOM to think about the way we collect certain data, and what to do with it. He suggested that much of the evaluation was client-driven and that the questions he raised had serious implications for child survival programs and their objectives.

Due to unexpected circumstances necessitating the absence of several workshop participants on the final day of the workshop, Friday's agenda was moved to the lunch period on Thursday. At this time, the group was asked to consider three key questions: 1) How might the HEALTHCOM Project experience be incorporated into your teaching? What can HEALTHCOM do to help? 2) How can you be involved in the work of HEALTHCOM in the future, both individually and institutionally? and 3) How can we best improve health communication capacities in countries in which HEALTHCOM works?

The discussion began with several participants underscoring the necessity of training policymakers as well as program managers and health care service deliverers. It is important, they pointed out, for policymakers to be "sold" on communication concepts and methodologies that they can move beyond epidemiological perspectives.

Dr. Kiyombo Mbela, of the University of Kinshasha shared the structure of a training program at the University of Zaire, which offers a minimal course curricula with an epidemiological emphasis. Eng shared what UNC is doing in collaboration with the University of Ibadan (Nigeria). There, a short course has been developed for health educators and program managers from the English-speaking Combatting Communicable Childhood Diseases (CCCD) countries. The course emphasizes team development, a proactive vs. a reactive approach, and behavioral indicators of changes in health practices. The course is now being offered for the second time, and a third iteration is planned. Eng reported that it has resulted in a greater understanding of health communication and an improved sense of the competence of communication professionals. Mechanisms for follow up and feedback include telephone calls at six

weeks, and visits at six months (although participants have requested that these be reversed).

Much of the remainder of this working session focused on research and evaluation skills, and what we should be imparting in that area to counterparts and others. Eng reported on a project in Togo in which a pilot village was selected to teach how to gather and use data. Yoder questioned whether people realize the value of reporting, and gathering data, and Rasmuson countered that in his experience, the power of research quickly enticed people who appreciated where it could take them. Hornik stressed that without an institutional location, R & E loses momentum. He then questioned whether Health Education Units were an appropriate "home" for these efforts. No matter where R & E efforts are housed, a socialization process is needed. Issues related to institutionalization and sustainability were also raised (e.g., Are counterpart agencies equipped to continue after a project like HEALTHCOM leaves? What is level of consciousness and commitment on part of decisionmakers)?

Following this general discussion, Verzosa, Shaw, and Roman shared with the group a training design they had devised for possible implementation regionally. The objectives of this would be 1) to reinforce and share with HEALTHCOM counterparts; and 2) to build on the HEALTHCOM experience and to share with colleagues in other countries--to "lead to a higher level of consciousness." Roman suggested a subtheme which would enhance communication through the use of micro-computers. The group then shared some key questions and modules for training which rely on both lecture and case study for explaining the HEALTHCOM methodology (See Fig. 5-7).

Some of the participants felt that regional workshops might be too ambitious a goal, at least at this stage, and that they might be better deferred until "HEALTHCOM II." For methodology institutionalization purposes it was suggested training needs to be done in each particular country. Later, this could be extrapolated to new countries. Two types of workshops were outlined therefore:

- 1) Methodology training--one country at a time
- 2) Regional workshops to share experiences

Following this fruitful discussion, evaluation issues were once again taken up with Dr. Robert Hornik of the Annenberg School using his experience with HEALTHCOM in Swaziland to illustrate approaches to summative evaluation. Before this, however, he presented a framework for considering what research questions help operating projects.

REGIONAL WORKSHOP DISCUSSION GUIDE QUESTIONS

WHAT IS TRAINING OBJECTIVE?

- a. Technical skills
- b. Selling communications programs to policy-makers?

WHO WILL BE TRAINED?

- a. Policy-makers
- b. HEALTHCOM counterparts in DOH and NGO/Private sector

WHAT IS TRAINING CONTENT?

