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Health Technical Services Project

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ACCOMPLISHMENTS, CHALLENGES, AND FUTURE DIRECTIONS:

COMMUNICATION ACTIVITIES OF THE USAID OFFICE OF HEALTH AND NUTRITION

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Preface

This report is based on information from two sources: (1) a series of interviews with USAID cognizant technical officers involved in previous and current communication activities, as well as with key staff of the implementing organizations of these projects (see List of Persons Contacted, Annex A); and (2) a review of documents generated from these activities that describe the activities conducted, results obtained, and lessons learned (see References, Annex B). The author is grateful to those who took time to share their views on this important topic.

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Executive Summary

Purposes of this Paper

1. To synthesize the accomplishments to date of health and nutrition communication projects of the G/PHN/HN (USAID Office of Health and Nutrition).

2. To identify ongoing challenges and unresolved issues for the current G/PHN/HN health and nutrition communication projects.

3. To propose directions (objectives and components) for future program and/or project activities in the area of health communication.

USAID Achievements in Health Communication

USAID has played a leadership role in demonstrating the effectiveness of mass and interpersonal communication to bring about behavioral change in numerous health sectors. The main achievements with regard to health communication interventions supported to date by USAID include the following.

- Empirical demonstration of effects of communication programs
- Widespread application of the Health Communication Methodology within projects
- Use of behavioral analysis in program design
- Shift of focus toward the consumer (e.g., "Mothers matter")

Challenges in Health Communication

Despite these notable advances, there are still technical, financial, and managerial problems that deserve further attention in USAID-funded communication programs:

1. In some cases it may be more effective to attempt to change policy than to change the behavior of the target population directly through communication programs.

2. Communication activities are most effective when they are fully integrated with service delivery. Yet too often, program managers treat communication as an "add-on."

3. With shrinking resources for development assistance, program directors and project managers must weigh the cost-effectiveness of alternative strategies.

4. Community participation is essential to the success of certain interventions, yet costly on a per capita basis and limited in the number of persons reached.

5. Interpersonal communication between health worker and client (counseling) is markedly inadequate in many countries.

6. It is fairly easy to achieve a measurable change in behavior, but the effects often subside once the communication support is withdrawn.

7. There are few cases where the health communication methodology has been institutionalized.

8. All programs are designed to change behavior, but demonstrating these effects is often difficult.

The Future of Health Communication

It is proposed that future communication activities within G/PHN/HN complement existing activities and promote sustained behavior change, working to advance the state of the art in four areas:

1. Design and implementation of health communication programs

2. Policy communication/advocacy

3. Evaluation (program monitoring **and** impact assessment)

4. Continuous updating of "what works" across health problems/disease areas.

Proposed objectives of future communication activities are:

1. To make the health communication methodology the "industry standard" for all communication projects supported by G/PHN/HN.

2. To establish "standards of practice" for designing and implementing communication programs aimed at policy makers, based on actual interventions and testing.

3. To improve the evaluation capacity of CAs and counterpart organizations in developing countries with respect to monitoring and impact assessment of communication interventions.

4. To serve as an intellectual clearinghouse to continuously analyze and update the knowledge base on "what works" across different disease areas.

A series of issues to be addressed and illustrative activities for each are described.

I. Purposes of Document

The purposes of this paper are:

1. To synthesize the accomplishments to date of health and nutrition communication projects of the G/PHN/HN (USAID Office of Health and Nutrition).

2. To identify ongoing challenges and unresolved issues for the current G/PHN/HN health communication projects.

3. To propose directions (objectives and components) for future program and/or project activities in the area of health communication.

There is a substantial literature that has developed in recent years on the main lessons learned regarding health communication (Parlato et al., 1992; AID, 1993; Graeff et al., 1993; Jenniskens and Obwaka, 1993; WASH, 1993). Thus, this paper will briefly highlight key accomplishments, but will focus mainly on continuing challenges and future directions.

II. Accomplishments in Health Communication to Date

Behavioral change is critical for achieving improved health. Specifically, the sustained use of appropriate health practices by populations is necessary for public health impact. Because in many cases, morbidity and mortality can be prevented, the role of health communication to teach and support preventive practices has become more central to public health programs in developing countries (Graeff and Waters, 1994).

USAID has played a leadership role in demonstrating the effectiveness of mass and interpersonal communication to bring about behavioral change in numerous health sectors. The approach used and the name given to it may vary from one context to another (e.g., the health communication methodology, social marketing approach, the research-based approach to development communication, etc.). However, the common element is to systematically (scientifically) assess the behavior, relevant knowledge, attitudes, and skills of target groups within a given population; and to use this information in designing/modifying service delivery and communication activities accordingly (Graeff et al., 1993). The main achievements with regard to health communication interventions supported to date by USAID include the following.

A. Demonstration of Effects

In marked contrast to the situation two decades ago, there is now a substantial literature that demonstrates the effects of communication interventions on changing behaviors in the area of health and nutrition (Seidel, 1992). Evidence is clear-cut that well-designed communication programs can bring about measurable change. It does not occur in every setting, nor on every intervention; however, it is consistent enough to strongly affirm the contribution of communication programs to the behavior change process.

Characteristics of effective IEC interventions tend to include:

- A clearly defined target audience
- An intensive "campaign" using multiple channels
- Targeting of specific behaviors

- Appropriate messages, pretested among the target audience
- Coordination of timing and content of messages with other service delivery systems
- Monitoring and mid-course corrections.

There are no "formulae" for the correct mix of channels. These decisions depend on multiple factors, including the desired behavioral change, the target audience, the types of communication channels available, and budget, to name a few. However, there are some "standards of practice" that influence these decisions.

