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FIELD NOTE

**The Learning Community:
a Tool for Institutionalizing
a Public Health Communication Methodology**

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"Men are never so likely to settle a question rightly as when they discuss it freely." Lord Macaulay.

It is six o'clock in the improvised building of the Health Education Division of the Honduran Ministry of Health and we can still hear voices coming from the end of the hall. An ongoing debate has taken place after work during the last few evenings about how to plan and carry out the communication strategy in support of the Acute Respiratory Infection Program. According to group members, these discussions are more fruitful after the daytime interruptions of meetings, phone calls, and visitors have ended. Difficult decisions in terms of content, behavioral objectives, messages, and personnel training need to be made in order to speak to mothers' perceptions and, at the same time, address the Ministry ARI norms. The discussion is animated but cordial. Innovative and even daring ideas emerge from each one of the seven professionals sitting casually around a table full of research reports, computer worksheets, coffee, and doughnuts.

The staff members of the Health Education Division of the Honduras Ministry of Health have undergone a kind of metamorphosis since 1985 when debate or discussion might easily have ended up in a polarization of views. At that time, team work was a rarity; individuals held onto their fixed opinions about various communication issues. Agreement and decision making by consensus was almost impossible. It is true that these professionals now have new technical skills in designing, developing, and implementing communication plans, but, more important, these people have developed the capacity to learn from each other and from their own past experiences in the field. They all have a field background either as promoters, field supervisors, or health education workers. The Ministry has provided them with many institutional skills, but only during the last few years has a "learning community" been created.

The concept of a "learning community" is based on cooperative group interaction and on experiential learning. In Honduras, communication plans for child survival interventions in diarrheal disease control, immunization, and acute respiratory infection have been developed through this approach. Consensus building begins in the earliest planning stages. Once qualitative and quantitative data have been collected, a group of professionals get together among themselves and later with regional health teams to devise communication strategies aimed at modifying behaviors, strengthening existing behaviors, and providing positive reinforcement for practices leading to better health for children under five.

Honduras is the site of HEALTHCOM's longest-running technical assistance program. The Mass Media and Health Practices Project (or MMHP, HEALTHCOM's predecessor) provided support to the Ministry of Health beginning in 1980, and a total of four resident advisors and numerous short-term technical consultants have worked with members of the Ministry's Health Education Division (HED) since that time. The Honduras program offers an unusual chance to look at the evolution of a communication for child survival program over a period of years. This field note looks especially closely at management issues--at the difficult process of transferring technologies to a specific group of people and to a bureaucracy of ever-changing members and shifting priorities. The recognition and cultivation of a "learning community" has been one key to the success, so far, of this "institutionalization" of a communication methodology within the Honduran Ministry of Health.

Background--PROCOMSI I and PROCOMSI II

In 1980 the Honduran Ministry of Health requested assistance from the MMHP Project to support its promotion of a new ORT product. The Ministry had minimal resources to devote to its public health communication project. The Education Division consisted of three people (one physician and two health educators) and the Audio Visual Unit consisted of three people. Funds were scarce for the project, known as PROCOMSI I, or Proyecto de Comunicaciones Masivas. Technical assistance through A.I.D. brought in critically needed funds and staff. The program combined intensive use of print, radio, and interpersonal communication channels to promote LITROSOL, the government's new ORS product in Health Region I. By 1983, 60 percent of rural women interviewed in the region reported using LITROSOL. Mortality associated with diarrhea in children under five dropped from 40 percent to 24 percent in the target region. The PROCOMSI I story has been analyzed extensively in many HEALTHCOM documents.¹⁻³

¹Applied Communication Technology. Summary Report of the Major Findings: the Mass Media and Health Practices Evaluations in Honduras and The Gambia. Stanford: Stanford University, September 1985.

²Baume, Carol. Preliminary Report on the Results from the 1987 Resurvey in Honduras. Menlo Park, CA: Applied Communication Technology, February 1987.

³Mata, Jose Ignacio. ORT PLUS: Combining Themes in Public Health Communication--A Final Report of the Honduras Primary Health Care Communication Project. Tegucigalpa: HEALTHCOM Project, December 1985.

The demonstration of concrete, positive results provided much-needed credibility to the health communication approach. The Ministry of Health saw the value of expanding these activities. At the end of PROCOMSI I, the project staff was incorporated with that of the Health Education Division and the Audio Visual Unit, to create a single health communication office reporting to the director general. Two new positions, radio and graphics specialists, were added to the team. The project was extended to Health Regions II, IV, and VII, and the methodology was applied to a broad new range of interventions including TB and malaria prevention, immunizations, and family planning. The HEALTHCOM Project participated in the transition from PROCOMSI I to PROCOMSI II beginning in 1985.

