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FIELD NOTE

**PARTICIPATORY PROJECT DESIGN:
THE FIRST STEP IN SUSTAINABILITY**

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For a development project of any kind--whether child health, agriculture, or basic education--"getting started on the right foot" means building consensus regarding goals and methods among diverse individuals and groups. A fundamental sense of cooperation and mutual ownership is the key not only to planning and carrying out initial activities, but also to the eventual sustainability of a project at any level. Although the process of involving groups with varying needs and expectations can seem to create "extra" work and even to impede progress at times, it is really the only route to long-term success.

How does one bring together strategic players who have different impressions of what a development project has to offer? How does one assure that the "grass roots" perspective is not lost in an effort to build agreement among high-level donors and government officials? How does a project engage participants from the national, regional, and community levels in the common task of preparing an appropriate project implementation plan which might satisfy a wide range of needs and yet simplify and clarify the task at hand? Is it possible to create a sense of project "ownership" when the institutions which are directly and indirectly involved are separated by thousands of miles and have few real opportunities for interaction or collaboration? These were some of many challenges facing the design of the Communication for Child Survival, or HEALTHCOM Project, in Zaire.

This field note explains in broad terms the logistical, socioeconomic, bureaucratic, and health care environment in which one child survival project was initiated, and the approach taken by the resident advisor to bring about cooperative activities. As a communication project, HEALTHCOM supports ministries of health in applying social marketing principles and techniques to products and services associated with priority health concerns. In Zaire, assistance was originally provided through one resident advisor (for two years); seven months of short-term technical consultancies; and training in health communication for project counterparts and health professionals at the national, regional, and zonal levels. The project was asked to address a range of child survival issues, from AIDS to vaccinations.

ZAIRE—SPECIAL CHALLENGES

Consensus-building in the Zairian context presents challenges typical of, and in some ways exceeding those, of the average development project. Geographical and

logistical factors alone create imposing barriers. Zaire is the third largest nation in Africa with a land area of 2,344,932 sq. km., or approximately that of western Europe. The country is divided into four geographical regions including a vast low-lying central area, which is surrounded by mountainous terraces in the southwest, plateaus merging into savannahs in the south and southeast, and dense grasslands in the northwest. High mountains enclose the country in the northeast where altitudes rise as high as 5,000 meters. The difficult terrain is not matched by suitable transportation or communication infrastructures. Travel overland between major Zairian cities is virtually impossible, particularly during the rainy season. Even transportation of basic foodstuffs such as corn can be blocked for months due to poor roads or irregular train schedules. Travel by plane is not an option for the average Zairian. Telephones work at best sporadically and even the telex services have been known not to work for weeks at a time.

Although during the first two years of the project, distribution of local newspapers in Lubumbashi was closely monitored by the government and copies were not always available due to lack of ink, a number of diverse publications are now available on a regular basis. Some radio and television work is carried out locally; however, most programs are produced in Kinshasa. In spite of the fact that over 200 ethnic groups are represented in Zaire, television and radio production is conducted exclusively in the five lingua franca--French, Lingala, Kikongo, Tshiluba, and Swahili. In the Shaba region, programs are broadcast in French and Swahili. Although reception of national broadcasts throughout the country is relatively good, access to local programs is limited in the regions.

With an estimated population of 33.3 million people belonging to dozens of ethnic groups, Zaire is multi-cultural and multi-lingual. It is also a poor country, and the relatively low literacy rate (20 percent) and low annual income (about U.S. \$160 per year) contribute to the isolation of different groups. Approximately 70 percent live in rural areas. The persistence of local traditions, combined with varying economic and geographic conditions, means that public health realities must be defined from community to community.

Regional and Community Emphasis

The size and diversity of Zaire undermines the workability and relevance of any top-down or centrally-driven health care system. While national health goals for combatting particular diseases help focus energy and funds, plans inevitably must be tailored for different regions and different communities. In 1981, the Government of

Zaire formally adopted primary health care (PHC) as the basis for the national health strategy, which included the promotion of a decentralized health care system. Although many health facilities are government run, most are funded by international donor agencies and an extensive private voluntary organization (PVO) network (particularly religious missions) which relies primarily on health centers and village-level health workers.

