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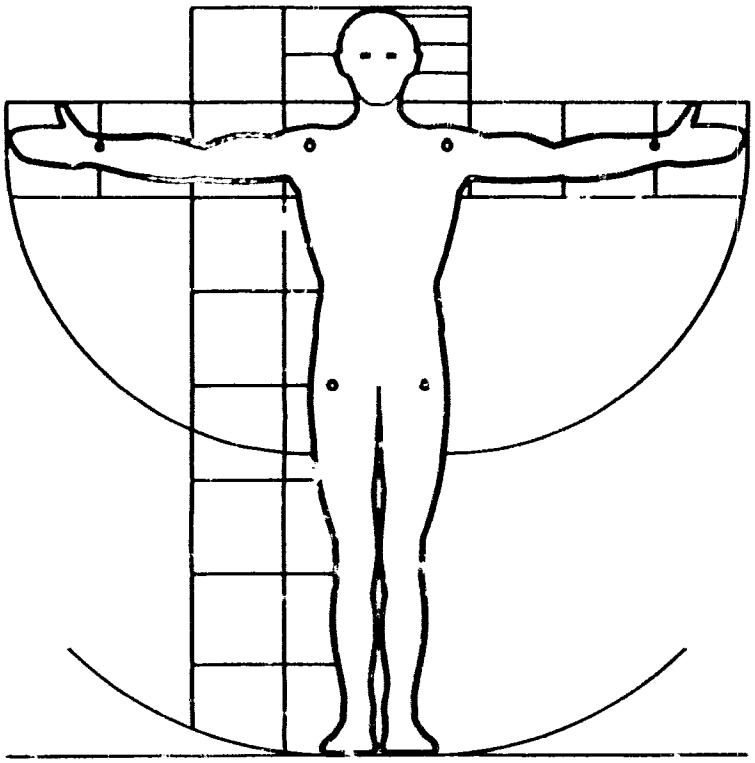

AIDS EDUCATION:
LESSONS FROM INTERNATIONAL HEALTH

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The Academy for Educational Development

The Academy for Educational Development is one of the principal organizations working with nations and donor agencies seeking solutions to international development problems. Since its founding in 1961, The Academy has worked with hundreds of projects and thousands of professionals in education, agriculture, health and family planning, telecommunications, radio, television, vocational and technical training, and cultural exchange. The Academy has organized farmers' extension groups supported by specially designed radio programs, planned computerized information systems, and designed and installed radio and television studios. It has created university consortia to develop teaching and research faculties in medicine, engineering, architecture, and veterinary science. The Academy has worked with telecommunication engineers to design innovative earth station hardware for satellite communications; it has worked with governments and private sector agencies to strengthen their institutional capacity for management, planning, training, evaluation, and internal problems; it has conducted and administered exchange programs and seminars for professionals from all over the world in the fields of education, communication, journalism, telecommunications, and development; and it has administered student placement and monitoring of academic and technical participant placement programs.

THE SPECIAL CHALLENGE OF AIDS

AIDS is a behavioral disease. It is transmitted largely by human action. It can be contained by changing the way we practice sexuality, the way we manage blood supplies, and the way we use recreational drugs. Finding effective ways to alter one of our most intimate and pervasive behaviors is the central challenge facing the international AIDS community today. In a global context where hundreds of languages, cultural differences and poverty are common, the challenge is particularly staggering.

But there is also reason to hope we can make a difference now. In the U.S. and Europe, AIDS information has made a significant impact on key practices already. **Family planning** programs have worked successfully for three decades on modifying sexual behavior. For the past ten years, **child survival technologies** such as oral rehydration therapy and immunization have achieved behavior change in a wide spectrum of cultural and economic groups around the world. **Cancer and heart disease education,** along with **seat belt** programs, **alcoholism, drug abuse** and **sexually transmitted diseases** have used intensive public education as effective control strategies.

Several key lessons have emerged from this experience which can guide our effort to stop AIDS transmission. This paper reviews the AIDS problem, outlines lessons learned from similar international health problems, and suggests an approach to effective AIDS education.

THE DISEASE

Acquired Immunodeficiency Syndrome (AIDS) and the spectrum of disease associated with lymphademopathy-associated virus/human T-lymphotropic virus type III (LAV/HTLV-III) infection is now being recognized as an international problem. LAV/HTLV-III infects the immune system and the nervous system (brain) and incorporates its genetic material into the genetic materials of the infected person, resulting in what appears to be a life long infection.

AIDS, the most severe consequence of the infection, is characterized by destruction of key elements in the host immune system, resulting in a series of severe and ultimately fatal opportunistic infections and malignancies. A series of severe yet lesser clinical manifestations of LAV/HTLV-III infections are classified as the "AIDS related complex" or ARC. Persons with ARC suffer ill health - e.g., chronic fever, diarrhea, weight loss, night sweats, and swelling of lymph glands.

By September 19, 1986, a total of 31,646 AIDS cases had been reported to the World Health Organization. Seventy-four of 100 countries which report on AIDS to WHO have reported AIDS cases. The largest number of reported cases is from the Americas. Thirty-three countries in the Americas reported 27,166 cases -- 86% of the total. Europe has reported 3,127 cases from 22 countries; Africa, 1,008 cases from 10 countries; Oceania, 293 cases from Australia and New Zealand; and Asia, 52 cases from 7 countries. AIDS cases reported to WHO only reflect a small portion of the worldwide AIDS problem.

The first case of AIDS was described only five years ago. AIDS is present in many countries and in many population groups, and it will continue to spread unless efficient control programs are established.

THE AFRICAN SITUATION: One Example of the Problem Worldwide

Fifty thousand people have died from AIDS since its first confirmed appearance in the late 1970s in 11 nations from the Congo to Tanzania. The unreported death toll to date may be several hundred thousand. Five million Africans may carry the virus. Between 10 and 30 percent of persons exposed to the virus are expected to develop AIDS. Conclusions about mortality are imprecise due to limited resources for epidemiology, under-reporting, and misattribution of cause of death.

Spread of AIDS in Africa is predominately by heterosexual relations or passed in utero from mothers or recipients of blood through transfusions. Transmission is also possible through male bisexual relations.

THE EDUCATIONAL IMPLICATION

AIDS presents a particularly difficult educational challenge because:

AIDS is fatal. There is no effective cure or vaccine to prevent its spread. It represents the ultimate threat. From an educational perspective, this is both a plus and a minus. Death attracts attention, and AIDS has received widespread media attention already. But death also frightens people, and the absence of a simple answer frustrates and turns many people toward denial behavior.

AIDS is transmitted sexually. Sex is not the only transmission vehicle, but it is a primary one. And sex is the most intimate and taboo-laden of all human practices. Again, sex attracts attention, but it also places special constraints on the willingness of governments to be candid and explicit about educational messages. And sustained change in sexual behavior doesn't happen easily.