Under PROCOMSI II, the Division of Education began to function as a minimarketing agency within the Ministry of Health, relating to the technical offices as though they were direct clients. In many ways, the role of health communication has been "institutionalized" within the Ministry. Staff have been increased, the status of the activity has been raised, and the applications to child survival expanded to new areas. How deep, and how permanent, is this "institutionalization"? What have been the most important factors in bringing this about? Is an initial success story--with data to show definite increases in positive behavior and decreases in child mortality--enough? Or are other factors equally or more important? This field note examines some of these questions within the Honduras context.

When Outside Technical and Financial Assistance End

When HEALTHCOM assistance to a ministry ends in any country, a crisis of some proportion is predictable. Behind this crisis may be loss of financing, loss of political support, and many other elements. Within a given bureaucracy, a project is often valued to the extent that it strengthens an institution by concentrating funds, staff, and prestige. Outside funds and technical assistance can legitimize a project for awhile, giving it "artificial" life, but what happens when available funds become scarce or are withdrawn? In many instances, it is not even necessary for technical assistance to have come to an end for a project to pass through a crisis. Many HEALTHCOM programs are located in overburdened or inefficient bureaucracies, and their long-range viability is continuously challenged.

The initial phase of a HEALTHCOM project is especially important. If the methodology is not accepted and adopted in some significant way, later institutionalization is very unlikely. A certain momentum must be generated so that critical processes are begun.

"Success" vs Institutionalization

"The beginning is the most important part of the work." Plato.

It is possible to execute virtually any communication project successfully on a small scale, at a demonstration or experimental level. Requirements include a sufficient commitment by the local agency (or at least a certain permissiveness), a degree of sensitivity to and consistency with the target audience's needs, some technical assistance, and efficient resource management. The history of social development abounds with examples of small, creative projects which have demonstrated some degree of positive short-term results.

However, very few social communication projects having a deliberate educational purpose manage to sustain themselves once the initial intervention has been concluded. Most simply disappear, or are reduced to minimal expression, when outside technical assistance is withdrawn, when financial support is reduced, and when political support dries up. Frequently, especially in the field of health, local as well as international bureaucracies are geared toward obtaining dramatic, short-term results. Such accomplishments help demonstrate a project's value, but in the long-run can prove to be a liability if not dealt with properly. Eventually, political support is usually cut back (after a change in government or decision-making officials) and one or more of the following may take place: a) users (institutional and community) compare the first phase of "project success" with the subsequent phase, which is frequently less efficient, and lose confidence or withdraw their support; b) the personnel involved no longer receive the incentives which they most likely received in the earlier phase and enthusiasm flags and work productivity drops off; c) a backlash may take place among midlevel officials who were originally pressured to see that the project succeeded, and now perceive that the project is vulnerable. Additionally, the early "project success" may have been documented by foreign experts, and their names and publications bearing their names received broad visibility. The host country personnel may have developed a degree of resentment which becomes an obstacle to later project viability.

These unhappy situations arise out of many intangible experiences and reactions among host country personnel. The role of these personnel is the most important single factor in the successful institutionalization of a communication project.

After "Success" in Honduras

A few of the destructive trends described above faced the Honduras HEALTHCOM Project in 1985 when we began a second wave of technical assistance to the Ministry of Health. Some of the staff in the newly-formed unit had felt left out of the previous "success story." Others felt their office had been "invaded" by new personnel. Some were not completely committed to the methodology employed under PROCOMSI I. Not only have some of the personnel distancing themselves from one another and from their work, but communication with other branches of the Ministry was not ideal.

Significant efforts to reconcile goals, personalities, and styles had been made, but little progress had been achieved. PAHO provided a short-term consultancy in order to reorganize the Health Education Division, establishing new units and assigning responsibilities to each one of the eight health educators working in the central office. But this was a formal decision difficult to implement without the creation of a more dynamic and cooperative style of management that would meet the demands being made upon the group.

Since the problem was at least in part one of human relations, one option might have been interpersonal confrontation in the old style of "sensitivity training," but the risks involved were a little too high since the emotions were intense and the staff lacked the skills necessary to handle this intensity openly. Another possibility considered was an organizational development intervention, involving a diagnostic test for employees and then remedial plans to address each problem identified. We also abandoned this strategy because it would require too much time and attention from management over too long a period and because some external issues were beyond the group's control.