- a. If technical skills
- b. If policy-maker oriented

Fig. 5

TRAINING CONTENT

CDD

EPI

ARI

COMMUNICATION PLANNING

Using research data
for developing a
communication strategy

MATERIALS DEVELOPMENT & PRETEST

TRAINING OF PUBLIC/PRIVATE SECTOR PROMOTERS

DEVELOPING THE MEDIA PLAN & BUYING MEDIA

TRACKING MESSAGE DIFFUSION & BEHAVIOR CHANGE

SUMMATIVE EVALUATION

-8b-

Fig. 6

	PLANNING	MATERIALS	EXECUTION	TRAINING	SUMMATION	
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	
CDD	PLANNING PROCESS	RESEARCH METHODS & ROLE	PRODUCT DESIGN & DEVELOPMENT	APPROPRIATE TECHNICAL MODES	CDD REVISED ACTION PLAN	<u>LECTURE</u> 9:00 - 10:00 <u>CASE STUDY</u> 10:15 - 11:15
EPI	COMMUNICATIONS STRATEGY	MATERIALS & COMMUNICATION MATCH/FIT	MEDIA MIX PLAN	INTERPERSONAL SKILLS	EPI REVISED ACTION PLAN	<u>LECTURE</u> 11:30 - 12:30 <u>CASE STUDY</u> 2:00 - 3:00
-8C- ARI	IMPLEMENTATION & EVALUATION	FOLLOW-UP CONTINUITY SUSTAINABILITY	LOGISTICS & DISTRIBUTION GAME	PROGRAM DESIGN	ARI REVISED ACTION PLAN	<u>LECTURE</u> 3:15 - 4:15 <u>CASE STUDY</u> 4:30 - 5:30
NING ARKS				GRADUATION **		

** WORKSHOP MODE
1st session presentation
2nd session presentation

Fig. 7

In thinking about process evaluation, he pointed out, we need to face the question: Does evaluation have any purpose? How might it be more productive? The question usually asked is: Did it work? This may not really give us useful information. There are always political sensitivities to the question, and from a reality perspective, one can say that a project that worked politically worked. We are not always answering the question on technical grounds. Dr. Hornik stated that we need to be able to tell people what to do next. The question might more reasonably be: Why didn't something work? We need to be realistic with operational designs which, Dr. Hornik pointed out, are "often set in political stone." The question, therefore, becomes what useful evaluation can be done? What questions are there? Here, it is critically important that the evaluator understand how the project is to work and what the political climate is. Therefore, a strategy must be developed which helps to clarify this.