AIDS is also transmitted through blood exchange: IV transfusions, recreational drugs, or traditional healing practices. Again, all three areas are difficult to control or manipulate.

AIDS is new and not well-understood. While our knowledge of the disease is growing rapidly, there is much about its life cycle, consequences, and transmission we do not know. This means that messages which appear sound today, may be proven erroneous tomorrow. But one cannot wait for complete understanding. What we know now could save thousands of lives. We must be willing to risk.

Finally, **AIDS is a pariah disease.** It has been stereotyped as retribution and stigmatizes not only its victims, but whole groups and societies. This means many countries are reluctant to admit the problem exists, much less adopt aggressive public education to stop transmission.

LESSONS FROM PAST PROGRAMS

International health and population education, as traditionally practiced, has often meant:

- A poster, pretested with the local cleaning lady because "she's from the rural areas;"
- A flipchart developed for group presentations that never take place because there is no money for travel or the flipchart never reaches health workers;
- A few "slick" TV spots which please the ministers but give little useful information;
- Radio programs which advertise services that do not exist or give advice no one can take;
- Hours of lectures on community participation given to health workers who are too overworked to treat patients, much less organize community groups.

Far too often we have pushed **ill-conceived messages** through **weak channels** at the **wrong people** with almost **pitiful levels of resources.**

All of this occurs despite the fact that we know better. It is not that we do not know **how** to teach people - just as it is not true that we do not know how to rehydrate a child. The problem is how to implement what we know - how to put a system in place which reflects our understanding of how people learn and what works in the real world of poorly-trained and overworked staff, scant and unreliable budgets, and shifting health priorities.

PRINCIPLES THAT WORK

Effective public health communications means to:

- **Have a complete plan** , not a piecemeal one. Necessary elements of the plan are:

  - A **product** designed to meet consumer needs at a **price** they are willing to pay;

  - An adequate **supply and distribution** system;

  - A single set of **simple,** noncontradictory **messages** and an explicit **linkage** between what service providers, product distributors, radio, and print media tell the public;

  - A **training program** for health workers and product distributors which emphasizes teaching skills as well as service delivery;

  - A **broadcast schedule** timed to reach specific audiences;

  - A series of **simple print reminders** of primary skills for each health technology.

- **Base the plan on field research.** An effective plan must be based on field research of existing audience practices and beliefs, as well as product and feasibility testing, and channel research.

- **Segment audiences** for specific, consistent, and ongoing messages and maintain regular, direct contact with and feedback from these groups. Do not neglect influential members of these groups.

- **Develop messages that are compatible** with the audience's belief structure, that emphasize the personal advantages of the health technology for the target audience, and that attract and hold attention.

- **Collaborate closely with health care providers**--government and private, medical, traditional, and commercial--to stimulate their use of or reference to materials and messages in working with clients. Provide training as needed.

- **Use many intermediate measures,** as well as goals, to assess project effects and make mid-course corrections. Encourage attention to management needs and capabilities, as well as audience impact.

- **Provide for coverage, timeliness, and credibility** - all three are needed. Coverage is the ability to reach many people quickly, and it is best achieved through the **media.** In most countries, this means radio. **Timeliness,** or the availability of specific reminders about child survival behaviors at the moment they are needed, is best accomplished by print and graphic materials - for example, a growth

monitoring chart or immunization card. **Credibility,** or the acceptance of child survival behaviors by patients, is best achieved through the full support and use of these technologies by recognized health professionals in the country - physicians, nurses, and health workers - as well as product distributors and community-level opinion leaders, such as traditional healers.

- **Build in participation** of local policy-makers and training of project implementors to the extent possible, so that they can learn from the project and replicate the process with minimal outside expertise. The local agency should be encouraged to articulate project design and take the lead in project implementation.

- **Consult with** people from **different disciplines** and backgrounds (including physicians, marketing professionals, auxiliary health personnel, commercial retailers, and communication specialists) throughout the life of the project, to secure the diverse skills and technical expertise needed.

- **Emphasize the need for** communication projects to accompany and **reinforce service availability.** To this end, maintain contact with other activities and private agencies to share resources and ensure well-trained communication support in expanding services.

Programs that seek to teach new behaviors, particularly to large, dispersed audiences, are better when they:

- **Define through research** what the health problem really is, whom it affects, how those people understand and respond to the problem, what obstacles they are likely to encounter, and how the audience can be influenced to change.

- **Segment general audiences** into smaller groups of people who view the problem in similar ways, permitting more effective appeals to be directed at each different group.

- **Use marketing behavioral analysis and anthropological research to create message/products** that are

  - **salient** in solving the problem,

  - **actionable** given the real-life constraints on the audience segment,

  - **attractive** when compared to other alternatives facing that segment.

- **Test** these messages and products to determine whether they actually meet the requirements, and make appropriate changes if they do not.

- **Ensure the practical and timely availability** of whatever materials, supplies, and equipment are needed for the audience to act on the advice being given.

- **Integrate** various communication channels (media, print, face-to-face) around a single set of coherent themes for each segment, thereby ensuring that the audience receives the same messages from more than one credible source and maximizing the particular strength of each channel.

- **Monitor** all of the inputs through repeated mini-evaluations of selected outputs to determine if the system parts are in place, and if changes need to be made in the approach.

- **Commit to the long haul,** thereby avoiding quick solutions and flashy campaigns, in favor of a long-term strategy which is modifiable but consistent over time.

We know that **people learn new behaviors best when:**

- They are learning something **they** feel is useful.

- They **practice** what they are learning to do; the more practice the better.

- They receive **feedback** on how they are doing and are **rewarded** when they do well.