B. Widespread Application of the Health Communication Methodology within G/PHN/HN Projects

There is no single "standard" or "model" for health communications; different organizations may choose alternative means of diagramming the process and labeling the steps. Nonetheless, there is remarkable consensus across USAID cooperating agencies regarding the need for a systematic approach to developing and implementing communication programs for changing behavior. Common to this approach is the feedback loop with the stages of:

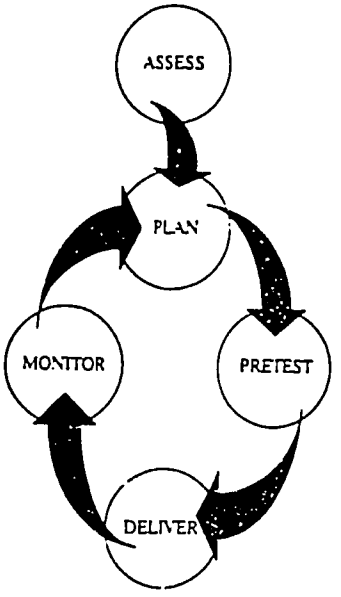
Assess -- Plan -- Pretest -- Deliver -- Monitor

This commonality in approach is illustrated in Figure 1, which shows the strategy or approach advocated by selected cooperating agencies or projects dealing with different health problems.

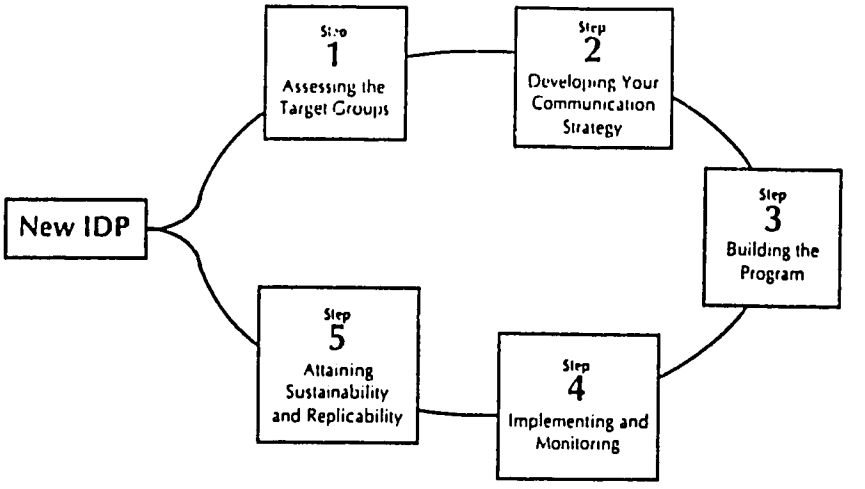
Given the common tendency for organizations to want to put their "original stamp" on their work or to claim a unique approach, the consensus that exists regarding the most effective approach to designing and implementing a communication program is truly an accomplishment. Ideally, different organizations working in a given country would promote this common approach, increasing the likelihood that it would be adapted by counterpart implementing agencies in developing countries.

Successful programs map out where they want to go and how they plan to get there. The technical term for this is a **conceptual framework**, which shows inputs, processes, outputs, and outcomes. It generally outlines the resources that will be used to carry out a specific set of activities, the behaviors these are intended to affect, and the health outcomes that will be achieved by such behavioral change. The "Pathway to Child Survival" (Annex C) is one such conceptual framework, which serves to guide the design of interventions and identify the variables to measure in evaluating its effectiveness.

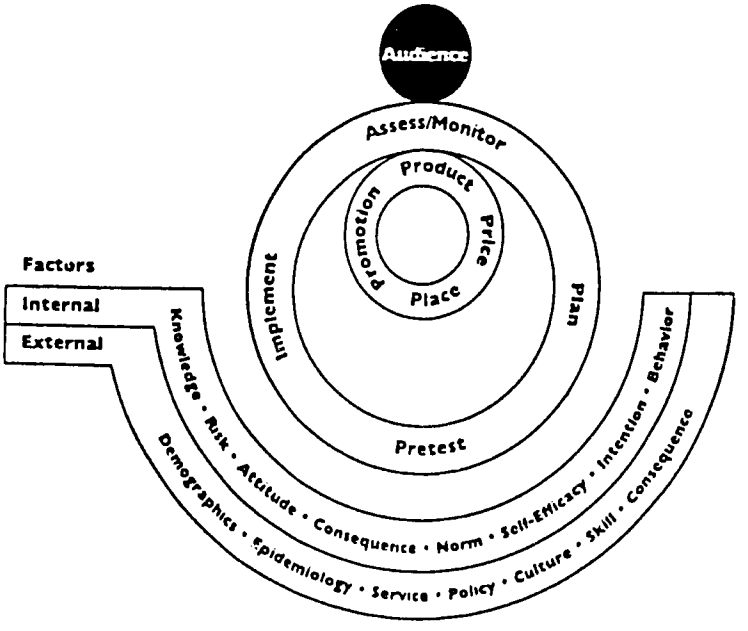
Figure 1. Alternative Presentations of the Health Communication Methodology