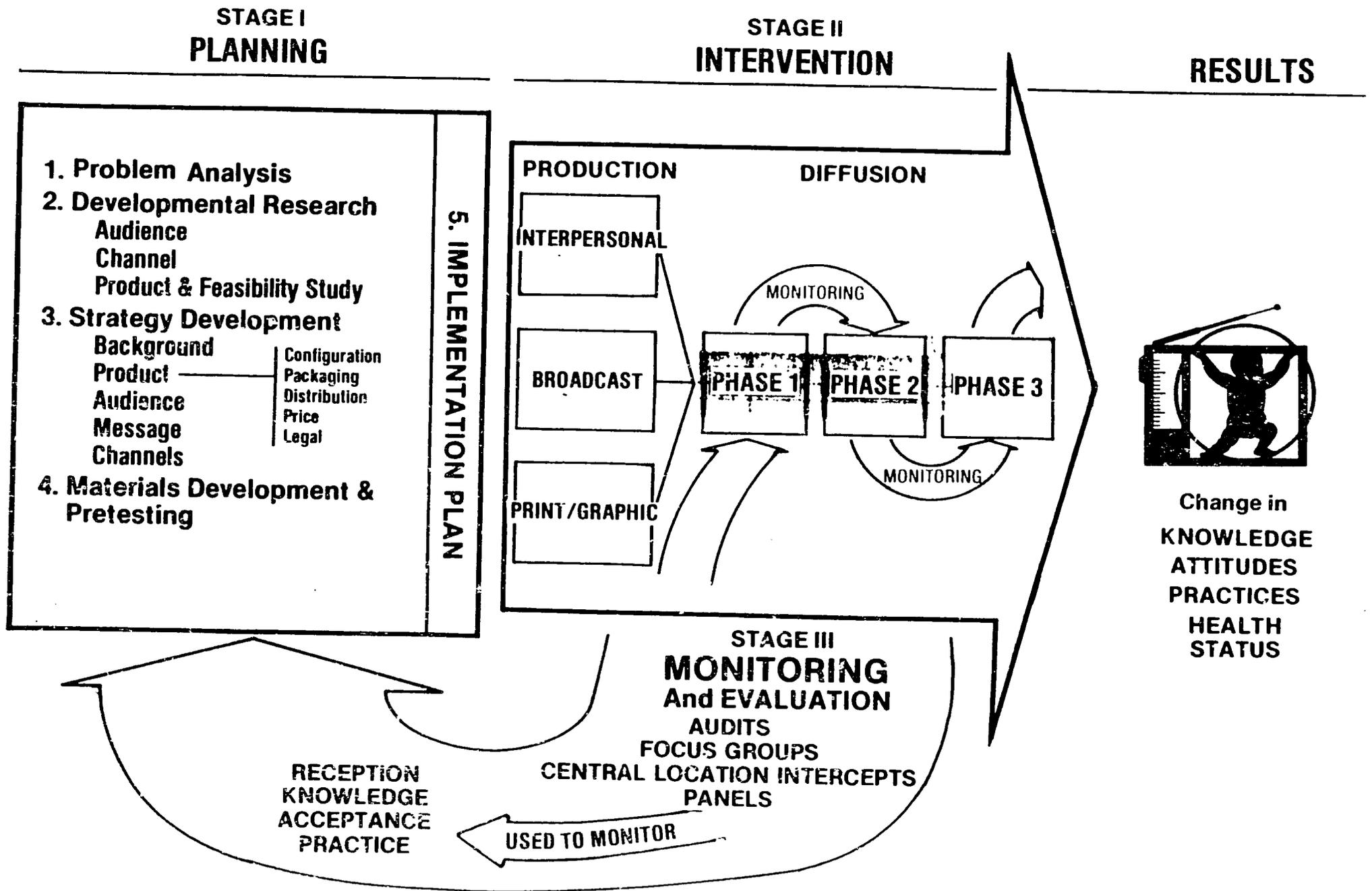
In terms of the logic behind how to ask questions, two models must be kept in mind: 1) the conceptual model, which helps us to examine what assumptions are being made, and 2) the operational model, which assists in planning the research for a formative or process evaluation. This model involves both monitoring and verification questions. Key to the evaluator's thinking are the questions: Is it working? What has to change? One wants to emphasize answers which affect what is happening, or what Dr. Hornik described as "gaining leverage" vs. "knowing absolute truth." Evaluators must also be mindful of whether enough resources exist, and what action might be taken on the basis of research.

Another point raised by Dr. Hornik was when is enough enough? Every design has challenges. The key point is whether or not a design is "tight enough" not to be challenged. This may be difficult when the donor "expects a cadillac" and the counterpart says "Why bother?"

Following a stimulating discussion of these evaluation issues, Dr. Mbela presented a case study on a poster campaign on Shistosomiasis in Zaïre, pointing out research difficulties and problems.

Mark Rasmuson then brought the Faculty Seminar to a close with a summary of the HEALTHCOM methodology and its component parts (see Fig. 8), drawing together the segments of the workshop into a cohesive whole. He thanked all participants and applauded their individual and collective contributions to the workshop, and stated HEALTHCOM's commitment to continued interaction with the group, individually and institutionally, towards future collaboration.

