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**FIELD NOTE**  
**INSTITUTIONALIZATION OF THE HEALTHCOM METHODOLOGY**  
**IN LESOTHO**

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In the context of international development, institutionalization is a process of insuring that what a project has introduced to and taught a host organization becomes an integral part of the organization's operation. Whether the project introduces new personnel, skills, equipment, objectives, or ways of accomplishing goals, these changes must be self-sustaining in order to say that institutionalization has occurred. This transfer will not take place if the project fosters dependence on short-term expatriate expertise or short-term donor resources.

Institutionalizing a health communication methodology is one of the goals of the HEALTHCOM Project. A resident advisor--a specialist who lives in the country for at least two years--is charged with implementing the HEALTHCOM Project in collaboration with health education specialists of the host country. These counterparts play a central role in the institutionalization of new approaches.

The fundamental "technology" utilized at HEALTHCOM Project sites is a particular way of going about the creation, presentation, and testing of health education strategies and materials. This communication methodology has as its ultimate aim the adoption of new behaviors among mothers so that the incidence of sickness and death in their children under five years of age will be reduced.

The Academy for Educational Development and USAID/Washington have a serious interest in institutionalizing the HEALTHCOM methodology in health education units in ministries of health. The methodology has proved effective in promoting important health technologies in several countries, and experience suggests it will be beneficial when applied to an even wider range of public health problems. However, application to specific interventions will reap only short-term benefits. If the methodology is embraced and utilized by the staff of health education units, there should be a noticeable increase in the effectiveness of public health education and information and a resulting change in health practices over the long term.

Ideally, the process of institutionalizing a complex human activity like the HEALTHCOM methodology would be carried out over the period of a generation. Unfortunately, HEALTHCOM resident advisors have only from two to perhaps four years to initiate this process. If progress toward institutionalization is to be made, with what should the resident advisor be concerned?

Experience with institutionalization to date in the Ministry of Health in Lesotho suggests two major tasks for the resident advisor. One is to introduce and teach the

methodology and demonstrate its effectiveness to Health Education Unit (HEU) staff and management personnel (as well as to their superiors) at every opportunity. The second task is to create or strengthen structures and systems of management so that the methodology has a favorable environment in which to persist after the life of the project.

## **TEACH AND DEMONSTRATE**

Formal classes, seminars, and workshops are common and useful vehicles for teaching a methodology. Upon initiation of a HEALTHCOM Project, one of the first priorities is an assessment (either formal or informal) of local skills and resources. Organized training sessions on specific methodology-related topics may be appropriate for professionals within the health education unit as well as for partners in other units and collaborators outside the ministry. If the budget allows, such training can be useful throughout the life of a project--to reinforce as well as introduce skills. These organized sessions have certain advantages which include focused attention on aspects of the methodology, systematic coverage of the topic, and some valuable public relations visibility for the project's activities and goals. They can also serve to motivate staff members in a variety of ways, not the least of which is to confer a degree of status on the participants and their new activities. Moreover, in bringing together participants from different divisions or organizations (possibly even from the private as well as public sectors) they can help to build important cooperative links for project activities.

Formal training events have disadvantages, too, however. The first is that seminars and workshops can be time-consuming for both trainers and trainees. Secondly, protocol and custom may require elaborate proceedings which take up time that might be better spent on teaching and practicing the methodology. A final disadvantage is that formal training tends to be theoretical, and practical applications can easily be underemphasized and divorced from reality.

A second approach for teaching essential skills involves the application of the methodology while working one-on-one with the staff. In this environment, advice-giving flows more naturally with the work and has a less authoritarian tone to it. In the day-to-day operations of a project, the way a resident advisor works with the staff and management team in the counterpart unit has an important effect on the extent to which new methods are learned and the extent to which they are merely observed. A useful principle is that the advisor should not carry out the work him or herself. Despite formidable temptations and pressures, the rule should be: always work with at least one member of the local staff. People tend to learn only a limited amount by watching.