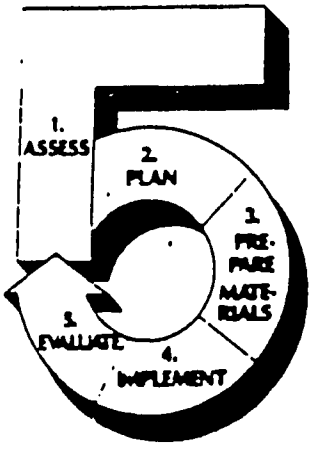
HEALTHCOM
Source: Graeff et al., 1993



Office of Health and Nutrition, USAID
Source: Oliver, 1994



AIDSCOM
Source: AIDSCOM, 1993



Network for Nutrition Education in Africa
Source: Parlato et al., 1992

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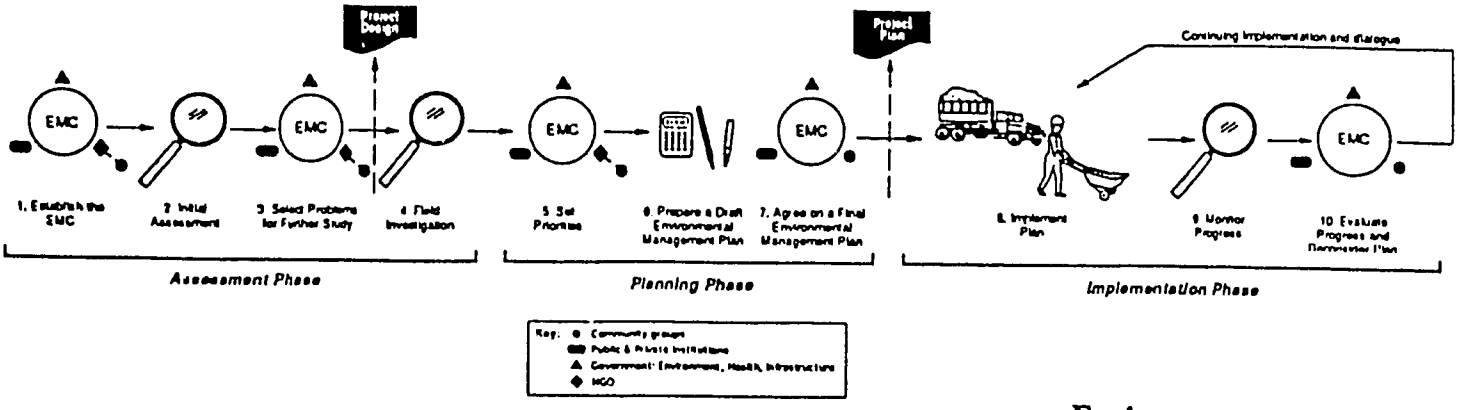
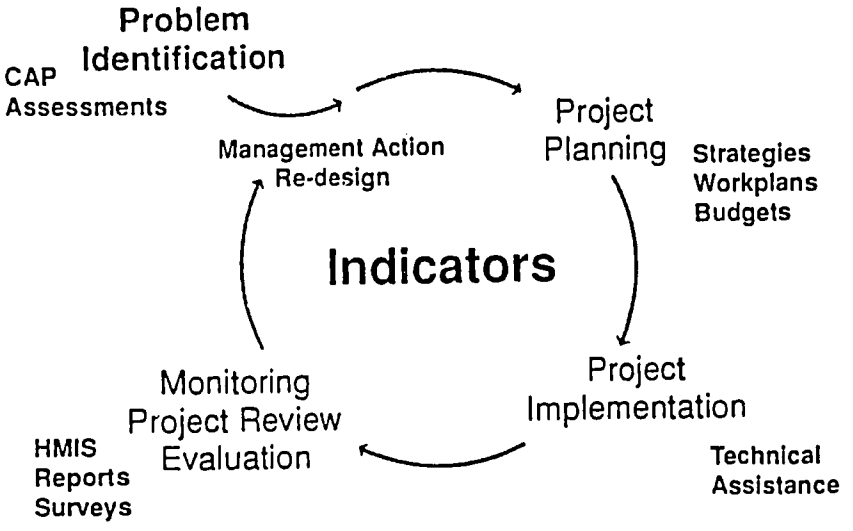
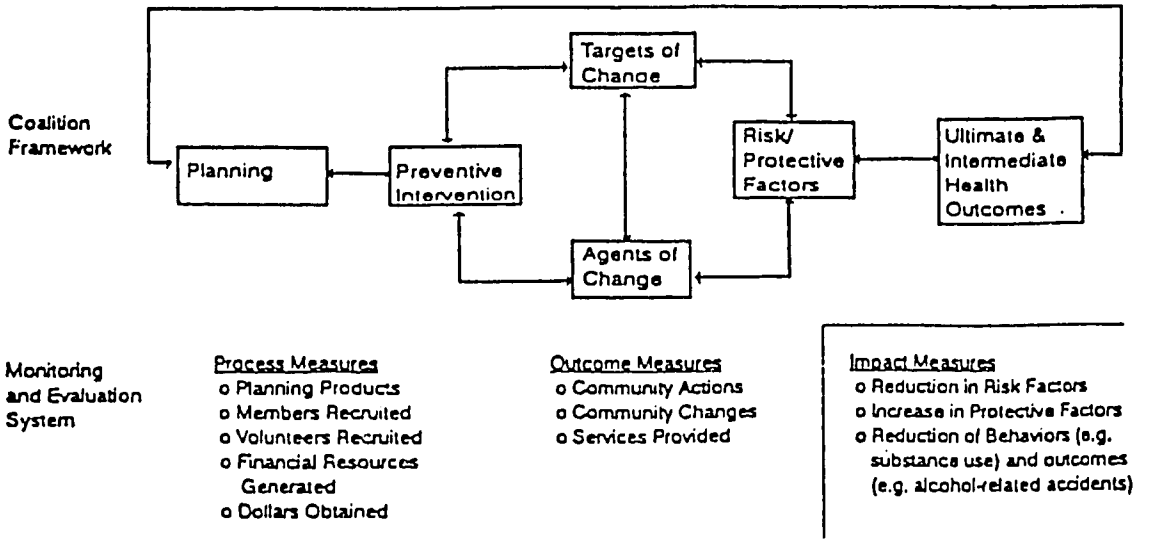
Figure 1 (continued)



Environmental Health Project
Source: Yacoob et al., 1994



BASICS
Source: Kleinau, 1994



Working Group on Health Promotion and Community Development
Source: Francisco et al., 1993

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C. Use of Behavioral Analysis in Program Design

A key element to effective communication programs is an understanding of the behavior(s) in question. What appears to an outsider as a simple task (e.g., giving oral rehydration solution to a child with diarrhea) in fact entails **many steps** that need to be performed in sequence. At each step there may be obstacles that can potentially derail the process, even where motivation exists, such as lack of knowledge, of skills, of supplies and equipment needed, of social support, of financial resources, to name a few. In designing communication campaigns, it is essential to understand the multiple steps required to successfully accomplish the "ideal behavior" and to understand the potential obstacles to successful completion (Graeff et al., 1993).