The first five-year National Health Plan (1982-1986) established the policy of decentralized health care by mandating the creation of well-defined rural health zones (RHZs). The purpose of health zones is to coordinate and standardize the administrative and technical supervision of all health services within specified geographic areas and to ensure coverage of the population with preventive, promotive, and basic curative services. Dispensaries are to be transformed from places offering only curative health measures to health centers with functioning primary health care programs. The plan proposes that every year three dispensaries in each operating health zone become a health center offering appropriate services.

By 1991, approximately 300 health zones were planned to be operative in Zaire. Within these zones, approximately 70 percent of the population should have access to primary health care services. Each health zone has a reference hospital (which includes the central office for the zone), one to three reference health centers, and 15 to 25 basic health centers which serve between 3,000 to 10,000 people. Each health center serves five to ten villages with populations of 400 to 2,000 per village.

The health center is the focal point for the health zone infrastructure. Boundaries or catchment areas for each health center are carefully delineated to ensure complete coverage of the population without overlap. Health centers are staffed by at least one nurse and several aids who are responsible for providing basic primary health care services and for supervising community-based activities within the catchment area. Approximately 90 percent of health problems can be treated at the health center; the remaining ten percent are referred to a reference health center or to the reference hospital. The health zone central team generally includes a medical chief, a public health administrator, a secretary, one or more nurse supervisors, and water and sanitation coordinators. One person is also responsible for coordinating drug distribution and is often also responsible for the hospital pharmacy. Many health zones have a mechanic.

Because of the emphasis in Zaire on community participation in primary health care activities, most rural health zones have encouraged the creation of voluntary village development committees. Members of these committees are generally trained and supervised by the health center staff. Individuals have specific roles such as health education, the promotion of environmental sanitation, water source improvement, encouraging the use of maternal and child health services, and selecting and training village health workers.

Decentralization of Health Education

Due to the decentralized nature of health services in Zaire, the Ministry of Public Health has adopted a flexible approach to enforcing policy with respect to different health issues. On the one hand, the ministry would like to diffuse essential messages nationally. However, the chief medical officer for an individual health zone who often determines the most appropriate approach to take given the particular circumstances of an area. This fact has broad implications for health education in Zaire.

At the national level, the Ministry of Public Health is divided into a number of technical units responsible for matters such as family planning, nutrition, AIDS, and basic rural health. Another institute addresses the establishment of quality PHC in rural areas. All of these units are located in the capital, Kinshasa. Each unit tends to take care of its own information, education, and communication (IEC) needs. An umbrella structure within the ministry coordinates all health planning and health education activities nationwide. Fonds National Medico-Sanitaire (FONAMES), or The National Medical and Health Bureau, monitors all of the IEC components of the technical units. However, even at this level, trained staff to plan and coordinate IEC activities are lacking. (The exception may be the Family Planning Services Project, which has four full-time Zairian IEC technicians and a coordinator.)

At the regional level, health education units as such do not currently exist. Although the regional Programme Elargi de Vaccination (PEV) offices and UNICEF carry out periodic work with the mass media and can organize campaigns, they do not have personnel available to do this work on a regular basis. Rather, health education planning generally takes place on a zone by zone basis and is the responsibility of the zonal chief medical officer and his staff. This decentralization of IEC activities increases the likelihood that messages and materials will be appropriate to local populations. However, it also makes sharing of skills, ideas, and resources difficult. Without adequate staff and training, many zones conduct little or no health education.

Multiple Goals, Complex Teams

When the HEALTHCOM Project was initiated in Zaire in August of 1988, the ministry requested that activities be conducted at the national, regional, and zonal levels. The project was officially attached to FONAMES and assigned a counterpart from that institution. The health themes to be addressed were extensive: vaccination, diarrheal disease, malaria, family planning, nutrition, water and sanitation, and AIDS. Given the decentralization of Zaire's PHC system, and in particular its health education efforts, the breadth of this assignment was sobering.

The project was asked to assist in strengthening national health communication planning at FONAMES and to work with the new School of Public Health and other nationwide health projects to strengthen their training efforts. At the regional level, the project was asked to assist in developing model health communication programs by working closely with other projects in the target region of Shaba. At the zonal level, the project was asked to demonstrate how chief medical officers and health education personnel can produce effective small-scale health education programs by capitalizing on existing means of communication such as traditional theatre and interactive radio broadcasts.