Tasks accomplished by hard-working advisors on nights and weekends have practically no potential for instilling confidence or building skills among counterparts. (Thinking through, planning, and preparing what needs to be done to involve counterparts in the methodology are appropriate after-hours activities.) It is unlikely that any of the local staff will feel much pride or take much responsibility in the work if they do not personally take part in it.

Common human foibles can tempt the advisor to break this rule. Temptations can include the creative desire to do something of one's own; the need to demonstrate one's skills; a drive for perfection that doesn't sit well with the early products of staff who are in training; and, most significantly, impatience. These pressures must be resisted. In addition, external pressures on the advisor stem from the urgency of project "deliverables" and the requirements of several "bosses" to list quantifiable accomplishments on an evaluation form. (The "bosses" might include the head of the health education unit, the project officer at the USAID Mission, the backstopping officer at the home office, and/or the technical officer of a CCCD project.) The resident advisor must always aim at a fine balance between the need to demonstrate success and the need to involve all appropriate counterparts in the project's work. Sometimes an apparent conflict between these two "goods" can be resolved by publicizing interim achievements that management would not otherwise perceive as valuable. Staff members likewise benefit from public validation of this step-by-step approach.

## **PUBLICIZE RESULTS**

Although training helps instill in ministry counterparts a degree of confidence in the methodology, this commitment only becomes self-reinforcing when counterparts see desired results coming from their own efforts. Practicing the skills and techniques which demonstrate concrete results during the life of the project are critical to institutionalization.

It is difficult within the time frame of a HEALTHCOM project to demonstrate that the methodology as a whole works and works better than what has been in use before, because significant data are only available near the end of the project. Successes of other similar projects, from the Mass Media and Health Practices Project (the precursor of HEALTHCOM), and other ongoing HEALTHCOM projects may help to convince, but these numbers do not provide local proof. However, results from early stages of implementing the HEALTHCOM methodology can begin to prove its value, especially if the resident advisor calls attention to these achievements. One approach is

to identify and share results from qualitative studies of the target audience. The findings can be very revealing to health educators as well as to professional health staff.

In Lesotho, for example, qualitative studies showed that mothers distinguished among eight different kinds of diarrhea. Mothers have differing levels of concern about these diarrheas and they had quite different behavior patterns in the treatment of each kind. For example, one kind of diarrhea is thought to be caused by a child's crossing the path of a woman who is wearing a kind of perfume said to be irresistible to men. The child contracts a virulent kind of diarrhea which, according to its symptoms, would be called dysentery by western medicine. Because of the perceived cause, the mother takes the child to a traditional healer and does not believe that ORS or SSS are appropriate treatments. This was new knowledge for most of the health educators and health professionals. It made them realize that they were not as conversant with diarrhea and its treatment as they thought they were. Furthermore, it was not difficult for the health educators to recognize that without this knowledge of what mothers knew and typically did, communication with this group would have been off target.

As a result of such discussions regarding research results and their implications, the terms "KAP studies" and "focus group interviews," techniques of formative research in the HEALTHCOM methodology, are among the new buzz words at the Ministry of Health.

The concrete results arising from the pretesting of health education materials provide a second opportunity to demonstrate the efficacy of an essential stage of the HEALTHCOM methodology. Health education unit staff are often capital-bound. They generate materials for a target audience, taking as much care as they know how to create messages that seem to be clear and unambiguous. Without familiarity with pretesting, they are not likely to view the process as a cost effective use of their limited budgets. However, an experience with pretesting frequently reveals that the target audience understands materials in an entirely unforeseen way. In some cases, the intended message is lost or, worse, misunderstood.<sup>1</sup>

The graphic artist or the radio producer is usually deeply embarrassed by the miscommunication and quickly learns that pretesting can save him or her from making a

<sup>1</sup>See also field notes entitled "Pretesting Health Education Materials" and "Pretesting Materials in Malawi: An Example of Improvement in Communications."

serious communication mistake. The materials development person or team will come to rely upon this part of the methodology. Moreover, once materials are revised and prove acceptable to a target audience. It becomes a design "success" quite beyond that of producing intrinsically "creative" materials. To the extent that pretesting is felt to be crucial to and is used regularly in the creation of educational materials, institutionalization of part of the methodology has taken place.