THE HEALTH COMMUNICATIONS PROCESS



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Fig. 8

The workshop formally came to a close with dinner for all participants on Thursday evening.

IV. ISSUES

Several key issues emerged during the course of the workshop. These are summarized below.

1. Training. It is critical that training be followed up with relevant activity which supports the continuation of acquired skills. Training is a key element to sustainability. It must be applied at the field level, and it must include the training of policymakers. Supervision and monitoring are vital. Incentives towards continued performance should be explored (e.g., recognition, respite, remuneration).
2. Primary Health Care vs. Child Survival Strategies. What is the relationship of CS to PHC? Are they appropriately integrated, i.e., Does CS constitute a subset of PHC, or has it been "extracted" as a quick fix approach? Particularly with respect to behavior change, has enough attention been paid to environmental influences? What are the implications of this relationship to research and evaluation issues?
3. Related to the PHC/CS issue is the issue of Community Participation with respect to program planning, implementation, materials development, and other aspects of the methodology. Is enough attention paid to this approach or has it been overlooked in the interest of change agent objectives? How can/should this perspective be addressed by the HEALTHCOM methodology?
4. Integration of Disciplines. Is this occurring appropriately, or are we tending to function vertically and therefore redundantly? How are the various disciplines contributing to the whole methodology of HEALTHCOM vs. duplicating for rhetorical reasons? On a larger scale, how far can communication go in contributing to the totality of child survival interventions?
5. Institutionalization/Sustainability. Where are we falling short? How can communication contribute more? What are the obstacles and how can we contribute towards overcoming them?

6. Research and Evaluation. Should we be concerned only with evaluating communication effects of a social marketing effort, or are we necessarily drawn into the epidemiological evaluation? Process measures need to explain and account for difficulties in interventions. Studies are needed on larger issues regarding effectiveness. Mortality appears to be dropping; the difficulty is to know why. We need to be mindful of the environmental influences affecting data. In the larger realm, does research serve its intended purpose? Are there other ways to evaluate that are less expensive, time-consuming? What are our training obligations? Who owns the data?

These six key issues emerged in a variety of forms and discussions throughout the entire workshop. They represent, in synopsis, the major concerns and viewpoints of the group, and clearly present or illuminate a series of challenges for HEALTHCOM as it continues to refine its methodology.

V. WORKSHOP EVALUATION

All participants rated the workshop good to excellent. These terms were particularly applied to the following categories:

- Usefulness of topics presented
- Organization of workshop
- Materials provided in workshop
- Case studies by participants
- Relevance of topics to your work
- Presentations by HEALTHCOM staff

Major strengths of the workshop were perceived to be the quality and expertise of the participants and staff; the openness of HEALTHCOM to critical analysis; diversity of topics; generosity of handouts; useful case studies; and personalities of participants.

Weaknesses were seen to include that objectives did not necessarily guide workshop; more integration of disciplines was needed; HEALTHCOM presentations should have "stretched" participants more rather than rely on description; more time to discuss/interact would have been welcomed.

All participants indicated that they planned to incorporate workshop experiences and materials into their own teaching. This ranged from the development of new courses/new course materials to the sharing of information with colleagues.

Suggestions for changes should the workshop be repeated included planning for four rather than five days; less emphasis on marketing; a summation plenary with all speakers available; the use of a single case study in which all disciplines could be demonstrated in a cohesive manner; increase time for discussion and interaction; include more developing country people; allow for small discussion groups to deal with issues in-depth; more discussion on how to incorporate lessons learned into curricula.

In summary, based on written evaluations, and informal feedback from the group during the workshop, it is clear that the Faculty Workshop received extremely high grades and was viewed as valuable and intellectually stimulating to all who participated.