The project, led by a single in-country resident advisor, was set up to collaborate with a number of programs and projects whose activities are coordinated by FONAMES. These included the Programme Elargi de Vaccination/Combating Childhood Communicable Diseases (PEV/CCCD) Program, a GOZ-managed, USAID-funded national program which addresses vaccination, diarrheal disease, and malaria. The Basic Rural Health Project (SANRU), also funded by USAID, focuses on the development of rural health zones including training, technical advice, construction/renovation. It provides financial support to health centers and health zones as well as to regional and national supporting services, stressing financial and program management, logistic support (especially for pharmaceuticals), and regular statistical reporting. SANRU is currently responsible for supporting about half of the health zones operating in Zaire. Other USAID-funded collaborating groups include Le Project des Services des Naissances Desirables (PSND) or Family Planning Services Project, the School of Public Health (SPH) in Kinshasa, and PRICOR (Primary Health Care Operations Research) Project. Le Bureau Centrale de Coordination pour la Lutte Contre la SIDA (BCC) or National Coordinating Unit for AIDS activities, is also an important planner with the project. Most of these groups--PEV/CCCD, PSND, BCC, and SANRU--have IEC units which are generally responsible for planning, training, and some materials development work.

The HEALTHCOM Project was thus mandated to operate at multiple bureaucratic levels in a health care system characterized by regional autonomy, to address communication/education needs regarding multiple child survival technologies, and to cooperate with numerous partner groups. The need for consensus building in project planning was quite apparent. So too was the magnitude of this challenge.

GOALS AND REALITIES

The Ministry agreed that the project office should be located in Lubumbashi, the capital of the Shaba region, approximately 1,250 miles from Kinshasa near the Zambian border. This gave the resident advisor reasonable proximity to two pilot health zones selected as starting points for intensified efforts in the Shaba region--Kabongo, a rural health zone situated 560 miles north of Lubumbashi; and Ruashi, a semi-urban zone associated with the University of Lubumbashi and located approximately three miles south of the city.

The prospect for institutionalizing a systematic approach to health communication in Zaire was deemed most promising at the regional level where HEALTHCOM would work directly with PEV, UNICEF, local health workers, and mass media technicians. By proving program effectiveness in the two pilot zones and providing training programs and regular technical assistance in the HEALTHCOM methodology to key groups and individuals, it was hoped that other areas of the country, assisted by FONAMES, PEV, and SANRU in particular, would plan and carry out similar health education programs.

The State of IEC

When the resident advisor arrived in Lubumbashi in August 1988, she found limited health education materials available for use by health workers or clients. A number of print materials had been produced at the national level particularly by SANRU, PEV, and CEPLANUT (the nutrition branch). SANRU had produced calendars, posters, student notebooks, and other materials. PEV had developed posters, technical guides or aide memoires for nurses, and pamphlets on oral rehydration therapy (ORT) and other topics. Most of the material was geared towards health workers rather than parents, and was in French. PEV had produced a poster featuring the vaccination calendar which is appropriate as a visual support for health education sessions. It had also created a flyer in Swahili, Tshiluba, Lingala, and Kikongo on how to prepare sugar-salt solution (SSS). CEPLANUT had produced a flipchart for primary school students in the Bandundu region. Although SANRU materials seemed to be relatively well distributed, PEV and

CEPLANUT materials tended to be in very short supply in the regions. PEV/Kinshasa had recently begun some limited work with mass media, including radio and television spots on vaccinations, that were being diffused nationally. -

At that time, no materials were being produced in the Shaba region which specifically addressed local beliefs or health practices.

Available Resources

Organized health education infrastructure and programs were lacking in the pilot zones and in the region as a whole. UNICEF had attempted to address the lack of a regional IEC capacity by forming a Social Mobilization Team in Lubumbashi. The fledgling group was composed of about a dozen health professionals (such as clinic supervisors and nurses) and media professionals from the local press and the radio/television studio who hoped to forge health communication strategies and community participation in Lubumbashi. They had just completed their first training activity and were in the process of deciding on team priorities and functions when the HEALTHCOM resident advisor arrived.

Although a counterpart at FONAMES was assigned to the project in August 1988, by late September he received a scholarship to study abroad. Because of limited funds in the IEC department at FONAMES, it was uncertain if a replacement would be identified. Later, a counterpart was assigned at the regional level in Lubumbashi; however, he already had a full-time job as the regional medical coordinator for PEV. At the zonal level, the project worked with the chief medical officers who were likewise extremely busy with their regular jobs. Although interest in the project was quite high, regular collaboration was obviously difficult.