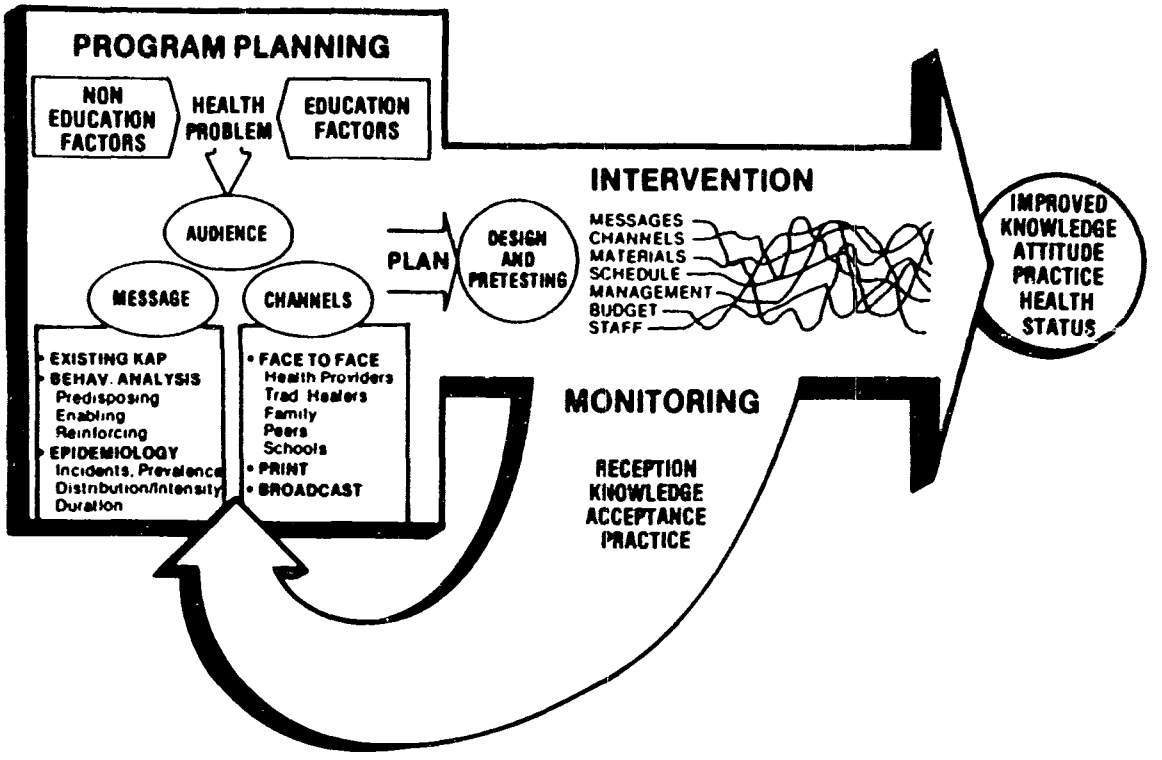
- Rewards come from **several sources** and are as **immediate** as possible.

A METHODOLOGY FOR EFFECTIVE AIDS EDUCATION

The success of AIDS education depends upon its ability to **change what people do,** as well as what they think and believe. It must make an impact upon the consciousness of the intended audience by rising above the everyday clutter of advice and suggestions and become an important new priority in their lives. This cannot be achieved by the repetition of simple slogans, the mass exhortation to do the right thing, or the indiscriminate use of mass media alone. It requires a sensitive understanding of how people are affected by specific health problems, articulate crafting of products and educational messages which are both useful and practical, and a coordinated distribution network which reaches each individual through various channels simultaneously.

AIDS education will require a long-term commitment to change. Public health comunications is often divided into sequential phases called "campaigns," which intensify activities during selected periods of time, but public health educations is **not a single campaign.** Campaigns have been shown to have important value as part of an overall change strategy, but alone they have generally proven to have short-lived impact and burdensome administrative demands.

Public Health Communications (PHC) produces sustainable changes in a large target population around a relatively narrow set of behaviors. It draws heavily on principles and procedures derived from **social marketing, behavioral analysis, instructional design,** and **anthropology.** Exhibit A illustrates the basic stages and organization structure of the **PHC Model.**



The model has three sequential **stages** and each stage is divided into several **steps** as indicated.

Stage I, the **Planning Stage,** emphasizes the collection of critical information needed to prepare an effective program design. This information answers important questions such as: (a) Who in the total population should be selected as the principal audience? (b) What communication channels are most critical for these people? (c) What behaviors or products should be advocated? (d) What resources are needed to conduct the program? The final program planning, including budget and resource requirements, is based upon the results of this investigation. It is here that special emphasis is given to health practice studies and to field tests of products, messages, and delivery systems.

Stage II, the **Intervention Stage,** is divided into **discrete message cycles.** Each cycle covers similar information but with slightly different approaches adapted to the changing needs of the audience. These periodic changes reduce audience fatigue and permit a continual renewal of audience involvement. More importantly, they permit program planners to incorporate results of the earlier phases into the planning of

subsequent phases. In essence, this strategy permits the planner to make important iterative changes in educational strategy. These changes must be made in response to information on the consumer acceptance and the actual efficacy of project activities.

Stage III, the **Monitoring Stage,** ensures that this information is available at relevant and timely intervals. A monitoring system which permits the random sampling of selected segments of the audience is developed. Planners know: (a) how a microcosm of their intended audience feels about the advice they are receiving; (b) whether they are taking that advice; and (c) what obstacles they are encountering. These monitoring devices can also point out important logistical problems, such as a breakdown in delivery of printed matter or inappropriate placement of broadcast materials. This type of continuing evaluation is essential in making corrective changes in future cycles, as well as in providing program administrators with a clear idea of their overall potential success.

An implementing agency or agencies is responsible for guiding this process. This agency may be either a private- or public-sector institution. Often there is a mix, bringing together the flexibility and professionalism of the private-sector with the power and prestige of the public-sector.

TOWARDS AN EFFECTIVE AIDS EDUCATION STRATEGY

THE APPROACH

The principal goal of WHO's national AIDS health education program is to prevent transmission of LAV/HTLV-III to uninfected persons. The strategy includes developing communication programs integrated within and strengthening to the maximum extent possible the national health infrastructure. Prevention activities will focus on educational programs for the general public, high risk groups, and health care providers.

For the general public, available scientific knowledge regarding risk factors and mode of LAV/HTLV-III transmission must be converted into messages and materials suitable to the national audience and designed to result in behavior modification. Behavior modification will focus on sexual activity and practices and upon attitudes toward injections.

High risk groups for sexual and parenteral LAV/HTLV-III transmission must be identified. Behavior modifications for these groups will be more complex than among members of the general public.

Health care providers must be educated regarding clinical aspects of AIDS and also about their role in preventing transmission through blood transfusions and use of contaminated needles/syringes or other skin-piercing instruments.

In addition to educational approaches, AIDS transmission through parenteral and perinatal routes can be addressed by changing medical practices. Preventing AIDS through blood transfusions and injections may require additional efforts to promote

single-use syringes/needles or methods to ensure sterilization. This same process should be applied to other instruments which pierce the skin or contact mucous membranes (e.g., scarifications, circumcision, ear-piercing).

A STRATEGIC MENTALITY

As already shown, effective AIDS Education will require more than just a clever slogan or an often repeated jingle. A more comprehensive approach is required, and should emerge from analysis of ongoing research.

- **Products** such as improved condoms, and non-reusable needles will have to be created. Educational messages about sexual risks will have to be tested for appropriateness and impact.

- **Distribution and Production Systems** for these products and messages will have to be created.

- The **Price** of each product (whether the dollar cost of a condom or the social costs of fewer sexual partners) will have to be established at levels people are willing to pay.

- **Promotion** systems will have to be created which reach large-numbers of the right people with frequent and impactful messages. This will require not only research and strategy, but creativity.

We know that an effective Creative Strategy answers five key questions.