Behavioral analysis also entails an analysis of the antecedents and consequences to behavior. This has been labelled the "ABCs" of applied behavioral analysis, referring to Antecedents, Behavior, and Consequences. Antecedents are environmental factors that set the stage for or trigger behavior; consequences are environmental events that follow a behavior and either strengthen, weaken, or stop it. The most powerful communication programs are those that strengthen the linkages between the antecedents, the occurrence of the behavior, and the consequences. "Marketing the consequences" is one example of incorporating this type of analysis into the design of a communication program (Graeff et al., 1993).

D. Shift of Focus toward the Consumer

A major accomplishment of health communication programs over the past two decades has been to shift the focus of interventions from the interests and needs of the **program administrators and service providers** to the interests and needs of the **consumer**. This shift is implicit in the steps above: assessing consumer knowledge and attitudes, identifying obstacles to change in the particular environment as well as sources of reinforcement for given behaviors. Where programs have succeeded, one basic message tends to pervade the messages disseminated and the thinking of the program personnel at all levels: **THE CONSUMER MATTERS**.

This focus on the consumer is manifest in somewhat differ ways for programs that depend on mass versus interpersonal communication. Those using mass media often follow the **social marketing** model, whereby considerable effort is invested in creating a product (or behavior) that will be maximally satisfactory to the potential consumer, in terms of name, type of packaging, price, accessibility of supply. The communications used to promote the product are carefully tested for attractiveness, comprehension, cultural acceptability, and related factors among members of the target audience.

With regard to interpersonal communication, one way in which the focus on the consumer comes into play is through **quality assurance**. The efforts of the G/PHN/HN over the past decade in this area have resulted in systematic approaches to determine what the health worker

should be doing and whether he/she is doing it. While this might seem obvious or simple, it is in fact an enormous task when one thinks of the sheer number of health workers providing care throughout developing countries today. To the extent they have been implemented, these efforts are intended to improve the technical and interpersonal aspects of service delivery, with the result that the target population will be better served and more likely to seek preventive services and proper care for episodes of illness in the future. This focus on the client is by no means limited to a clinic-based setting; it is equally appropriate for other types of face-to-face communication in a community setting.

This list of four main accomplishments hardly does justice to the many lessons learned from the numerous health communication projects conducted to date under the auspices of the G/PHN/HN. Rather, the accumulated knowledge from these efforts has been documented in numerous monographs, reports, and other papers (e.g., AED/HEALTHCOM, 1993; AIDSCOM, 1993; Parlato et al., 1992). This section takes one step back from the details of specific projects and attempts to highlight the principal contributions of this group of projects to the field of development communication.

III. Ongoing Challenges and Unresolved Issues in Current Communication Programs

Despite the notable advances in the state of the art in health communication programs over the past two decades, there are still technical, financial, and managerial problems that compromise their effectiveness. In the interviews conducted among communication experts and other key technical personnel involved in the existing G/PHN/HN projects, a number of issues surfaced. As G/PHN/HN contemplates strategies for developing future activities, it is important to address some of these issues.

ISSUE #1. In some cases it may be more effective to attempt to change policy than to change the behavior of the target population directly through communication programs.

In the past most health communication programs have attempted to bring about behavior change by targeting interventions to a specific segment of the general public. However, there is a growing recognition that in some cases, a crucial first step is to alter **policies** that directly or indirectly affect the behavior, for example (Policy Working Group/The EVALUATION Project, 1993):

- Tax and import policies (sales tax, import tariffs)
- Advertising and promotion regulations
- Restrictions on service delivery and distribution, licensing, private practice
- Restrictions affecting non-profit organizations (on the sale of donated commodities, use of field workers, fees charged for services, etc.)

Policy makers constitute a powerful audience for health communications. Not only do they set budget priorities, they also have the power to make broad legislative changes that can have a major impact on behavior (Parlato et al., 1992). However, communication specialists have relatively less experience in developing communications aimed at policy makers than programs for the general public.

There is considerable variation in experience with policy communication across existing projects. This area is fairly well developed in the AIDSCAP project, given the political and economic implications of AIDS to host countries. BASICS has identified the need for greater advocacy vis-a-vis child survival program development and funding, both in the developing country context and among donors; consequently, they expect to expand into this area. Similarly, staff from the Nutrition Communication Project cited the clear-cut need for advocacy or policy communication that would increase awareness of the importance of nutrition for the economic and social well-being of the nation.

It may be useful to enlist the assistance of professional communicators in-country, who not only understand communications but also the socio-political environment of the country. For example, one of the G/PHN/HN-funded projects cited a successful experience of enlisting assistance from a local advertising council in their advocacy efforts. This group was very interested in taking on a worthwhile cause and did it as a public service, charging only for production costs. They enlisted top talent who also volunteered time. Similar arrangements might well be possible in other countries.

In short, the need for policy communication is clear. However, the field has much to learn about how best to approach such activities.

ISSUE #2: Communication activities are most effective when they are fully integrated with service delivery. Yet too often, program managers treat communication as an "add-on."

This idea surfaced in several forms in the background interviews for this report:

1. When a communication specialist is part of the design team of a project, communication is incorporated from the start and becomes an integral part of the project. Yet, it is more often the case that communication is treated as an add-on, without much thought of how it will relate to other components of the design.

2. The project director/manager and the communication specialist on a given project may have conflicting agendas, presumably because the former feels the pressure to make demonstrable progress and show results, whereas the latter sees the need to advance systematically through the series of steps outlined in Figure 1.

3. Project directors are often trained as physicians or epidemiologists; thus, they may undervalue the contribution of the social sciences to achieving behavioral change or fail to recognize that there is a "technology" behind communication interventions.

4. Many communication activities are carried out but fall short of the mark because they are done on an ad hoc or piecemeal basis, not as part of a "holistic program" or "system."