These problems were in some ways typical of HEALTHCOM sites. A resident advisor more often than not assists a ministry health education unit which has limited staff, limited training and funds, and unwieldy responsibilities. Counterparts have overburdened agendas and are often transferred during the course of the project. In Zaire, however, the project was also faced with an enormous scope of work combined with extraordinary communication obstacles. Contact between the project office in Lubumbashi and both Kinshasa and Washington was very difficult and sometimes impossible for periods of days or weeks. In emergencies, the most reliable means of communication involved a four-hour drive to neighboring Zambia where telephone and telex systems were more predictable. Communication with the Ruashi pilot zone was relatively easy given that it was a ten-minute drive from Lubumbashi. Radio messages

to the second pilot zone, Kabongo, were possible via one of the USAID roads projects in Lubumbashi. However, travel to the zone required a two-day trip by four-wheel drive vehicle, weather permitting. Travel became particularly difficult after the project vehicle was stolen--a not uncommon misfortune. Political unrest added to the precariousness of travel.

Money was invested in the project by four different USAID-sponsored groups, three of which were located in Kinshasa and each of which had special needs and interests. As a result, pressure was especially high to respond rapidly to a range of concerns from several groups at several levels.

PROJECT DESIGN STRATEGY

Whereas many development projects begin their planning at the national level with representatives from government and donor groups, the resident advisor decided to avoid this "top down" approach to strategy development. It was extremely important that people at the national level be given the opportunity for input in the project design, particularly when so many of the activities were to take place so far away in the pilot areas. At the same time, a natural distrust of central interference and a host of logistical, administrative, and political barriers to interaction among the national, regional, and zonal levels made it important not to disempower or discourage those whose enthusiasm would actually drive project activities. And these were ultimately the zonal and local health center personnel.

Similarly, the resident advisor rejected the sometimes effective approach of "demonstrating a splashy success" to attract new investments of funds and ministry personnel. In some environments, expatriate specialists can through sheer individual effort produce short-term miracles which entice larger-scale government commitments. The Zairian context, however, made any sudden, impressive splash improbable.

Rather, the resident advisor concentrated by necessity on strengthening important links in the health education infrastructure and on supporting participatory decision making. The advisor's basic approach to project development rested on three major efforts: 1) a series of planning meetings to build consensus across levels; 2) workshops to build skills among local professionals and volunteers--communication managers, physicians, health workers, media personnel, and mothers; and 3) quantitative and qualitative research to provide an empirical basis for all health communication decisions.

The guiding principle of systematic public health communication is an emphasis upon the community and the client--in child survival programs, this means the caretakers of children under five. Decisions are based upon research among the target audience and strategies are molded by a community's perceptions of health problems. With this focus upon the beneficiaries, and given data regarding the beneficiaries' actual practices and needs, project planners from diverse perspectives should in theory have a common basis upon which to build. Research was therefore an immediate priority in the HEALTHCOM Project.

Research-Based Planning

Research activities were underway by the fall of 1988. Several studies were conducted in collaboration with different Zairian groups, particularly the University of Lubumbashi and the Lubumbashi Social Mobilization Team, and provided opportunities for sharing perspectives and for training local professionals. The first activity was a series of 15 focus groups, each with 14 to 15 mothers per group, to help analyze target audiences and investigate women's understanding of diarrheal disorders and common treatments. These were held primarily in the Ruashi health zone and were part of a workshop conducted with the Lubumbashi Social Mobilization Team. The team spent one week learning how to lead discussions and take notes, and one week in field work.

At approximately the same time as the focus group research, two students from the Medical School of the University of Lubumbashi conducted an inventory of medical services in the Ruashi and nearby Katuba health zones and observed health education activities in well-baby clinics. The students visited the main health centers and dispensaries and interviewed head nurses using a short questionnaire to determine which health facilities include health education with their curative services. Five facilities in Ruashi and five in Katuba were identified that regularly give health talks and vaccinations.

This was followed by an ethnomedical study with small groups of women in three different Lubumbashi health zones to identify the Swahili names of common childhood illnesses and to investigate how mothers diagnose them. A local anthropologist from the University of Lubumbashi examined the consistency of the diagnoses for five illnesses characterized by diarrhea. Insights from this work were subsequently used to help create a questionnaire for the major quantitative study carried out in March of 1989.