Objective	1.	What behavior(s) is my program designed to change?
Target Audience	2.	To whom, specifically, is the program addressed?
Key Consumer Benefit	3.	What benefit will the audience recognize as most compelling?
Support	4.	Why would they believe what we have told them?
Tone & Manner	5.	How are we going to make our case so that it is compelling and convincing?

This strategic mentality - one that looks at the educational problem as more than just "what am I going to say to people", is the key to long-term success. It is not the responsibility of any one individual on the program team, but must permeate the entire planning and implementation process.

ASSUMPTIONS

The educational approach is based on the assumption that transmission of AIDS is primarily through:

- intimate sexual contact,
- infected blood and blood products,
- infected mothers to newborns, and
- contaminated, unsterilized syringes and needles (including other contaminated instruments used for medical or ritual purposes).

There is no documented transmission through:

- casual/social contact,
- food or water, and
- airborne or fecal routes.

OBJECTIVES OF THE AIDS EDUCATION PROGRAM

There are a number of possible objectives for an AIDS education program. The choice of objectives to pursue will be a national decision. Some governments may be prepared to address public education on a wide scale; some on a small scale and others not at all. Education program objectives could focus on:

1. Creating political support for an AIDS campaign,

2. Creating public awareness of the seriousness of the AIDS problem,

3. Increasing the use of measures to prevent transmission of the disease (such as use of condoms, limiting the number of sexual partners),

4. Provide support to health workers in treating AIDS patients, and

5. Promote the sale of AIDS related products (e.g. condoms, one time use needles).

COMMUNICATION RESEARCH

The success of an AID intervention will depend significantly on adequate knowledge and assessment of the following variables. Many of these questions will be answered by the basic epidemiology, others will require specialized communication research. Tools such as ethnographics focus groups, in-depth interviews, and intercepts compliment large-scale survey research. The answer may be incomplete as the program

gets underway - but over time the quality of information emerging from this research will define the program's effectiveness.

AIDS Problem, Definition and Scope

- What are the measurable effects of AIDS on people's lives now?
- What are the perceived effects of AIDS?
- What are the major solutions being proposed?
- Who in the total community is best equipped to address the AIDS problem?
- What are the major constraints limiting the solution of the problem now?
- Which of the alternative solutions being discussed could be best supported by education?

Audience Research

- Who is affected by AIDS? What are the high risk groups?
- How can these individuals be grouped into audiences which share significant characteristics, such as sex, language, literacy, socioeconomic level, family structure, decision-making patterns, family mobility, and so forth.
- What do members of the public know about AIDS? Specifically, what do they know about the causes AIDS? Their own degree of risk or susceptibility? Are they aware of ways to prevent or minimize AIDS? Of detection or treatment methods?
- What misconceptions do people appear to have about AIDS? What factors have contributed to these misconceptions? How pervasive are they?
- How do people feel about AIDS? How important or serious do they perceive it to be? Are they afraid to do anything about AIDS? Do they believe that preventive measures are effective?
- Does the public know what actions should be taken? If so, would taking action conflict with their personal values or self image? What are the major barriers to taking action against AIDS?
- What do people believe to be the consequences of not acting?

What do they believe to be the benefits of taking action? Is it for their future well-being? For the well-being or approval of their loved ones? For monetary reasons?

- Which of the proposed AIDS interventions would be most acceptable to different audiences?

- What are the characteristics of each group's present sexual behaviors, knowledge, and attitude? Which contribute to the spread of AIDS? Which are most amenable to change?

- What elements of the existing cultural reward system might be associated with the selected AIDS preventive measures?

- What is the local name(s) for AIDS?

- What examples exist of each audience group's ability to make significant adaptation in behavior?

Communication Channel Research

- Who represents convincing sources of information on the topic for each target audience?

- What forms of mass communication are particularly effective in reaching the target audience? Radio, TV, press, music?

- What traditional communication channels are popular?

- What other institutions have potential for expanding outreach to the target audiences with viable information on AIDS?

- What private-sector resources exist (advertising or market research firms, universities, pharmaceutical and consumer product delivery systems, PVOs, and so forth)?

- How can these organizations be influenced and coordinated most effectively?

Product Research

- How can we improve the acceptability of condoms (color, lubrication, disposal, texture, thinness, size, etc.)

- How can we increase the protectiveness of condoms (non oxynol-9 or other anti viral agents) ?

- What other products (spermicides, foams) offer protection?

- What behavioral changes really matter (fewer partners means what)?

- What constitutes "safe sex" practices, and how can these be made more appealing?

Outcome Expectations

- What type and magnitude of change would be considered successful and would be practical, given defined resource levels?

THE TARGET POPULATION

The demographic characteristics of the consumers for an AIDS Education Program are:

- sexually active men and woman
- living in urban, semi-urban and rural areas
- of all socio-economic levels.
- specific high risks groups

SPECIFIC AUDIENCE SEGMENTS AND KEY BEHAVIORS

Target audiences can be segmented further by the following characteristics. Specific behavioral objectives to stop the transmission of AIDS are identified for each target audience.

TARGET AUDIENCE	BEHAVIORS
1. Policy Leaders - political - religous - traditional	1. promote reporting of AIDS cases support AIDS health education promote blood testing/screening
2. Sexually Active Adults - men and women - all socio-economic levels - infected and uninfected - prostitutes and users of same - military	2. have fewer partners use a condom everytime screen partners on past sexual practices refrain from oral/anal intercourse promote self responsibility
3. Health Care Providers (public and private sectors) - doctors - nurses - paraprofessionals - dentists - blood testers - pharmacists	3. promote awareness of transmission problem trained to provide patients with "safe sex" counseling able to list "safe sex" practices able to list risks able to list ways to acquire AIDS wear gloves use sterile or non-reusable instruments wear gowns
4. Traditional Practitioners - Midwives - Circumcision - Scaring	4. use sterile or non-reusuable instruments
5. People receiving injections	5. use sterile needles use disposable, one time use needles
6. Persons Receiving Blood Transfusions	6. request use of henatinics and plasma expanders request blood that has passed ELISA test
7. Perinatal	7. receive counseling practice "safe sex" use birth control
8. Infected persons	8. do not donate blood practice "safe sex" or abstinance
9. Youth approaching sexually active ages (male/female)	9. able to list "safe sex"

CHANNEL CONSIDERATIONS

In order to select the most effective and appropriate mix of communication channels for an AIDS education program, a number of questions will need to be answered for each country. However, we know that no single media channel is powerful enough by itself to make an effective program. Broadcast media (radio and television) are better for reaching many people quickly with fairly simple ideas. Print media are best for providing complex information or information people may want to reread at the time it is actually needed. Interpersonal communication channels, group meetings, community organizations, are best for developing credibility for new approaches. All three components are needed to make an effective program. Large numbers of people need to be reached quickly, they need a reminder about what they have been told, and they must believe in the integrity and worth of the program if they are to follow the advice and information received.