VI. **IMPLICATIONS FOR FUTURE TRAINING AND TECHNICAL ASSISTANCE**

A. Training.

In designing the Faculty Workshop, HEALTHCOM clearly envisaged that it would serve as a forerunner to continued training efforts aimed at diffusing knowledge about health communication both in the U.S. and abroad. Towards this objective, linkages between U.S. and third world academic institutions will be most important. A regional emphasis on further HEALTHCOM training initiatives was seen as appropriate in order to ensure that information shared is salient. In addition to supporting academic endeavors, HEALTHCOM also hopes to impart new knowledge to policymakers and program implementers. Again, applied as well as didactic instruction will be important.

For all of these reasons, the group assembled for the workshop was carefully chosen on the basis of teaching and consulting experience, existing or potential linkages to LDC programs and schools, and areas of expertise. The group proved to be outstanding in its ability to contribute to HEALTHCOM's training objectives. The level of interest and intellect demonstrated during the course of the workshop was impressive. HEALTHCOM found the experiences of the group to be not only germane, but stimulating within the context of creative criticism. It is envisaged, therefore, that individually and institutionally, workshop participants will be able to work with HEALTHCOM in designing and delivering further training, whether regionally or locally.

As HEALTHCOM continues to develop its training plans, it will be calling on the talents of those present at the workshop to contribute conceptually and practically towards those efforts.

B. Technical Assistance.

Once again, both individually and institutionally, participants are highly qualified to contribute to HEALTHCOM's work around the world. This might be demonstrated within the context of Technical Advisory Group (TAG) meetings, as in-country consultants, or in the conceptual refinement of an ever-evolving methodology.

HEALTHCOM looks forward to continued liaison with all the participants of this Faculty Workshop, and is grateful for the contribution each of them has already made.

VII. APPENDIX

Participant List

Questionnaire

Agenda

APPENDIX A

HEALTHCOM Faculty Workshop, July 11-15, 1988

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APPENDIX B

To help us plan the Workshop on Public Health Communication, please answer the following questions and return the questionnaire, along with the requested materials by May 15.

1. HOW MANY GRADUATE STUDENTS (Master's degree and Ph.D.) ARE ENROLLED IN YOUR SCHOOL OF PUBLIC HEALTH?

2. APPROXIMATELY WHAT PERCENTAGE OF THESE STUDENTS HAVE AN INTERNATIONAL EMPHASIS IN THEIR PROGRAM OF STUDY?

_____ %

3. WHICH OF THE FOLLOWING DISCIPLINES ARE INCLUDED IN HEALTH EDUCATION COURSES OFFERED IN YOUR PROGRAM? WHICH DO YOU TEACH?

OFFER TEACH

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | behavior analysis |
| <input type="checkbox"/> | <input type="checkbox"/> | community development |
| <input type="checkbox"/> | <input type="checkbox"/> | social marketing |
| <input type="checkbox"/> | <input type="checkbox"/> | planning/management |
| <input type="checkbox"/> | <input type="checkbox"/> | community diagnosis |

OFFER TEACH

- | | | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | formative evaluation |
| <input type="checkbox"/> | <input type="checkbox"/> | summative evaluation |
| <input type="checkbox"/> | <input type="checkbox"/> | medical anthropology |
| <input type="checkbox"/> | <input type="checkbox"/> | mass communication |

PLEASE LIST COURSE TITLES OF THESE OFFERINGS: _____

4. HAS YOUR SCHOOL OF PUBLIC HEALTH ESTABLISHED ANY JOINT PROJECTS OR VENTURES WITH FOREIGN INSTITUTIONS OF HIGHER LEARNING? PLEASE LIST BRIEFLY THOSE WITH WHICH YOU ARE FAMILIAR.