ISSUE #3: With shrinking resources for development assistance, program directors and project managers must weigh the cost-effectiveness of alternative strategies.

The initial challenge to communication programs was to demonstrate that they could influence behavior among the target population. Now that this has been convincingly demonstrated, this line of research must be pushed one step further: "at what cost?"

Among those dedicated to improving the quality of life of one's fellow man worldwide, the discussion of costs is often repugnant. It implies focusing on the "masses" rather than on individual human beings. It evokes a "one size fits all" mentality, in which the interests and needs of the individual are by-passed.

However, there is an unescapable reality that future directors and managers must address the question of "going to scale" with programs. It is often possible to achieve effects in the context of a pilot project or a program limited to a specific region of the country. Without sacrificing entire programs to the mass media approach, it is essential to gain a greater understanding of the types of behavior change that can be produced using mass media, in contrast to those which must rely on interpersonal communication.

This latter comment is not meant to reflect negatively on interpersonal communication, which is unquestionably superior in allowing for individualization of the message and instantaneous feedback. Nor is it meant to contradict conventional wisdom that the most effective communication programs are those that employ multiple channels, including mass **and** interpersonal. Yet it is meant to draw attention to the financial reality that future programs will need to make maximum use of the mass media to reach the growing numbers in the target groups.

Consistent with greater cost consciousness, it is imperative that evaluators develop and refine measures for estimating costs in relation to effects. The work to date in this area is fairly simplistic (estimating the number of persons exposed to a given communication by obtaining "percentage exposed" from survey data and multiplying this times the estimated number of the population or subgroup in the catchment area). Yet it represents a useful start, and it adds perspective to the debate on mass versus interpersonal communication. For example, radio programs may change the behavior of only 5%, in contrast to home visiting that results in a 30% change. However, if mass media reach 100,000 members of the target audience, whereas home visits reach 5,000 (for a given amount of money), this adds a new dimension in assessing the relative value of the two.

ISSUE #4: Community participation is essential to the success of certain interventions, yet costly on a per capita basis and limited in the number of persons reached.

The above discussion of costs might be interpreted by some as a call for great reliance on social marketing using mass media channels. However, this approach tends to be most useful for promoting behaviors that can be practiced on an individual basis.

However, other health problems require a greater degree of community participation. For example, in the Environmental Health Project (EHP), hygienic conditions of the village depend in large part on the willingness of the community to collectively undertake actions to dispose of waste properly, ensure that wells and pumps are appropriately maintained, etc. In this situation, the mass media may play a role in creating awareness of certain health hazards and reinforcing the actions of community members to maintain their village systems. However, they do not substitute for interpersonal activities at the community level. Moreover, the EHP has seemingly achieved a certain success in institutionalizing the process in counterpart agencies, an accomplishment which has eluded many of the projects that rely more heavily on social marketing/mass media.

On one hand, there is great attraction in mobilizing community groups to work on health programs in ways that appeal to their own goals and objectives. At the same time, interpersonal approaches are labor intensive and costly. The question arises: are there strategies for promoting community participation that can be modified to reach multiple communities simultaneously and thus make these approaches more cost-effective?

To date, USAID has tended to promote the social marketing strategy over social mobilization. The latter refers to the mobilization of resources from multiple sectors (health, education, labor, women's affairs, etc.) and at multiple levels (from advocacy at the top levels of government to grass roots organization at the field level). In contrast to social marketing, where planners design strategies to bring about specific changes, social mobilization works more directly in those areas identified by participants involved in the process to be important to their well-being.

A discussion of future directions would not be complete without revisiting the issue of this type of approach to behavioral change. It is an appealing strategy in that it truly empowers members of the target groups to have greater control over their environment. However, it is important to analyze the costs and benefits of this approach. Some argue that social mobilization is highly labor-intensive (and thus costly); the elements of the intervention may not be clearly defined; and there is no guarantee that the communities involved will have the same priorities as USAID in terms of disease areas to target.

ISSUE #5: Interpersonal communication between health worker and client (counseling) is markedly inadequate in many countries.

The Quality Assurance Project did extensive research on health worker performance in multiple countries. They did thousands of observations to compare what actually occurred to what **should** occur. The results showed that the performance of health workers was generally weak. Moreover, supervisors were out of touch with the actual level of technical competence of their staff. Of the different areas of performance studied, the weakest was counseling.

Given the armies of health workers around the world and their potential contribution to increasing knowledge and changing behaviors, the issue of counseling merits renewed efforts. The solution requires attention to two levels: 1) at the central level: development of standards and monitoring to ensure self-assessment; and 2) at the facility level: self-assessment (for problem identification and solving).

This activity does not need to entail a vast influx of external experts and resources. Rather, it requires that local institutions define quality for their own system (i.e., what workers should be doing), promote self-assessment at facilities, and monitor the extent to which this occurs. The health workers themselves identify the weaknesses and propose means of improving on performance where needed. By definition, this approach is conducive to institutionalization, since local staff participate in it from the start.

The technology for improving worker training and monitoring performance is not complex. Rather, the challenge is in identifying ways to systematically introduce this process into the vast public systems that serve clients in developing countries. Given the importance of counseling, this area should receive priority attention in future activities.

With respect to quality assurance, evaluators are faced with the challenge of determining whether such activities do affect program output (results), since this is a key reason for focusing on quality.

Programs should also focus on the quality of interpersonal communication in non-clinic settings. Much information is communicated and attitudes are formed in discussions in a myriad of community settings. To the extent that programs can influence this type of communication to the benefit of programs, they should try to do so.

ISSUE #6: It is fairly easy to achieve a measurable change in behavior, but the effects often subside once the communication support is withdrawn.

There is clear-cut evidence that a well designed communications program can bring about measurable change in health behaviors; however, when the communication supports are removed, the behavior in question may fade.