The challenge in developing an effective communication methodology is to orchestrate the various inputs to maximize their total impact and to minimize costs. Not all channels can be used all the time because costs would be exorbitant. Elements must be selected from each of the media groups and integrated in a manner that results in achieving a total impact that is greater than the sum of the individial efforts.

On the basis of previous experience in Africa, the following examples are some of the channels which could be used for an AIDS campaign for specific target audiences.

Policy Makers:

- symposiums
- print materials
- celebrity endorsement/appeal

Sexually Active Adults:

- bars and dance halls (posters, handouts)
- dramas (radio, TV, print)
- educational radio programs
- general news and commentary (print, broadcast)
- testimonial spots by influentials on radio or TV
- traditional media
- popular musicians and songs
- retail outlets point of purchase materials

Health Care Providers:

posters, booklets
training guidelines
audio visuals

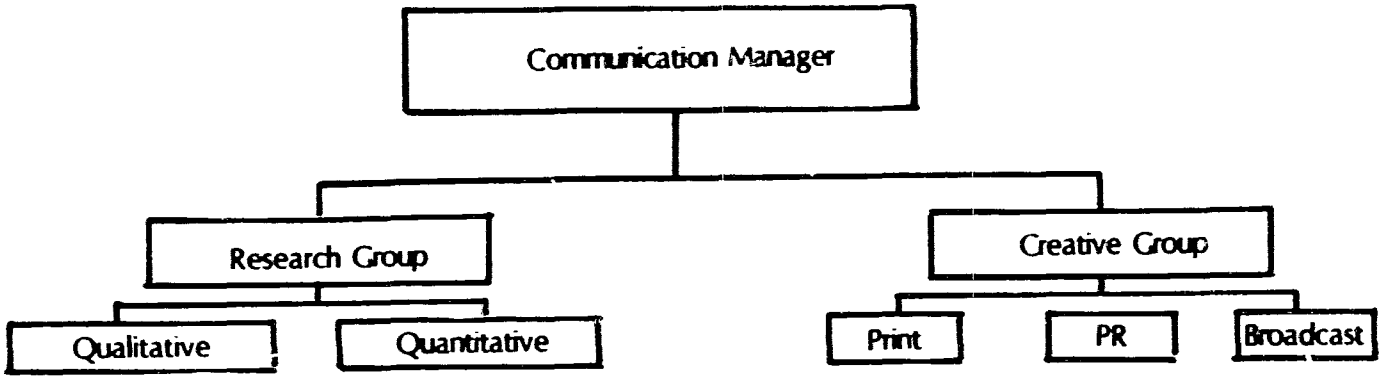
Regional messages could be sent over short wave: BBC, VOA, France International, and Africa Numero Un).

OTHER IDEAS TO PURSUE

- Seminar for URTNA broadcast directors from 43 African countries on AIDS and what the mass media can do.
- Development of generic print materials for key target groups that can be used/adapted directly by interested countries. (e.g., flyer for decision-makers, information brochure for health workers, posters for use in bars)
- Development of research strategies and protocols on KAP of target groups that can be used by universities and national research groups.
- Preparation of guidelines on how to design an AIDS public education campaign.

ORGANIZING FOR SUCESS

One element of long-term success is the program's management structure. What skills are needed and how should they be organized to maximize success? The following scheme emerges from our own experience at the Academy, but is reflected in the organizing structure of many successful programs.



The Communication Manager orchestrates the team and guides the strategic planning.

The Behavioral Specialists act as consultants to select appropriate behaviors, develops research protocols, and design interventions.

The Research Group includes specialists in both qualitative research (ethnography, focus groups, materials testing) as well as qualitative survey research.

The Creative Group includes graphic and print specialists, broadcast media (radio & TV) experts, and public relations people who are specialists in press, rallies, and other organizational attractions.

This group interfaces with the overall project team in the following way.

Research is jointly planned with the Epidemologist to avoid overlap and ensure coherance.

Messages and behaviors are selected jointly with the Program Manager and other team members to ensure appropriateness.

Budgets are developed for, and negotiated with, the Program Manager to reflect the existing resources and objectives.

This basic structured model can be reflected at different operating levels. The Key is an understanding that strategic, creative and research skills are quite different; require different talents and experience; yet must interact effectively.

CONCLUSION

Effective AIDS Education will require:

A Comprehensive Strategy, guided by

Communication research and organized around a

Management Structure which provides for the integration of marketing skills, qualitative and quantitative research and creativity in materials development and design.

THE ACADEMY'S ROLE AND EXPERIENCE

The Academy has embarked on an ambitious program, bringing together resources from a variety of areas, to expand and improve the use of these new health technologies in some of the world's poorest countries. In some cases, the Academy is playing the lead role; in others, it is cooperating with world-renowned health management and academic institutions, contributing to their programs in targeted areas. The Academy works regularly with the Agency for International Development, particularly the Offices of Education and Health within the Bureau for Science and Technology, which has provided the financial and technical support for many of the programs described below. This support, coupled with that of the World Health Organization, UNICEF, the World Bank, and other donor agencies, has moved many of the new technologies from the laboratory to the homes of those most in need.

The Academy now operates five major health and population programs, with seven resident advisors in Honduras, The Gambia, Ecuador, Peru, Egypt, and Swaziland. In Washington, D.C., a staff of five health communication specialists direct the Academy's overall health and population activities, which total some $25 million and include technical assistance to dozens of countries, information systems on primary health care and population communication, and seminars and workshops in Asia, Africa, and Latin America.

In 1985 alone, the Academy's health activities grew to include a major new population program in Egypt, a new worldwide program of expanded health technology, and a significant new program in nutrition education. Population communication has become a major area of interest, bringing much of the Academy's past experience in

development communication to the very special problems of effective family planning and population education. The Academy participated in the World Health Organization's Consultative Group on AIDS Education and was instrumental in crafting the group's final recommendations. In all these activities, special attention is being given to social marketing as an effective means to reach out, motivate, and inform tens of thousands of isolated people of the benefits and services offered by the new health technologies. The following profiles briefly describe the Academy's principal activities in communication for social change.

Academy for Educational Development

AED

Health Communication for Child Survival

OBJECTIVE: To apply communication technology to the prevention and treatment of childhood illness in developing countries.

DURATION: 1985 to 1990

SPONSOR: The Office of Health and the Office of Education, Bureau for Science and Technology, the U.S. Agency for International Development

One out of ten infants born in developing countries does not survive its first birthday. In some countries nearly two out of ten die before reaching one year of age. Death rates remain high until children reach the age of five. Most of these children die from diarrhea, malnutrition, or immunizable diseases and often of a combination of the three. There is also a close correlation between high infant and child death rates and high fertility. The more children a woman has and the closer together they are born, the greater the likelihood of death--especially among those children born high in the birth order.