## REEXAMINE STRUCTURE AND STAFFING

Beyond the resident advisor's teaching efforts, work behavior, and the highlighting of the value of particular steps in the HEALTHCOM methodology, lie a series of potentially more difficult challenges to institutionalization.

One fact which was immediately apparent in Lesotho was that the HEALTHCOM methodology is much more labor-intensive than the approach to health education used before. Because the methodology aims to achieve behavior change, it implies communication programs in support of diarrheal disease control or immunization, and not just campaigns. In Lesotho, it calls for an integrated effort involving health workers at all levels to teach the target audience(s); it calls for the extensive use of print and graphic materials, as well as the intensive use of radio. To produce behavior change, this tripartite effort has to be sustained over time, with special periods of intense work timed to a diarrheal season or a repeating urban vaccination cycle.

In Lesotho, this much energy and resources have never been put into health education efforts. The implications of the methodology in terms of size of staff and extent of their skills, and in terms of the management of human and material resources are very significant. Obviously, without appropriate staffing levels the methodology cannot be sustained, let alone extended to additional public health problems.

What can an advisor do when there are not enough staff members? One priority when setting up a project such as HEALTHCOM is to make sure that the resident advisor is assigned at least one counterpart. In Lesotho, the advisor assists the development of the Health Education Unit. The appropriate counterpart is the head of the Unit and this working arrangement was established from the beginning. But the advisor is also responsible for carrying out public health communication interventions in support of the country's programs in the control of diarrheal disease, immunization, breastfeeding and infant nutrition, and child spacing. No counterparts were assigned for the tasks of designing and implementing complex programs of communication support for these four child survival areas. Working with the graphic artists and the radio producers to create

materials was part of the task. But other important steps of the HEALTHCOM methodology, especially the management of a complex of activities, could not be carried out without additional counterpart(s) if institutionalization was to take place.

It has been very difficult for the government to provide the necessary staff positions to carry out health education according to the principles of the HEALTHCOM approach. The advisor needed to put considerable energy into working with the head of the Unit to persuade the Ministry authorities to fund new staff positions. The effort has paid off: the staff of the HEU nearly doubled in size in the first 18 months of the project and a counterpart has been assigned for the design and implementation of communication interventions.

Several tactics were used to increase the size of the staff. First, it was found that Health Education Unit staff positions had been previously "borrowed" by other units in the Ministry and not returned. It was easier to reclaim lost positions than to find new money. Efforts are currently being made to secure the transfer of positions from other units of the Ministry of Health. Because the Ministry is placing a higher priority on health education at present, it may be politically feasible to move positions away from other programs that do not enjoy the same priority and attach them to the Health Education Unit. Caution is being taken though, for at least two reasons. One is that an individual gained from another unit may be motivated and able, but may come with little or no experience in traditional health education, let alone in different aspects of modern health communication. The new staff member will need a period of training before he or she can be fully productive. The other reason for concern is that the "contributing" unit may see the request to give up an employee as an opportunity to rid themselves of a problem individual. A degree of screening is essential.

Whenever the resident advisor is asked to take on new responsibilities, he or she should also ask for new counterpart positions within the HEU, or encourage interministerial transfers (secondments). The sudden and massive attention now being given to AIDS is a case in point. When the the Health Education Unit in Lesotho took on this new health challenge, the Unit successfully made the case for three new positions so that staff members who were being counted on for work in the areas of immunization and oral rehydration therapy would not be diverted.

It is worth noting that none of the tactics described above for obtaining more staff involve the use of donor-funded positions. Donor funding is usually of short duration and does not contribute to the long-term building of the Unit. Donor-funded positions are very useful, however, in two cases. One is to cover a position while a

regular staff member is sent off for further training. The second is to contribute in the short term to on-the-job training programs of the Unit.