Some would argue that this "drop-off" simply confirms the power of communication to affect behavior. With the intervention, one sees effects; as it disappears, so do the effects. Others claim that there should be ways to design communication programs so that they at least minimize if not eliminate the drop-off effect.

The one means proposed to achieve more sustained behavior change was for a given program to make the desired behavior "part of the medicine cabinet." That is, the product or behavior becomes as familiar as aspirin (in the Western household), and the general population recognizes and accepts it as the logical solution to a given health problem. One could argue that in many countries, ORS has become or is becoming part of this medicine cabinet. Those working in AIDS prevention aspire to doing the same for condoms. While this might eventually lead to a situation where less reinforcement is needed, it implies a very resource-intensive activity until the "transition into the medicine cabinet" is achieved.

Another approach to the issue of sustaining behavior involves a shift in the focus of communication. Instead of the strong focus on information and skills needed to do a specific behavior correctly, the focus should instead be on social support for the behavior (reinforcement from the media or health workers for the desired behavior).

The experts consulted for this paper tended to concur that it is unrealistic to expect sustained behavioral change following one-time communication campaign. ("Has Coke stopped advertising?") A more productive strategy may be to experiment with alternative strategies that provide intermittent reinforcement. The BASICS project is currently focusing on this issue as a key part of its activity, in part because the project works in the disease areas where it has been possible to achieve initial changes in behavior (vaccinations, diarrheal disease).

The topic of sustaining behavior change lends itself well to operations research (and is included in Section IV on Future Directions).

ISSUE #7: There are few cases where the health communication methodology has been institutionalized.

The purpose of strengthening technical capacity is to advance the organization toward self-sufficiency in the design, planning, and evaluation of high quality communication programs.

Moreover, it heightens the credibility of the IEC unit within the institution, thereby increasing the likelihood of favorable funding allocations in the future.

This was a main objective of HEALTHCOM II, yet the results are mixed at best. Despite long-term collaborations with USAID communication projects, staff of MOH and other implementing agencies often lack the skills to take the leadership role in:

- Assessing the needs and interests of the target population
- Developing a communication strategy based on this information
- Developing appropriate messages
- Encouraging community participation in the design and implementation of activities
- Training staff in counseling techniques
- Training staff on "missed opportunities" and creating systems to reduce them
- Monitoring activities and using the results to make mid-course corrections.

There are various reasons that it has been difficult to institutionalize the systematic approach to health communication:

1. There is considerable turnover of personnel in counterpart organizations. Once staff learn the skills involved in this process, they are frequently hired away by the private sector, leaving the original implementing organization with little institutional capability in this area.

2. To do the full-blown model (including demonstration of effects) requires more human and financial resources than implementing agencies have available on a routine basis (in the absence of a specially funded communication intervention).

3. Staff who have participated in different steps of the health communication methodology may nevertheless feel insufficiently prepared to do them without external technical guidance. In contrast to the expatriate communication specialists who tend to have masters or doctoral degrees in relevant fields, counterparts are often trained in short workshops and on-the-job exercises, which may not be sufficient to provide the necessary knowledge and skills to do a quality job on their own.

4. The process is by nature slow. It is essential to allow time for ownership; counterparts need to participate fully in the process and contribute their ideas to the project. Pushing too hard can be counterproductive to institutionalizing technical capacity.

5. Efforts to establish this type of training through local universities in developing countries have been hindered by red tape and other factors both in-country and at USAID.

ISSUE #8: All programs are designed to change behavior, but demonstrating these effects is often difficult.

HEALTHCOM I was designed to include detailed evaluation of communication effects. To this end, two research groups were given substantial funding to study behavioral change at the program level (e.g., in clinics) and at the population level (e.g., among a random sample of the target population) following the interventions. This effort produced an impressive body of research on communication effects (HEALTHCOM, 1993), which constitutes a large part of the evidence that communication programs can influence behavior.

However, the investment in this type of evaluation research is substantial. Although well justified to definitively establish the contribution of health communication to behavioral change, this type of research can not be conducted routinely.

In the existing G/PHN/HN-funded projects, rigorous evaluation is planned for only a small fraction of them. Some projects have tried to incorporate a solid demonstration of effects into their design, only to have the plans scrapped because of civil unrest, political disputes at an international level, or other factors beyond the control of project staff. For example, the Wellstart project planned a series of in-depth evaluations of effects in selected countries; however, it was unable to carry through with these projects which were planned for Rwanda (because of political and civil turmoil in spring of 1994), Cameroon (the USAID Mission closed), Nigeria (political restrictions on working with government), and Guatemala (contract with INCAP fell through). Thus, even with the best of plans, there may be political or administrative obstacles to implementing this type of research.

In projects financed by the Missions, support for all activities including evaluation comes from the Mission. It is not uncommon that Missions want **all** the money to go toward the program, with little or none to be spent on evaluation. These situations do not lend themselves to an evaluation of effects.

There is general consensus that attempting to demonstrate communication effects (i.e., behavioral change attributable to the intervention) on **every** project would be a poor use of funds. It would consume a large part of project budgets, and it would most likely produce what is now well demonstrated: that well-designed communication programs (e.g., that are well integrated

with training, supervision, and service delivery) are effective in changing behavior, although not in every setting for every desired behavior.

However, if USAID wants to maintain its leadership position in health communication, it is essential that it continue to support evaluation research that demonstrates effects, at least on a small scale. In a few years HEALTHCOM I results will seem dated, and "skeptics" will look for evidence that current programs work. G/PHN/HN should build this research into its current portfolio to assure it will be there in the near future.

IV. Directions for Future Communication Initiatives

This section explores possible programmatic options for new communication activities in the Office of Health and Nutrition to complement existing activities.

A. Objectives

Future health and nutrition communication activities should ensure that USAID maintains its leadership role in the area of health communication by advancing the state of the art in the four following areas:

1. Design and implementation of health communication programs

2. Policy communication/advocacy

3. Evaluation (program monitoring **and** impact assessment)

4. Continuous updating of "what works" across health problems/disease areas.

Specific program objectives should complement existing objectives of the Office of Health and Nutrition in terms of increasing desirable health/nutrition practices and improving technical capacity of implementing agencies in developing countries.