There are now proven and appropriate technologies to address virtually all of these causes of death and severe illness and high fertility. The leading child survival technologies include oral rehydration therapy, immunizations, improved nutrition, and growth monitoring. While these technologies are available and relatively easy to apply, making them available to the client population and having them properly used present an entirely different set of problems.

The Academy has used communication technology such as radio and graphic materials together with the training of health personnel to reach large numbers of rural people to promote these health technologies and the behavior related to their use. The Mass Media and Health Practices Project (MMHP), an AED-directed project, demonstrated that mothers, health professionals, and other relevant personnel in Honduras, The Gambia, and Swaziland could correctly mix and give oral rehydration solution to children who needed it. In Honduras after only one year of broadcasting 43 percent of rural women interviewed had used the government's new oral rehydration salts and infant mortality from diarrheal dehydration had dropped by 33 percent. In The Gambia after one year 66 percent of rural women interviewed had correctly learned how to mix a new sugar, salt, and water rehydration solution. Similar AED programs are under way in Peru and Ecuador.

HEALTHCOM is a five-year project which will expand the MMHP experience. It is designed to help developing countries and USAID missions improve the impact of their child survival programs by increasing consumer demand for child survival services. It is part of the Agency for International Development's overall strategy to reduce infant mortality and works with other AID programs such as PRITECH, SOMARC, CCCD, and the Agency's Child Survival Action Program. HEALTHCOM also works with international agencies such as WHO and UNICEF, to improve consumer education and to promote the correct use of ORT, immunizations, and other child survival technologies.

Through resident advisors HEALTHCOM is now working in Ecuador, Honduras, and Indonesia and will add some 14 countries, adapting lessons learned from past programs to the special needs of each country. Primary attention is given to diarrheal disease control, immunization, breastfeeding, vitamin A, infant nutrition, vector control, and personal hygiene.

HEALTHCOM provides assistance in social marketing, mass media planning, advertising and promotion, behavioral studies, ethnographic research, and program evaluation. Additional objectives of HEALTHCOM are the diffusion of its concepts and methods to other countries and the institutionalization within countries of social marketing and the use of mass media for child health.

As subcontractors to the Academy for Educational Development:

- the Annenberg School of Communications of the University of Pennsylvania is evaluating the effectiveness of the communication strategies in each country,
- Applied Communication Technology is doing a follow-up evaluation of the programs in Honduras and the Gambia,
- Needham Porter Novelli is providing marketing and advertising assistance,
- PATH/PIACT is developing print materials and appropriate health and birth spacing technologies for these programs.

Ciba-Geigy, The Futures Group, Management Sciences for Health, the John Snow Health Group, University Research Corporation, and the Wilmer Institute (ICEPO) and the Department of International Health of Johns Hopkins University have all agreed to work as collaborating institutions with the Academy in the development of this program.

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Academy for Educational Development

AED

Egyptian Population Communication

OBJECTIVE: To improve the development and delivery of effective population education materials in Egypt, in cooperation with the Information, Education, and Communication Center of the Egyptian State Information Service, as well as various private sector organizations in Egypt.

DURATION: 1983-1986

SPONSOR: U.S. Agency for International Development/Cairo

Since 1978 the Egyptian State Information Service (SIS) has provided information, education, and communication (IE&C) services on population and family planning in order to improve public awareness of the need for limiting family size and the availability of family planning services. Although most Egyptians know about modern contraception, they tend to underestimate the reliability of specific methods and overestimate the possible health risks. About one-third of a recent study's respondents believed that family planning was discouraged in Islamic teaching. Very few of the respondents had ever seen a pamphlet on a family planning topic, and the home-visiting program had failed to reach all but a small fraction of the population. In addition, nearly one-quarter of Egyptian adults of reproductive age are not being reached by any form of communication regarding family planning.

SIS, in its first two campaigns begun in 1980, produced an impressive number of materials focused on raising the general public's awareness and promoting a national family planning symbol. A 1982 follow-up of the 1980 baseline survey conducted by the SIS Center showed evidence of changes taking place during the two-years of the SIS population program operations. More recent survey findings report that most adults in Egypt now recognize the continous rapid population growth and understand what family planning is and why it is needed.

To assist in meeting the challenges of improved cooperation among the agencies involved in family planning and an increased capacity to plan and implement a comprehensive Family Planning Communication strategy, the Academy for Educational Development is providing technical assistance and in-country training to the Egyptian State Information Service aimed at expanding and improving the use of communications in support of the family planning and population programs in Egypt. This technical assistance and training involves four major activities:

- Developing an integrated IE&C strategy, management, and evaluation plan.
- Increasing interorganizational linkages.
- Developing and implementing the systems necessary for improved management.
- Introducing innovation in the use of communication techniques for the problems of family planning.

Based on an initial organizational assessment, a comprehensive plan and an assessment of user organizations' needs are being developed through interorganizational workshops. Through specialized training sessions and technical assistance, improved management information, distribution, and monitoring systems are being developed and implemented. Emphasis also is being given to systems for managing private advertising agencies, for developing educational soap operas, and for adapting commercial marketing techniques to the problems of family planning.

The project is helping the Egyptian SIS to clarify needs and opportunities, to establish bridges with the other organizations, and to identify ways in which coordination can be established. It is part of a growing Academy commitment to improve IE&C for family planning throughout the world.

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Academy for Educational Development

AED

Mass Media & Health Practices

OBJECTIVE: To develop a practical methodology for the application of mass media to the treatment and prevention of acute infant diarrhea among rural populations.

DURATION: 1978 to 1985

SPONSOR: Ministries of Health, Governments of Honduras, The Gambia, Ecuador, Peru, Swaziland, and the Offices of Education and Health, Bureau for Science and Technology, U.S. Agency for International Development

Infant and early childhood diarrhea is a serious health problem in the developing world, responsible for the deaths of one to four percent of children under age two. In Latin America it is responsible for at least one-third of all early childhood deaths. Appropriate treatment of diarrhea relies heavily on simple rehydration techniques that can be taught to rural mothers and administered by them in their own homes. One goal of the Mass Media and Health Practices project is to develop a public education campaign that combines radio, graphic materials, and health worker support to promote widespread adoption of this technique in isolated rural villages. To achieve this goal, the project aims to integrate mass communications planning and design procedures into the cooperating health agencies of various developing countries.

Experience indicates that mass media, such as radio and graphic materials, can reach large numbers of rural people with important new information, but it has been difficult to show that behavior has in fact changed as a result of these efforts. This project develops an instructional campaign that goes beyond increased knowledge and improved attitudes. It combines the latest experience in community research, social marketing, and behavior modification to promote change in critical village behavior.

Educational content related to both prevention and treatment of infant diarrhea includes recognition of dehydration, proper use of oral rehydration therapy, and the adoption of improved personal hygiene and infant-feeding practices, including special emphasis on breast-feeding. Recent expansion of the project has included emphasis on family planning, malaria, tuberculosis, and immunization.