5. WHAT PERCENTAGE OF YOUR OWN PROFESSIONAL ACTIVITIES FOCUSES ON THIRD WORLD HEALTH PROJECTS?

_____ %

Academy for
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AGENDA
FACULTY WORKSHOP
July 11-15, 1988

Monday-July 11

9:30 a.m.	Welcome & Introductions	Mark Rasmuson
10:00 a.m.	The A.I.D. Perspective	Robert Clay
10:30 a.m.	Overview of Public Health Communication Methodology	Mark Rasmuson
11:30 a.m.	Strengths & Weaknesses of Methodology	E. Richard Brown
12:00 noon	Discussion	
12:30 p.m.	LUNCH (On your own)	
2:00 p.m.	Case Studies (Each case study will be 20 minutes long, followed by a 10 minute discussion period.)	
2:00-2:30 p.m.	The Measles Campaign in the Philippines	Cecilia Verzosa
2:30-3:00 p.m.	Training Challenges	Erma Wright
3:00-3:15 p.m.	Break	
3:15-3:45 p.m.	The Role of Market Research	Francisco Roman

3:45-4:15 p.m. Discussion

5:30 p.m. RECEPTION (Main Conference Room, Suite 400)

Tuesday-July 12

9:00-9:15 a.m. Introduction Michael Ramah

9:15-10:45 a.m. Feeding the Creative Fire: Segmentation and Concept Exploration Rob Gould

10:45-11:00 a.m. Break

11:00-12:20 p.m. How Hot Did the Fire Get? Execution Testing Case Study: Package Design in Mexico Exploratory Qualitative Research Michael Ramah

12:30 p.m. BUFFET LUNCH

1:00-2:30 p.m. Luncheon Speaker "Guidelines for Creative Excellence" Merrill Rose

2:30-4:30 p.m. Case Studies Outcomes from Training Health Workers to Conduct Focus Groups Eugenia Eng
The Photonovella Debra Roter

Wednesday-July 13

9:00-10:30 a.m. Small Group Practicum on Creative Creative Strategies Rob Gould

10:45-12:30 p.m. Presentation of Creative Strategies

Ad

12:30 p.m.	LUNCH (on your own)	
2:00-2:15 p.m.	Health Behaviors: A Behavioral Psychology Perspective	Judy Graeff John Elder
2:15-3:00 p.m.	Principles of Behavior Analysis for Health Promotion	Judy Graeff John Elder
3:00-3:45 p.m.	Implications for Programmatic Research Types of Questions to Ask Research Design and Selection of Dependent Variables Methodology and Results - The Programmatic Fit	Judy Graeff John Elder
3:45-4:00 p.m.	Break	
4:00-4:30 p.m.	Case Study Exercise	
4:30-5:15 p.m.	Integrating Behavioral Research Into a Health Promotion Curriculum	John Elder Judy Graeff
5:15-5:30 p.m.	Discussion	
<u>Thursday-July 14</u>		
9:00-11:00 a.m.	Doing Ethnomedical Research for Formative Purposes	Stan Yoder
11:00-11:15 a.m.	Break	
11:15-12:15 p.m.	Case Studies	
	Evaluating Educational Radio in Swaziland	Vicki Freimuth
	Evaluation Issues	Steven Gortmaker

12:30 p.m.	BOX LUNCH	
2:00-3:15 p.m.	Choosing Research Questions To Help Operating Projects	Bob Hornik
3:15-3:30 p.m.	Break	
3:30-4:30 p.m.	Summative Evaluation: Examples and Approaches	Bob Hornik
4:30-5:00 p.m.	Effectiveness of Poster Campaigns	Kiyombo Mbela
7:30 p.m.	DINNER Delegate Room Embassy Suites Hotel 1250 22nd Street, N.W.	
<u>Friday-July 15</u>	Blue Conference Room, Suite 440	
9:00-10:30 am	Planning for Regional Workshops	Three Groups - Facilitators: Diane Urban - L.A. Mark Rasmuson - Africa Coby Verzosa - Asia
10:30-11:30 am	Presentation of Proposed Plans	
11:30-1:00 pm	Discussion and Summary	Mark Rasmuson
1:00 p.m.	CLOSING	