Finally, we settled on a three-tiered strategy. Our goal was to revitalize personal commitment to the program among three different levels of influence. Importantly, the process started with the "top" layer--the political and policy-making power structure. The next level was that of influential primary health care groups, both inside and outside of the government. The last, but not least important level, was that of professionals and technicians who would directly implement the program. This last group also became known as the "learning community." These people would be motivated by, among other factors, the degree of support offered by the other levels.

Gaining Commitment from Friends and Possible Foes

At the beginning of PROCOMSI II, not all of those forces which could potentially help--or harm--the project in significant ways were committed to its underlying goals. Although PROCOMSI I was viewed as a "success," the prospect of expanding this somewhat limited program (covering initially only one health region) to a national scale required "ownership" by a much larger constituency. Project management therefore decided to try to arrange an event which would bring together some of the major figures who could exert political influence and give visibility to their support for child survival. The president himself agreed to call a conference to promote the theme, "Por la Vida del Ni o," or "For the Health of our Children." His office invited 12 ministers as well as members of congress, several bureaus of the government, leaders of unions and prominent private sector groups, and members of the international donor community including UNICEF, PAHO, WHO, the European Economic Community, and USAID--a total of 55 attendees. The president and the minister of health addressed the group and also signed a decree stating their commitment to the child survival program. The conference was widely publicized in the press.

This conference was followed by a series of workshops with high ranking health professionals. We arranged four workshops within the next six months and invited representatives from the pediatric society, the association of social workers, the school of medicine, and so forth. The goal of these seminars was to present in a dramatic fashion a "revolutionary" approach to health education, involving the use of media, face-to-face interventions, print media, and a systematic research-based methodology. The methodology was presented as a sophisticated system for promoting health, which had implications for and could potentially benefit the interests of all of those in attendance.

A power structure which is indifferent to health interventions is actually an obstacle to them. By informing and engaging many levels of the power structure in even this relatively superficial way, the project neutralized some potential obstacles to its activities and laid the basis for possible support. Later on, when something seemingly simple would be needed, such as an approval for a trip to the field to pretest materials, an official would be more likely to recognize the need for this step in the methodology. When activities were planned involving some new constituency--such as school children and teachers--the minister of education might be more likely to encourage their participation. When radio broadcasts began, physicians might be more likely to take an interest in the messages.

Regaining Commitment by Project Staff

The process of assuring "ownership" of the project by the actual Health Education Division staff was in some ways more challenging than promoting it among the higher tiers of political and policy oriented personnel. In 1985 the staff of the Health Education Division amounted to a total of 34 professionals, including 12 assigned to the eight health regions who visited the project office approximately once a month. Commitment on the part of staff to the program and to the group itself ranged from high to minimal. Although the success of engaging commitment from above, through the publicized signing of a child survival decree and the holding of professional seminars, was a powerful motivator, its long-range effect on staff attitudes could not be profound. The daily management processes of the project would be the most important determinant of staff productivity and satisfaction.

We decided not to emphasize the already-established office hierarchy in our management structure, but rather to introduce formally a new organizational development plan which would be task-oriented and would stress sharing of responsibilities. We began by issuing a document, "Organizational Development Process for the Division of Education," and held a four-day seminar to stimulate new working relationships within the core group. The document stated that the HED was entering a new era and facing greater challenges: an expansion of its duties, an increase in its personnel including technical staff from various disciplines, and a greatly increased workload implying a greater dependence by the Ministry on the contributions of the Division. These new demands, in turn, called for new, tighter strategies of response and planning. Work would be best organized around a systematic approach to dealing with specific tasks. The "general objective" of this reorganization would be:

To strengthen the HED structurally, organizationally, and operationally in order to optimize the use of available physical, economic, and human resources, and so to provide timely, high quality technical services, tailored to the needs of the Ministry, and to those of the beneficiary population.⁴

In other words, this whole process also represented adoption of new technical standards and a heightened professionalism of the Division as a whole.

⁴Honduras Ministry of Public Health. Proceso de Desarrollo Administrativo (PDA). Tegucigalpa: October 1986.

During the four-day seminar, HED staff members met together to write work plans. As a group, they made lists of specific objectives and of factors that were either favorable or unfavorable to the achievement of those goals. They categorized the sources of all identified obstacles, and evaluated the likelihood of their being resolved. The process of writing the work plans encompassed nine specific phases, and included the naming of work groups and coordinators. The four days offered staff a chance to step back and view their problems somewhat objectively. The experience also required that they take a "long" view of project goals and analyze the various steps involved in achieving them. This was the first meeting of the "Organizational Development Committee," later to become the "learning community."