In order to obtain information about places women often meet and associations they participate in, a professor from the University of Lubumbashi conducted a series of

24 in-depth interviews in Ruashi to study information exchange among women. The interviews revealed patterns of going to market, of other common meeting places, of popular associations, and uses of schools and medical services.

The large-scale quantitative survey was carried out approximately eight months into the project and after much of the qualitative research for Ruashi and Lubumbashi had been completed. The decision to conduct the survey was made collectively by groups at the national, regional, and zonal levels during the January 1988 Implementation Workshop (described below). Technical assistance was provided by the project's subcontractor, the Annenberg School for Communication, University of Pennsylvania, together with the School of Public Health of the University of Kinshasa. The survey included a representative sample of 1125 Lubumbashi mothers having children under three years of age. Questions addressed knowledge, attitudes, and practices relating to diarrhea, the use of oral rehydration, the use of medical services, vaccinations, and the prevalence of different media. The survey provided valuable insights into how women might be reached with information on infant health care. Of those surveyed, most got their information from health education talks at health centers. In addition, about one-half of women listened to the radio from time to time and about 40 percent watched television.

The survey provided data which was later useful for making decisions about media channels and the kinds of messages to be formulated about oral rehydration therapy and vaccinations. It functioned as a baseline for studying the impact of health communication efforts. A similar survey at the end of the second year would allow for comparisons.

Formative research in Kabongo health zone was also conducted later in August 1989, and was used for message development and for preparing health worker training activities.

Implementation Workshop

In January of 1989 the resident advisor planned a five-day implementation workshop to allow IEC and medical personnel from all levels to prepare a general action plan for the project. Much of the qualitative research had been completed at this stage and was available for use. The challenge was to get key players to engage in a productive discussion regarding directions for the project and at the same time to clarify and apply elements of the HEALTHCOM methodology to this planning process.

Representatives from the central offices in Kinshasa and representatives from the two pilot areas came to Lubumbashi. This was a notable variation on the usual direction of travel (that is, toward the capital and the source of funding). The workshop emphasized field realities--as presented by the zonal chief medical officers and as reflected in the research. Twenty-three participants from a range of organizations and disciplines attended. They included IEC program managers, physicians, nurses, social scientists, and mass media professionals. Organizations from the national level included SANRU, PEV/CCCD, the Family Planning Services Project (PSND), and Le Bureau Central de Coordination pour la Lutte Contre la SIDA (BCC). Local level groups included PEV/CCCD, the local radio and television station (Voix du Zaïre), the University of Lubumbashi, the Department of Public Health, and the Lubumbashi Social Mobilization Team.

The stage was set by the chief medical officers for the two project pilot zones who presented overviews of the priority public health concerns for their respective zones. During these presentations information such as basic health statistics and infrastructure for the zones, local health communication efforts to date, and the findings of recent research were shared and discussed. The national-level IEC technicians representing FONAMES, SANRU, PEV, PSND, and the BCC made presentations on national IEC plans and strategies. PEV/Lubumbashi explained the results of the baseline study. The UNICEF-organized social mobilization team in Lubumbashi discussed findings from the focus group work it carried out in October 1988. Lastly, the medical anthropologist from the University of Lubumbashi presented data from his ethnomedical study on diarrheal disease and vaccinations. The HEALTHCOM Project director and FONAMES counterpart also gave an overview of the HEALTHCOM methodology emphasizing communication strategy development.

Setting Behavioral Objectives

A major component of the implementation planning workshop was a two-day discussion analyzing positive and negative behaviors associated with vaccinations, diarrheal disease, malaria, and malnutrition vis-a-vis both the community and health professionals. Participants outlined what they believed were current practices in the zones of Ruashi and Kabongo. They also formulated lists of key behavioral problems on the one side, and ideal behaviors on the other, for mothers and for health workers. The discussion produced suggestions for appropriate health education activities and specific HEALTHCOM interventions. Since developmental research was not yet complete,

participants were not equipped to identify detailed behavioral messages and strategies at this time. However, the exercise allowed the group to determine the range of practices which could be addressed within the context of a comprehensive health education program. It provided a basis for developing overall objectives and activity plans for the two zones and the project in general. At this time, planners also decided that the initial focus for project interventions would be on diarrheal disease and immunization, reflecting primary needs for both Kabongo and Ruashi.