The following proposed list is illustrative but nonetheless indicates the types of results that future health communication programs/activities should be held accountable for.

1. To make the health communication methodology the "industry standard" for all communication projects supported by G/PHN/HN.[1]

[1] Although the systematic approach is widely accepted by G/PHN/HN cooperating agencies, it is not necessarily implemented consistently in projects at the field level. The exact steps in the process may differ by type of health problem or implementing organization, but the key elements to include are: (1) the diagnosis of community interests and needs, (2) the design of communications consistent with the social context, (3) the planning of communication activities

2. To establish "standards of practice" for designing and implementing communication programs aimed at policy makers, based on actual interventions and testing.

3. To improve the evaluation capacity of CAs and implementing agencies in developing countries with respect to monitoring and impact assessment of communication interventions.

4. To serve as an intellectual clearinghouse to continuously analyze and update the knowledge base on "what works" and to synthesize the lessons learned **across diverse health problems**, making this available in user-friendly formats to multiple audiences worldwide.

B. Complementarity of New Program Activities and Existing Projects

It is essential that any new health communication activities complement and enhance--not compete with--existing G/PHN/HN projects, and provide technical resources that will directly benefit the existing projects without duplicating efforts. Such resources include:

- Communication expertise in specific areas, if it is not already available in-house on existing projects[2]
- Continuing education on emerging technologies and key developments in the field
- Technical forum for addressing problems that crosscut G/PHN/HN-funded projects (e.g., indicators for evaluation)
- Co-funding of activities (e.g., design and testing of policy communications).

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with key aspects of training and service delivery.

[2] For example, BASICS, AIDSCAP, MOTHERCARE, etc., have one or more communication specialists as part of the project. By contrast, the Health Care Financing and Sustainability Project does not have this in-house expertise. Nonetheless, they have periodic need for it, for example, in projects where systems of cost recovery are to be implemented and these changes need to be marketed to the target population. Although they could simply hire a consultant to do this work, he/she might not use the health communication methodology. The advantage of having a source of technical capacity within the family of G/PHN/HN projects is to assure greater consistency in approach.

C. Issues to Address and Proposed Activities

The text that follows reflects the types of issues that could constructively be addressed in future health communication programs under the four objectives (listed in Section IV-B), as well as relevant activities. Included in this list are a number of the issues described earlier as "ongoing challenges" or "unresolved problems."

Objective #1. To make the health communication methodology the "industry standard" for all communication projects supported by G/PHN/HN.

Illustrative issues to address:

- (Although many communication programs include both mass media and interpersonal communications), is the health communication methodology appropriate primarily to those projects with a heavy mass media focus?
- How does the approach differ or what adaptations are called for in projects that rely largely on interpersonal communication or community mobilization?
- Can USAID missions be persuaded to build communication activities into projects from the start?

Proposed activities:

- Technical assistance (TA) to USAID Missions requesting it, stipulating that G/PHN/HN can only support TA in which the communication component is part of a system and not ad hoc, piecemeal communication work on a low budget.
- Technical guidance to existing G/PHN/HN projects that do not have a communication specialist.[3]
- Identification of focal countries and concentration of activities in them, where different activities can be mutually reinforcing and lead to more measurable results in terms of behavioral change and institutionalization of the process. One of the criteria for selecting focal countries should be perceived political stability.

[3] Technical experts should not do the work of the existing projects, but rather assist in strategic thinking and review of the process as it evolves.

- Establishment of a "emergency response team" for sporadic disease outbreaks. A kit of procedures and guidelines relevant to emergency response situations should be developed, that would be ready when the need occurred.

- Development of a curriculum to be introduced into local universities or other training organizations for teaching the health communication methodology in public health and related disciplines. This activity is designed to institutionalize the health communication methodology in developing countries. HEALTHCOM (II) staff initiated this type of activity, but learned that as a general rule it requires substantial time to get new courses added to the curriculum of a university. However, given the current expansion of schools of public health in developing countries, this curriculum should be developed into a package and translated into French and Spanish for use in the training of the next generation of health professionals. Given the dearth of such materials, it is likely to be well received and implemented, quite possibly into existing courses.

Objective #2. To establish "standards of practice" for designing and implementing communication programs aimed at policy makers, based on actual interventions and testing.

Issues to address:

- What are the most effective channels for reaching policy makers and other influentials?

- How can the messages be most effectively delivered or packaged?

- How does the nature of the message or the type of influential affect the choice of channel?

- What indicators exist to measure the effects of the communication intervention?

Proposed activities:

- Operations research projects involving policy communication and advocacy in different cultural settings that carefully document the process and monitor the results.

- Preparation of "how to" materials with results from case studies on policy communication and advocacy for dissemination to relevant audiences.

Objective #3. To improve the evaluation capacity of CAs with respect to monitoring and impact assessment of communication interventions.

Illustrative issues to address:

- Based on field experience to date, what are the most useful indicators for monitoring program effects that are both affordable and practical?

- What approaches and indicators are appropriate for measuring "community participation" or "community empowerment"? What does a community do when it is empowered? Does such empowerment lead to a change in norms?

- Is it practical to design new projects as natural experiments, which can be evaluated using routine service statistics, but still yield conclusive results regarding effects?

Proposed activities:

- Formation of a communication research working group that crosscuts all existing projects within G/PHN/HN, to meet several times a year to discuss a specific technical issue each time.[4]

- Development of a reference document on monitoring and evaluating communication programs, including (2) indicators, (b) methodological issues, (c) practical study designs, and (d) case studies.