Afterwards, weekly meetings were instituted to program, to evaluate, and above all to share experiences (good and bad) stemming from the execution of the plans. Because the reports encompassed all aspects of the methodology--including radio and printed media production, research, publication, and administration--each member of the newly emerging team began to identify with the tasks of the others. At first, individual reports at the meetings were somewhat cold, and there were almost no comments from the others. Debate and discussion were not part of the group culture. To provide feedback to each other about individual performance was even stranger. From time to time conflicts would arise because of some criticism, and the staff had to learn to make comments constructively. Detailed discussion of technical problems often brought more problems than solutions. In this group culture, where there were already pre-existing rivalries, any disagreement was interpreted as antagonism toward the person presenting the idea. It was difficult to achieve a level of technical debate while maintaining detachment and maturity. Many of these conflicts were really manifestations of a lack of self-confidence and self-esteem.

As the weeks passed, the antagonistic attitudes began to disappear somewhat, giving way to a more collaborative attitude. The learning community became a kind of oasis where both ideas and feels could be shared and legitimized. Over time, it also allowed individuals to process feelings about previous experiences related to work. What we had really accomplished by the end of three months was to "make room for discussion." In a society where decisions tend to be made along vertical lines, group consultation is infrequent. But an autocratic and manipulative style is not conducive to the flexibility and group interaction necessary to an integrated methodology such as public health communication.

Management continued to find ways of removing staff from their usual surroundings for periods of concentrated planning. For example, we took a core group of Health Education Division staff together with professionals from other divisions involved with diarrhea control and acute respiratory infections, respectively, for a week's special retreat in order to write the communication plans for those two programs.

After several months, one of the group characterized its achievements by saying, "Only now can we say that the work is ours; we programmed, we implemented, and we will evaluate..." Participation in the decision-making process was perhaps the best incentive for the HED team. However, it was not the only incentive. A short time later, when the communication plans for ARI and ORT were presented to higher MOH officials including the minister and the director general, the staff received glowing and warm congratulations.

Including Physicians and Nurses in the Learning Community

The extension of the learning community to members of other divisions was one of the major reasons for the success of the two communication plans. Initial meetings showed that the HED was able to provide specific services to the ORT, EPI, and ARI programs of the Epidemiology Division. As is common, the first request from the Division was for educational materials. The HED's response was to suggest a complete intervention including research and a nationwide strategy. Staff then divided themselves into two subgroups: one dedicated to elaborating a communication strategy for ORT (both public and private sector) and a second oriented toward initiating qualitative research for the ARI program. Physicians and nurses from the Epidemiology Division were included in the process of designing and implementing the new plans. This design process became a self-motivating factor, allowing the HED technicians to evaluate themselves vis-a-vis the epidemiologists. They were able to share their knowledge regarding a systematic approach to communication.

Extending the learning community to members of different professions and a different division was a difficult but gratifying experience. It was the first time physicians, nurses, and communication specialists related with one another at the same professional level. The new learning community served several purposes: a) it built communication bridges among various professions; b) it established a team approach to management; c) it encouraged members to learn from each other's past experiences, d) it provided a forum for dealing with differences of opinion in a constructive fashion. The most important outcome of the approach was a sense of collective ownership of the work

accomplished. Members of the different groups felt that the plans not only belonged to them, but that all participants were also committed to their implementation.

The Theory Behind a Learning Community Approach

The learning community is more than a committee or task force; it is a work and study space that fosters analysis, reflection, discussion, and decision making. Within it, ideas are put to the test by experts from several areas, and plans are formulated through consensus. The group's members take on responsibility for projecting and executing HEALTHCOM tasks while simultaneously learning the theoretical and practical aspects of each of the auxiliary disciplines.

Seeking consensus through group analysis fosters commitment and growth more effectively than decision making through "majority rule" or formal leadership. Creativity is stimulated and unconventional responses are explored. This in turn encourages investigations of new ways of conducting health communication. In short, the learning community is an administrative approach aimed at legitimizing a series of processes which do not fit into the traditional institutional order.

A learning community is not only a technical group that carries out required activities; it must also be a management group that advocates and promotes its methodology. The learning group constitutes a point of reference for interacting with other sectors of a bureaucracy. Identification by personnel with the project's overall goals and methodology not only strengthens their commitment to the project but also facilitates negotiations with an institution's changing authorities. Concessions can be made, if necessary, without sacrificing crucial aspects of the operation.

In Honduras, the learning community additionally became a professionalizing force for the project. By bringing together decision makers, physicians, technicians, artists, and those with many backgrounds, we encouraged their appreciation of each other's skills and raised the status of the whole. Most of HEALTHCOM's efforts take place within a government context in which a "meritocracy" system prevails and greater importance is given to those who have academic credentials. An official's academic standing is closely related to his or her level of influence in the government. For this reason, it is extremely important to bring into the working group professionals such as physicians, accredited nurses, economists (if possible), sociologists, journalists, social workers, and others.