Writing a Draft Project Plan

Immediately following the workshop, the facilitators (the HEALTHCOM resident advisor and the FONAMES director) compiled the results of the discussions into a draft project implementation plan featuring interventions and general directions for the project in Shaba over the next eighteen months. They then reviewed these suggestions with the chief medical officers of the two pilot zones. The approved plan included the following recommendations for principal project activities:

- conducting qualitative and quantitative research for the purposes of project planning, monitoring, message development, and evaluation, including a large-scale baseline survey for Lubumbashi city;
- training health workers in interpersonal communication and health education skills and the creation of a core team of trainers capable of carrying out this work, first in the two pilot zones and then in the region;
- developing, pretesting, and distributing educational materials for use by health workers with mothers, featuring key messages about diarrheal disease, oral rehydration, and vaccinations;
- planning and carrying out community motivation strategies and outreach activities around health issues including:
 - the creation of village development committees and teams of women community leaders, or Maman Tengeneza, who would serve as liaisons between the health centers and communities, encouraging mothers to participate in well-baby clinic activities and health education sessions.

- carrying out community motivation campaigns (particularly in Lubumbashi) in collaboration with PEV/CCCD, UNICEF, and Rotary International as appropriate, featuring mass media, local theater and church groups, and supported by promotional materials such as banners, posters, T-shirts, and so forth.
- the elaboration of a primary school health education program featuring seminars for teachers in health education, the creation of school health committees, and the development of appropriate print materials such as notebooks, posters, and stickers.

Keeping the Planners Informed

This implementation document was not the last opportunity for formal input from the regional and national levels. Even those planners who were not actively involved in carrying out the project were kept closely informed of subsequent stages. Again, research was an important vehicle for bringing together high-level representatives. When results became available from the HEALTHCOM/University of Lubumbashi baseline survey, for example, 25 health professionals and social scientists from the university, zonal medical officers, members of the Social Mobilization Team, and officials from PEV/Lubumbashi and BCC attended a day-long meeting to share results and discuss the findings. Two additional presentations were made in Kinshasa to colleagues from the School of Public Health, SANRU, FONAMES, PEV, CEPLANUT, PSI, PRICOR, and Santé Pour Tous (a Belgian-funded health services project). These events provided formal opportunities for many invested groups to learn about project accomplishments, to provide input into future directions, and to maintain a sense of ownership in the project.

FROM REGIONAL TO ZONAL PLANNING

However, the general recommendations of the Lubumbashi implementation planning workshop could only be carried out through frontline health workers, their supervisors, and the chief medical officers. A major goal was therefore to involve these individuals in preparing operational action plans in health promotion/education for their

respective zones. The hope was to give the health zones a sense of self-reliance and to avoid creating a dependency on outside "expertise" which would lead to a natural end to the project or discourage other health zones from conducting similar activities.

One of the first steps was a zonal planning and trainer-of-trainers workshop in Lubumbashi for three weeks in the spring of 1989. Participants included selected health workers, supervisors, and the chief medical officers from the pilot health zones, and members from the Lubumbashi Social Mobilization Team who would continue building the IEC capacity in the region. The 17 professionals received in-depth training in IEC planning, management and supervision, objectives design, team building, adult learning skills, counseling, health education techniques, focus group research, creative health message delivery, and technical subjects including diarrheal disease, vaccinations, malaria, and AIDS. Because of the strong influence of person-to-person contact upon mothers' levels of knowledge in this region, the workshop emphasized interpersonal skills and creative message delivery such as songs, stories, theatre, and demonstrations. As part of this effort, members of the national theater troupe were invited to perform health skits and helped participants write and practice their own scripts.

The participants also worked in two teams--one for Kabongo and the other for Ruashi--to develop one-year action plans for their respective health zones. Each group went through the steps of identifying problems, deciding which could be resolved through IEC, setting priorities and realistic objectives, and pinpointing target audiences. The Ruashi health zone also had the advantage of being able to work from the results of the recently completed community baseline survey. Both groups identified resources and assigned responsibility and completion dates for various tasks. For the Kabongo team this included plans to conduct focus group discussions in specific areas throughout the health zone.

Features of the action plans prepared for both zones included health education training, formative research, supervision, materials development, campaigns, and outreach work via community leaders, women's groups, primary schools, and/or churches. The action plan for Kabongo also called for work with village health committees. In Ruashi the action plan called for the creation of a team of volunteer Maman Tengeneza, or "mothers for improvement," who will be trained to act as child health resources in their neighborhoods.