The project model includes an initial period of preprogram research, a two-year public education campaign aimed primarily at rural mothers and other child caretakers, and a period of dissemination of its findings to interested development professionals around the world.

Five countries presently serve as project sites—Honduras, Ecuador, The Gambia, Peru, and Swaziland—to ensure that the techniques used are applicable to different development settings. Rigorous developmental research is carried out in the selected geographic regions of each country and applied to the design of specific interventions. These interventions—which use radio spots, mini-programs, radio dramas, photonovels, posters, flyers, and extension services through health personnel and village midwives—are designed jointly with Ministry of Health personnel in each country.

The Academy for Educational Development assists the host government in implementing the program—designing, testing, and broadcasting the radio programs; developing graphic materials; and training local health workers. A summative evaluation of the project is funded under a separate U.S. Agency for International Development contract with the Institute for Communication Research at Stanford University. This evaluation focuses on the ability of the communication campaign to change target behaviors.
Project outcomes include:

- An integrated public education campaign aimed at the treatment and prevention of acute infant diarrhea.
- Three to five Ministry of Health personnel trained in the application of mass communication systems to health education in each country.
- Continued application of systematic communication planning to health education within the cooperating Ministries of Health.
- A methodological handbook and 10 technical notes which describe a practical system for promoting widespread and significant behavioral change in rural villages.

Early results show remarkable gains in recognition of the new health messages—93 percent of the mothers interviewed in Honduras recognized the new diarrheal remedy, Litrosol, after one year of programming. After 12 months in The Gambia, 47 percent of the mothers interviewed claim to use the simple sugar and salt formula being promoted by the project.

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Dietary Management of Diarrhea

OBJECTIVE: To design, implement, and assess dietary management interventions to ameliorate the adverse nutritional consequences of diarrhea.

DURATION: 1986 to 1989

SPONSOR: U.S. Agency for International Development, host country governments, and local USAID Missions.

Infant and early child diarrhea is a serious health problem in the developing world, responsible for the deaths of one to four percent of children under age two. Most children do not die from diarrheal episodes, but instead suffer from increased malnutrition caused by decreased appetites, food withholding, and increased energy needs during illnesses. Now that appropriate treatment for diarrhea-associated dehydration has achieved worldwide acceptance, health professionals are searching for ways to improve diarrhea-associated malnutrition. The Johns Hopkins University Department of International Health has been contracted to address this problem through research of present practices, field trials of potential diets, and the eventual creation of special dietary regimens for children during and after diarrheal episodes.

The Academy has been subcontracted to assist Johns Hopkins in the investigation of present feeding practices, and in the development of a nutrition/health education and communication strategy to promote the special diets. Program efforts will include: 1) defining current home practices, cultural beliefs that govern those practices, and local medical recommendations regarding feeding of children during and after diarrhea; 2) cataloging locally available foods, their forms of preparation, their uses, and apparent effects; 3) designing optimal dietary regimens for management of acute diarrhea; 4) evaluation and clinical studies and field trials; 5) development of a nutrition/health education and communications strategy to foster adoption of improved dietary practices; 6) promotion of improved dietary practices during and following acute diarrhea; 7) evaluation of the promotional strategy, implementation, and impacts; 8) collaboration with local health authorities to implement the program on a broad scale; and 9) training and dissemination of information about dietary regimens for acute diarrhea, their impacts, and their promotion.

Information on dietary management of diarrhea and on strategies and activities for promotion of dietary regimen: will be disseminated at the field site, in the professional literature, on a regional basis through the Clearinghouse on Infant Feeding and Maternal Nutrition, and with other regional centers involved in diarrheal disease control.

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Social Marketing for Change

OBJECTIVE: To increase the availability, knowledge about, and correct use of contraceptives among eligible couples in developing countries.

DURATION: 1984-1988

SPONSOR: Office of Population, Bureau for Science and Technology, U.S. Agency for International Development

Support for voluntary population and family planning programs in the developing world has been a vital component of development assistance for over 20 years. The marketing of family planning was first undertaken more than 15 years ago with the introduction of programs in India, followed by Sri Lanka and Colombia.

The underlying concepts of these programs were first developed formally by Philip Kotler and Gerald Zaltman in an article in the 1971 Journal of Marketing which defined an approach to planned social change. This approach, known as social marketing, was described as the "design, implementation and management of programs calculated to influence the acceptability of social ideas and involving the consideration of product planning, pricing, communication, distribution and marketing research"--in short, the application of the full spectrum of commercial marketing techniques and management to the advancement of a social cause.

The Academy for Educational Development, a principal subcontractor to The Futures Group, the prime contractor for Social Marketing for Change Worldwide (SOMARC), is responsible for developing programs in countries which have expressed interest in contraceptive social marketing (CSM). This large-scale project will work with developing countries using commercial marketing and promotional and distribution techniques to deliver affordable contraceptives and to inform potential users about the products and their correct use. CSM programs will benefit couples who have limited access to sources of supply and cannot afford commercial products. CSM efforts will build on the existing private sector marketing networks and will use market incentives to encourage private sector participation. By using the private sector, CSM programs will seek to increase efficiency and effectiveness of family planning service delivery systems and complement ongoing government programs and private sector investments. CSM programs are targeted to reach people and develop markets which have not been commercially viable to date.

The Academy's expertise in communications, social marketing, behavioral technology, and management will be provided to existing social marketing programs, special studies, and training programs. Working with The Futures Group, Needham Porter Novelli, Management Sciences for Health, and John Short and Associates, the following five major activities will be undertaken:

- Funding and developing new social marketing programs: Using marketing research, advertising, distribution, pricing, promotion, and other techniques, SOMARC will draw upon host country resources, particularly in the private sector, to develop efficient, cost-effective CSM programs.

- Providing state-of-the-art assistance in social marketing: To strengthen CSM programs already in operation, SOMARC will provide short-term marketing assistance to support new product introductions, pricing strategies, distribution planning, management information systems, advertising, and updating marketing strategies.

- Providing information on the latest trends in social marketing: The SOMARC newsletter will keep the public informed of current activities and accomplishments of CSM programs around the world. The resource center will provide information on request related to the state-of-the-art of social marketing.

- Upgrading social marketing skills through training: SOMARC will conduct regional training workshops in Latin America, Africa, and Asia for social marketers to strengthen management skills. A worldwide conference will be held to review and assess CSM strategies and progress.

- Advancing the state-of-the-art: Special research studies will be designed to examine regional and worldwide issues of concern to social marketers. The studies will yield strategies to increase the effectiveness, efficiency, and impact of social marketing programs.

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Technologies for Primary Health Care

OBJECTIVE: To help developing countries to lower infant and child morbidity and mortality through the introduction and improved delivery of key disease technologies in primary health care.