Professionals associated with the project should be involved in all aspects of the methodology, including research, behavioral analysis, design of the social marketing strategy, and even materials pretesting within local communities and health institutions. Those who make decisions regarding plans, budgets, and schedules, should have a hands-on understanding of the methodology, rather than merely a superficial, intellectual understanding. Experiential, or inductive learning, is a crucial aspect of the success of any learning community.⁵

Contributions of a Learning Community Institutionalization

The learning community approach can support the institutionalization of a health communication project in several ways. It does so through four interrelated processes which should operate within the group. These functions include motivation, information, mutual support, and generation of new understanding.

Motivation is directed at several goals:

- Towards efficient management of communication activities. The learning process begins with an intellectual treatment of communication planning and gradually focuses more on hands-on experience.
- Towards service to the community rather than to political, institutional, and personal interests.
- Towards a focus on preventive medicine rather than the curative emphasis which currently prevails in health institutions. This means developing valid and convincing approaches to the medical establishment and to political authorities, to demonstrate the efficacy of preventive medicine and community education.

⁵For more on an experiential approach to learning, see Pfeiffer, W. and E. Jones. A Handbook of Structured Experiences for Human Relations Training. San Diego: University Associates and Consultants, 1981, and HEALTHCOM field note, "Using an Experiential Approach for Learning," Barriga, Patricio and Hector Espinal.

- Towards viewing communication systematically and seriously rather than merely as a series of unconnected activities. This effort should encompass every stage of the administrative process: planning, organization, leadership, personnel management, follow-up, and evaluation.

The informative function of the learning community concentrates on the following goals:

- Teaching the HEALTHCOM methodology, emphasizing the importance of each stage. Staff must develop the skills required in different stages, including formative research, planning, monitoring, and so forth.
- Refining basic elements of the management process, especially for expanding the project nationwide.
- Sharing results of similar experiments in other countries in which the communication component has been considered a priority.

The mutual support function of the learning community consists of identifying and improving ways of communicating within the group. It concentrates on the following goals:

- Encouraging the process of making decisions by consensus and of seeking outside input from various sources, including both the institution and the community.
- Encouraging two-way communication, fostering an attitude of respect for the opinion of others and stimulating discussion as a problem-solving mechanism.
- Encouraging horizontal communication and communication with those who are at a lower administrative level in order to learn continuously from everyone involved.
- Practicing feedback as an alternative to criticizing or judging fellow workers.

- Practicing group solving of problems in project development, stimulating mutually discovered solutions.
- Practicing participatory leadership, promoting the training of new cadres who will eventually be able to take on leadership responsibilities.

The learning community also helps generate new kinds of understanding among the group members. It can help them develop or appreciate some of the following:

- A critical attitude towards public health as a discipline. Staff learn through experience to assess aspects of the public health system rather than merely accepting conventional assessments.
- An understanding of the causal relationships within the field of health communication itself.
- A re-evaluation of the valid approaches of traditional medicine, and indigenous forms of communication.
- A holistic approach to medicine which places the individual's health within a broad environmental context.

Conclusion

In the Health Education Division of the Honduran Ministry of Health, the problems of organizational development have not been completely solved, but at least the feasibility of a systematic effort toward communication in the public health arena has been confirmed. Recently, the Division has made two important decisions reflecting the group's understanding of the HEALTHCOM methodology as an integrated approach to public health, and also reflecting their support for expanding the working group and increasing its productivity. The Division has designed an intervention for combining promotion of EPI, ARI and ORT, and growth monitoring within a single "good health" theme. The strategy will involve participation of local communities, public health volunteers such as midwives, health promoters, and guardians. In addition, the Division has decided to establish a support system for the staff at the eight regional health offices, offering them consulting services so that they may take on greater local

responsibilities in the area of health communication.

The HEALTHCOM approach is no longer simply experimental but can be geared effectively toward large populations. Therefore, it is crucial that health communication be institutionalized within the state apparatus, so long as there are no other promising institutional options. A group of individuals who have developed favorable attitudes towards preventive medicine and who have at the same time developed skills for managing HEALTHCOM's methodological process, provide the basis for institutionalizing the program. If a learning community approach is used, the group can become its own self-sustaining mechanism. Program continuity can only be partially assured by higher officials. Sustainability is a combination of several factors. Not the least of these is commitment and cooperation among a diverse group of trained professionals.