- Demonstration of effects on selected projects. For reasons outlined above, it is essential for USAID to continue to support evaluation research on a limited basis that provides convincing evidence of the ability of communication programs to influence behavior. Future health communication program activities could assist in this effort in at least two ways: (1) in the context of the communication research working group, proposed above, identify targets of opportunity across the different G/PHN/HN-funded projects (the "portfolio of projects designed to demonstrate effects"), and use the working group as a forum for an exchange of technical information; select as coordinator of the working group an individual who is qualified and available to provide technical assistance to specific projects in this area on an ad hoc basis; (2) in the case where an existing project has no communication research expertise, design and conduct the research under the technical direction of the new program activities (in close collaboration with existing projects in the country in question).

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[4] To be effective, these meetings need to be organized along the lines of a "technical experts meeting," with background materials, an agenda with clear objectives, a strong moderator, and appropriate participants. The objective is not to promote one's own project but to share information on technical issues of mutual interest.

Objective #4. To serve as an intellectual clearinghouse to continuously analyze and update the knowledge base on "what works" across different disease areas.

Issues to address:

- How does health communication differ by type of sector? What is common to successful communication programs across sectors?
- What are the particular characteristics of disease areas or health problems that require different approaches?
- What approaches or conditions favor sustained behavioral change? Can it be achieved in the absence of big budgets/mass media support?
- Are key theories of behavioral change verifiable in differing settings (e.g., reasoned action, social learning theory, health belief model); except in connection with AIDS, little such research has been conducted on this topic.
- What are gaps in our knowledge of how mass and interpersonal communication work to influence behavior?

Proposed activities:

- Meta-analysis of communication projects across disease areas, both inside and outside USAID, updated as new information becomes available; to be used in synthesizing lessons learned across disease areas, organized by topic (e.g., types of media used, nature of message, characteristics of target audiences, obstacles in carrying out the intervention, type of monitoring/indicators used).
- Development of a multimedia data base (with continuous updating).
- Dissemination of materials in electronic form for dissemination to practitioners and researchers worldwide (e.g., executive summaries of each category, with abstracts of relevant articles).

Annex A

List of Persons Contacted

Persons Contacted

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Annex B
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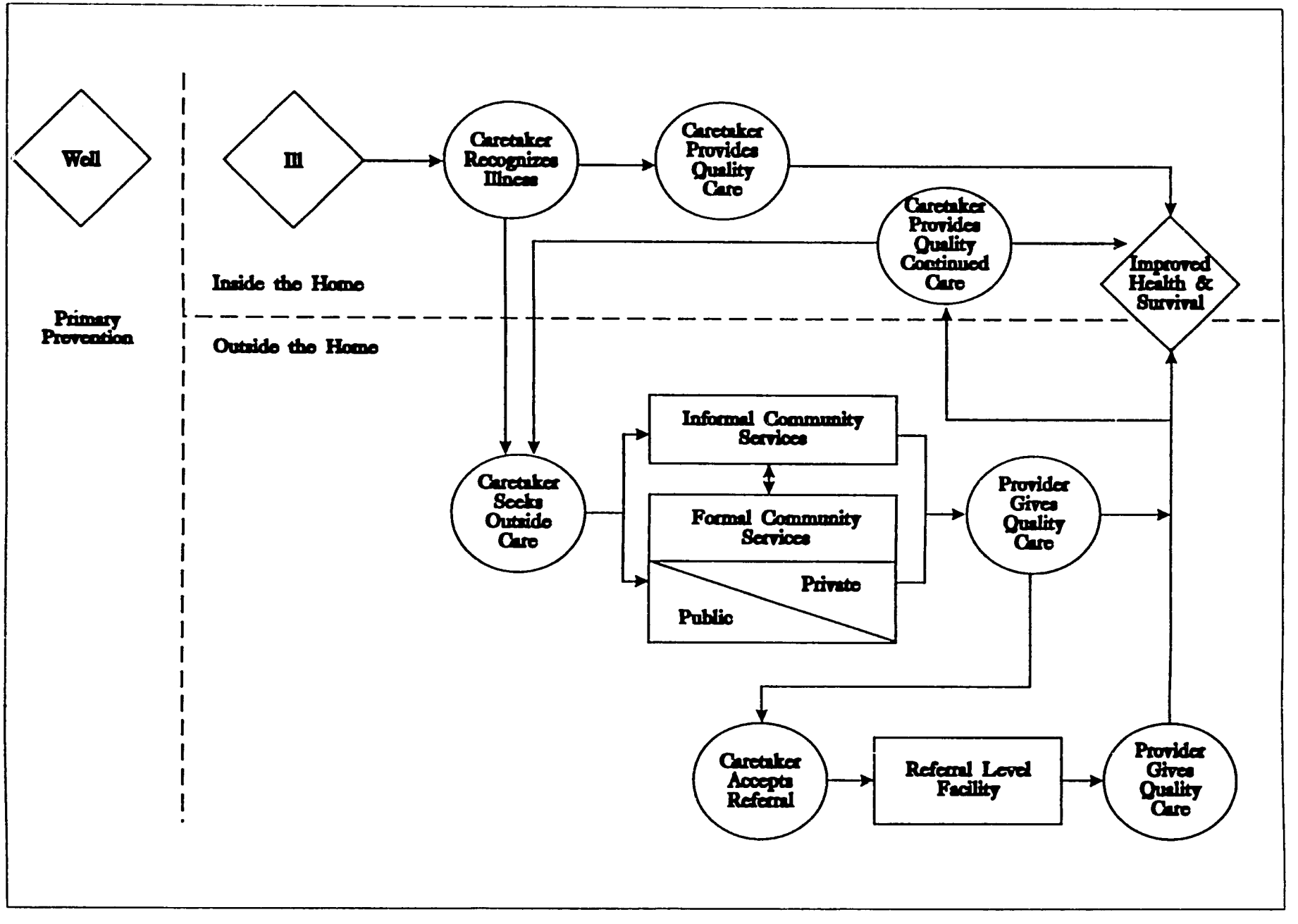
Annex C

Pathway to Child Survival

Pathway to Survival



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