Objectives for both health zones focused on diarrheal disease and vaccinations and included:

- increasing mothers' knowledge of how to prepare sugar-salt solution (SSS) correctly (from the current figure of 15 percent for Lubumbashi, baseline unknown for Kabongo) to 50 percent by the end of May 1990;
- increasing to 40 percent: mothers from the target areas in Kabongo who are capable of correctly explaining how to administer SSS to a small child;*
- increasing the number of completely vaccinated children between the ages of 12 and 23 months in urban Ruashi from 35 percent to 70 percent by August 1990;
- increasing to 50 percent from Kamungu; 60 percent from Lenge, Kyondo, and Kime; and 70 percent from Kina (all Kabongo neighborhoods) those mothers capable of correctly describing the vaccination calendar.

In order to realize these objectives, both zones planned to increase significantly the number of mothers who attend the under-five well-baby clinics conducted in the health centers. According to the community baseline survey, women who attend the well-baby clinics or kipimo to have their children's growth monitored are more likely than others to have had their children completely vaccinated. The kipimo is also a focal point for information on oral rehydration therapy, malaria related issues, nutrition, family planning, and so forth. A logo and slogan encouraging mothers to attend their nearest neighborhood kipimo was planned under the Ruashi strategy.

TRAINING AND SHARING

As part of their action plans, the health workers from Ruashi and Kabongo health zones developed a strategy in which health workers and supervisors would themselves be responsible for training their peers in such matters as interpersonal communications skills, effective health education planning and delivery, and appropriate teaching

*Since writing the plans, ministry policy has shifted away from sugar-salt solution, and health workers are now recommending a rice-based solution.

techniques. In this way, training--both formal and informal--would be possible on a continued basis at the zonal level under the direction of the chief medical officer and without the need for extensive external assistance or funding. The group planned a series of about eight workshops for the two zones. A small study was initiated to monitor the success of these workshops. Observation of health education sessions, both before and after training, would provide information on the success of the new interpersonal techniques and on ways to improve both training and supervision. Preliminary monitoring has shown that health workers are taking some pleasure in trying out their new skills and are experimenting using role plays, demonstrations, and new songs, to the great interest of local mothers.

It is also expected that as other health zones move to strengthen their own health education programs, the HEALTHCOM core team will serve as a resource group for the region. To help bring this about, HEALTHCOM is developing an interpersonal communication and IEC training guide for use in Shaba and other regions throughout the country.

Lastly, the team decided that a "sister health zone" arrangement be formed between Kabongo and Ruashi. Health workers from Ruashi would make periodic visits to Kabongo and vice versa to share ideas, discuss strategies, and work with colleagues to carry out collectively such tasks as focus group research, training, and supervision. Biannual meetings between the two groups were likewise proposed to maintain a sense of team spirit.

Nurses and Radio Producers

The resident advisor also sought training for several professional groups which would have a lasting involvement in any successful health communication program. Among these were two somewhat disparate professions--nursing instructors and radio producers.

One of the most important links in the Shaba region health education infrastructure is provided by the 16 medical technical institutions which train thousands of nurses each year in two- and four-year programs. To strengthen this link, the HEALTHCOM resident advisor and a technical consultant collaborated with SANRU in conducting two two-week workshops in Ruashi to promote integration of primary health care and health educational skills development into the current nursing school curriculum. The workshops were co-facilitated by the prefect of Lubumbashi's largest nursing school, who was also a member of the Social Mobilization Team. Representatives

from nearly all of the institutions attended both workshops. The participants were nursing instructors, directors, and physicians who supervise students during their field practice. They were exposed to innovative teaching methodologies and to both theoretical and practical course planning. More than 25 percent of the workshop consisted of field practice and observation.

In response to participant evaluations, the second workshop spent more time on discussions and field work. More responsibility was also given to the two Zairian co-trainers, thus encouraging institutionalization and less dependence on expatriate involvement.

The workshop for radio producers held in June of 1990 was to an even greater extent designed as a field practicum. The ten participants included programming chiefs (who are also producers) for radio and television of the Voix du Zaire, six radio producers including a popular comedian and sports announcer who also prepare programs on health and development topics, and two health educators. Most had familiarity only with long-format programs. The purpose of the workshop was to give the participants experience in applying elements of social marketing to the creation of audio spots which would subsequently be used on radio to support upcoming vaccination drives in Lubumbashi and environs. It was also designed to help "bridge the gap" between radio producers and health professionals.