## **ADJUST ORGANIZATION AND MANAGEMENT**

An additional factor in the institutionalization of a public health communication methodology is the organizational structure of the health education unit itself. Does the structure favor the methodology? For example, is the structure appropriate for activities dealing with the design and implementation of integrated, multi-media, and face-to-face programs? Do the graphic artists work independently of the radio producers or, preferably, do they work in teams? Who plans programs and coordinates the work of the graphic artists, radio producers, and researchers? Does nearly everyone report directly to the head of the unit or, preferably, is there a middle level of management which can devote time to actual program implementation?

As a result of the introduction of the HEALTHCOM methodology to the HEU in Lesotho and the introduction of new skills to the staff (as well as the introduction of new staff members) the kinds of work performed within the Unit are changing. Health education is changing from being essentially a one-person effort to a team effort involving specialists: radio producers, newspaper writers, developers of materials for the educational system, creators of training manuals for health workers, persons who work through traditional and other social organizations, artist-illustrators, printers, and others.

As these changes occur, a change in management technique is necessary. Emphasis now must be put on coordinating staff efforts to create and implement sustained programs of formative research, health communication, and evaluation. The head of the Unit must be more and more a manager of health education activities and less a "doer." Furthermore, the staff in the Health Education Unit in Lesotho has grown in size to the point that no single individual can keep adequate track of and provide guidance for all the activities currently underway. This means that a middle level of management, with responsibility and authority to delegate and oversee all aspects of health communication interventions, is essential. In the absence of such a system, public health communication can only be carried out for one or two health topics at a time. If the management system and style are not appropriate to the methodology, institutionalization will be difficult to achieve.

The resident advisor in Lesotho has worked with HEU staff to help with the development of a management system appropriate for carrying out modern public health

communication interventions in a range of health areas. One of the steps has been the joint writing of a mission statement by and for the Unit. This is a declaration of what the Health Education Unit exists to do (and by implication, what it is not prepared to do). The process of thinking through the document helped to develop a sense of unity of purpose among individuals with different responsibilities.<sup>2</sup> A second step has involved writing or re-writing job descriptions for each staff position to fit new tasks inherent in implementing the HEALTHCOM methodology. This exercise has helped the staff know what is expected of them and has required management to think through the Unit's personnel needs.

A third step has been to encourage management to build incentive and reward systems for excellent performance. At present there is no system for reviewing work and providing rewards of value to members of the Unit. Ideally, compensation would involve higher pay or upward job reclassification. However, these are difficult times financially for Lesotho. At the risk of fostering dependence on donor funds, outside money is often made available for overseas training or to purchase equipment long sought by deserving employees. Although financial rewards can be powerful, they are not the only reinforcers available or potentially effective. Management needs to be creative in finding appropriate social rewards for outstanding staff performance.

Assisting in the process of making structural adjustments within part of a bureaucracy can consume an enormous amount of an advisor's time. These are inherently slow processes and are sometimes impossible to effect within the lifetime of a HEALTHCOM project. Yet, if at the beginning of the project a resident advisor sees that the counterpart structure is inhospitable to modern public health communication activities, relevant areas need to be strengthened in order to carry out the project's objectives. A weak or inappropriate organizational structure can be an impediment, not only to institutionalization, but to progress in implementing individual interventions.

### **The Bigger Picture**

Institutionalization is also affected by factors outside the health education unit, within the larger organizational structure of the ministry. Is the unit in a position to coordinate health education in the country or is health communication carried out by

<sup>2</sup>See also the field note entitled, "Building Management Systems on Cultural Traditions in Developing Countries: An African example."

several organizations which are not able to cooperate effectively? Is the health education unit an integral part of the development of the ministry's health care programs or is the unit brought in only to promote specific desired practices? It is most fortunate in Lesotho that in terms of structure and responsibility, the Health Education Unit is in a position to participate in every aspect of health education in the country, particularly with respect to face-to-face training.