The resident advisor co-conducted the workshop with a radio specialist working in Lesotho. The participants learned how to use the results of audience research to develop short messages which would encourage desired health practices. They studied the objectives of the Shaba region immunization program, learned about the results of the community baseline study, and developed a creative strategy for a series of spots utilizing a popular vaccination song. Brainstorming among the producers and the health educators led to agreement on eight basic messages for mothers. Among the more predictable (such as "Take good care of the vaccination card" and information about the vaccination calendar) were messages tied closely to the reality of Shaba life. For example, research had shown that although mothers were not discouraged from going for vaccinations by any overt "expense," a hidden cost had proved important to them. Gathering at the health center was a high-visibility social event, and many women would not go if they could not dress properly. The producers came up with several messages emphasizing that "you don't need a new pagne [or skirt wrap] to get your child vaccinated."

The spots were recorded in Swahili and French at the production studio of the Voix du Zaire. Air time was also donated by the station. Irregular radio listening called for a high repetition broadcast schedule--a minimum of ten spots a day for four days before each campaign and three days during each one. Later, the producers would create longer programs for both radio and television, explaining in detail the importance of each message.

The quality of production equipment remains a problem in Lubumbashi. However, the workshop organizers were careful not to raise standards or expectations to a level which could not be maintained by participants in the future with available equipment and techniques. The primary value of this workshop was seen as a training event with useful products--not as an opportunity to demonstrate sophisticated options. Although this perspective required patience on the part of facilitators, it produced confidence among the participants.

Unusual Mothers

Although health workers and radio spots are undoubtedly important in reaching Zairian mothers, communication occurs most profoundly at the community level, from family member to family member and from woman to woman. An awareness of this fact led to the creation of a new category of volunteer health worker in Ruashi--the Maman Tengeneza, or mother for improvement--who would be a liaison between the communities and the health center. The idea was conceived by the Ruashi IEC team. Together with a consultant, they created a two-day curriculum for selected mothers, followed up by an additional day of training each month. The consultant created a guide which could be used in future trainings. Criteria to become a Maman Tengeneza included 1) regular attendance at well-baby clinic sessions; 2) a voluntary spirit; 3) a dynamic personality including community influence and acceptance; and 4) having at least two children. The Maman Tengeneza practiced ways to motivate their neighbors to have children fully immunized, to encourage mothers to attend growth monitoring sessions, and to use ORT as soon as their children have diarrhea.

Monitoring has shown that mothers are especially interested in coming to Maman Tengeneza for advice on nutrition and on how to prepare and administer the rice-based gruels for children who have diarrhea. The Maman Tengeneza are reaching out more actively than was anticipated. They have been especially successful in identifying those children who have not been vaccinated. Some of the volunteers even take these children to the health center when mothers are unable to do so themselves.

LESSONS LEARNED

In many development projects, "participatory decision making" is an oft-used phrase and a seldom-risked process. In the HEALTHCOM/Zaire project, it was a necessity. The structure of the health system made top-down planning unfeasible. Logistical obstacles and a small staff made local initiative the only true engine for action. At the same time, the interest of many organizations at a variety of levels made consensus-building the only workable approach to planning.

Although the project design process was a long one, it was evidently quite successful in terms of clarifying roles, building commitment, and establishing good working relationships among a variety of groups representing several layers of the Ministry of Public Health infrastructure. It also served to introduce certain elements of the HEALTHCOM methodology to dozens of people involved in the planning process as well as generate a great deal of interest in the methodology.

The process of institutionalizing skills and systematic methods is not an easy one. In Zaire, the situation is even more complex given the decentralized nature of the health education infrastructure at the national level and the lack of such infrastructure at the level of region and zone. The resident advisor approached this problem by casting the training net as wide but as carefully as possible, rather than by concentrating efforts among a few centrally-located individuals. She also took care that techniques and expectations were appropriate to local capacities so that expatriate involvement would help solve, rather than create problems. The Zaire experience demonstrated that there is no replacement for local skills and local enthusiasm. The "payoff" was the discovery of just how powerful such commitment can be when it comes from those who are closest to the beneficiaries themselves.

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