The HEALTHCOM methodology relies heavily on face-to-face interaction with the public by professional health workers of all grades. The Health Education Unit in Lesotho participates in the continuing education of health workers of all kinds. The Unit creates training materials and teaching aids which effectively guide the content of what nurses and village health workers teach mothers. The promulgation of standard health education messages helps to avoid the danger that disparate parts of the health system will communicate different messages to the target audience(s). It also assures that messages conveyed through personal interaction and through other media, such as print and broadcast, are consistent. If mass media messages conflict with and undercut the teaching of mothers by nurses, a problem of serious proportions could arise.

The Unit also reaches out to groups not within the Ministry's immediate structure. In Lesotho, physicians in government service as well as in private practice have an important influence on the success of a child survival program (such as diarrheal disease control or immunization) because of mothers' high regard for their opinions and advice. The number of physicians in Lesotho is growing rapidly. Many of them are expatriates who come only for two-year tours, creating a large turnover. These physicians are often given positions of great responsibility, such as heading district hospitals and health management teams. Depending on their training and prior experience, they can have varying levels of enthusiasm for certain technologies (such as oral rehydration therapy). Recently the Unit has supported what will become a regular orientation program by the Ministry for new physicians. The Health Education Unit presented these physicians with an overview of the Unit's most active health education programs, provided them with health education materials, and appealed to them to support the ministry's policies and programs through their patient education efforts.

About half of Lesotho's hospitals and 60 percent of its clinics are operated by religious mission organizations. These institutions organize themselves through the Private Health Association of Lesotho (PHAL). In view of their significant role in health care delivery and health education, it is important that mechanisms for coordinating activities be established. The Unit is in the process of developing standard messages to

be used by all health educators in Lesotho. The messages are accompanied by a cover letter, signed jointly by the head of the Ministry program and the chief health educator, explaining the critical importance of offering consistent information to target audiences.

The Unit also engages in outreach to faculty of the health training institutions so that course content (e.g., interpersonal communication techniques, development and use of visual aids, specific health messages, and so forth) is consistent with what the Unit is teaching. This means that in the long run, professional health workers such as nurses and pharmacists will know and be able to teach the same information that the public is learning from other communication media such as radio.

Coordination of training and message development is only possible if other departments within the Ministry of Health are also able to communicate and work smoothly together. The structure of the Ministry in Lesotho favors the coordination of work by the Health Education Unit with the activities of programs such as immunization, the control of diarrheal diseases, family planning, and acute respiratory infections. The Unit is represented on the technical coordinating committees of all these programs. Furthermore, one of the Unit's stated purposes in its mission statement is to provide communication support to these programs, as the heads of these areas are regarded as the experts on the technical aspects.

### **Avoiding Donor Dependence**

A technical assistance project can unfortunately easily erect its own barriers to institutionalization. This happens primarily through the pursuit of an unsustainable scale of operations. A temporary abundance of resources and prestige can detract attention from the need to establish processes which are appropriate to an imperfect environment, or to focus attention on the process of changing that environment. Vision must always be aimed at the day when donor resources will be withdrawn. In Lesotho, the HEALTHCOM Project has money to pay for many of the costs associated with the methodology over a given time period. However, the temptation to spend at rates which the Health Education Unit's budget could not sustain after the project is over has been resisted. More work has to be done with the chief health educator during the life of the project to increase the size of the annual budget so that the costs of a public health communication approach can be provided for. Without the money to pay for research, media talent, large numbers of radio spots, printing costs, and so on, the methodology cannot be kept alive.

## CONCLUSION

Is institutionalization achievable in the time frame of a typical HEALTHCOM country project? A great deal depends on the country situation and how the resident advisor goes about his or her work. In the space of two years, the answer to the question is probably "no." However, progress toward institutionalization--the elimination of some of the impediments to carrying out the HEALTHCOM methodology--is realistic.

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