DURATION: 1983-1987

SPONSOR: Office of Health, Bureau for Science and Technology, U.S. Agency for International Development

Infant and child mortality remain disproportionately high in developing nations. Some 17 million children under five years of age died last year; eight million of them never reached the age of one. Over five million of these children died from dehydration, the loss of liquids and vital salts caused by diarrhea. Many more died from the vicious cycle of malnutrition and infectious diseases contributed by the child's diarrhea. In addition, three to four million children die annually from diseases that can be immunized, particularly measles and tetanus. Polio, diptheria, and tuberculosis, other immunizable diseases, continue as major health problems frequently causing disabled and unproductive lives.

Many of these deaths could be prevented if existing disease control technologies were made widely available to families in the Third World. PRITECH seeks to work with developing countries to lower infant and child morbidity and mortality through the introduction, expansion, and improved delivery of these technologies, particularly oral rehydration therapy (ORT) and immunizations, through primary health care programs.

The Academy for Educational Development is a principal subcontractor to Management Sciences for Health (MSH) under this large-scale program to promote and develop expansion of the use of oral rehydration and immunization in the world's emerging nations. As such, the Academy is responsible for technical expertise and direction of the health communications and social marketing components of the Disease Control and Systems Support activities of PRITECH, and for its information services.

The project involves four major activities:

- **Disease Control:** PRITECH will implement limited intervention in selected countries to introduce, improve, or expand the use of ORT and immunizations, especially through primary health care programs. The project approach will emphasize those areas which are principal constraints of widespread effective use of ORT and immunizations, but which have not always been included or emphasized in previous projects. These include expansion of programs through the non-governmental sector, more cost-effective self-sustaining financial analysis and planning, commodities production, competency-based training, retail sales, and public education/social marketing.

- **Systems Support:** Short-term (up to three months) technical assistance can be provided through the USAID Mission for the design, implementation, and evaluation of primary health care and disease control programs.

- **Information Systems:** PRITECH offices house the Primary Health Care Information Center, a basic reference library on primary health care, ORT, immunizations, and key training and systems management technologies. The Information Center also will publish annual technical updates on key PHC technologies, particularly ORT and immunizations.

- **Promotion of ORT** and immunizations to motivate host country and donor agency decision makers to commit resources to these programs.

One of the principal constraints of ORT and immunizations is the lack of effective public education. The Academy is drawing on its experience in the Mass Media and Health Practices Project in Honduras, The Gambia, Ecuador, and Swaziland to assist in designing and implementing health communications activities which effectively link new medical technology in the village. The Academy also is responsible for planning, establishing, and operating the PRITECH Information Center as well as providing technical direction in the design of promotional activities in coordination with MSH and the other members of the PRITECH consortium.

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Population Communication Services

OBJECTIVE: To improve population communication among private and public sector institutions in countries throughout the world. The Academy is a subcontractor to Johns Hopkins University and a part of a consortium of institutions.

DURATION: 1982-1987

SPONSOR: U.S. Agency for International Development, Bureau for Science and Technology, Office of Population

A comprehensive national information, education, and communication (IEC) program can do much to spread public awareness of family planning methods and service supply outlets and to legitimize the idea of family planning among the general public. Even where a comprehensive national program is not politically feasible, well-designed specific IEC activities, such as improved person-to-person communication, skillful use of print media, and mobilization of available private sector IEC resources, can make a difference in family planning acceptance.

In 1982 a consortium of institutions, led by the Johns Hopkins' Population Information Program and including the Academy for Educational Development, Porter Novelli and Associates, and PIACT (the Program for the Introduction and Adaptation of Contraceptive Technology), began a five-year program to improve population communication.

The overall goals of the Population Communication Services project include:

- Assisting public and private population/family planning agencies based in developing countries in all stages of communication program design and implementation, including audience identification, message design, media communication, and evaluation.
- Developing and expanding the capacity of population/family planning specialists in developing countries to design, implement, and evaluate communication programs.
- Improving coordination of population/family planning communication activities among agencies and organizations in developing countries.
- Expanding the knowledge base on which to make decisions about communication programs.

The activities which PCS carries out include:

Needs Assessment and Planning—Expert communication consultants and staff are available to review current and planned population/family planning communication activities, to develop comprehensive plans and strategies, and to recommend effective approaches.

Project Funding—PCS provides full or partial financial support for activities in the field of population/family planning communication.

Evaluation—PCS staff and cooperating agencies are available to help organizations to design and carry out methodologically sound evaluations of population/family planning communication, as requested.

Technical Assistance—PCS provides short-term technical assistance in specific aspects of population/family planning communication, as requested.

Dissemination of Prototype Materials—PCS answers requests from developing country organizations for information and ideas on communication materials in any medium. Particularly effective materials are distributed to interested population/family planning organizations for use as models or prototypes.

Distribution of Films—PCS provides some population/family planning films from its collection to qualified organizations in developing countries. A film catalogue is available on request.

Meetings and Workshops—PCS organizes national and international workshops and meetings to teach new skills and to promote information exchange.

The Academy's particular responsibilities in the consortium include mass media planning, international seminar and workshop organization, and information services. Academy staff have led needs assessment and planning missions to Colombia, Peru, Senegal, Zimbabwe, Nepal, and Sri Lanka, helping to develop project proposals to be funded under the projects' grant program. The program's first major workshop, held in Quito, Ecuador, in August 1983, brought together more than 78 population and communication specialists from 17 countries to discuss and learn how new communication approaches can be added to existing programs in Latin America.

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AED

Rural Water & Sanitation Communication

OBJECTIVE: To design and execute a community health education component for a rural water and sanitation project.

DURATION: 1981 to 1983

SPONSOR: Ministry of Health, Government of Honduras; Office of Education, Bureau for Science and Technology, U.S. Agency for International Development; U.S. Agency for International Development/Honduras.

Ministry of Health statistics set infant mortality in Honduras at 103 per 1,000 live births, and it is estimated that 80 percent of children under five years of age suffer from some degree of malnutrition. Gastric intestinal illnesses are highly prevalent, with some 24.4 percent of infant deaths attributed to diarrhea. Studies have shown a synergistic relationship between malnutrition and diarrhea. The findings suggest that improved water and sanitation facilities would result not only in reduced diarrhea incidence and infant mortality rates, but also in improved nutritional status among the under-five age group.

The contrast between rural and urban health conditions further strengthens the case for improving access to water and sanitation sources in rural areas. Some 78 percent of the urban population have access to drinking water facilities, and 49.7 percent have access to some means of human waste disposal. Comparatively, only 30.3 percent of the rural population have reasonable access to safe drinking water, and only 18.4 percent have access to basic waste disposal facilities.

The project involves four major activities:

- Expanding construction capabilities to permit installation by rural Hondurans of approximately 180 gravity-flow aquaducts, excavation of 3,000 hand-dug wells, rehabilitation of 800 wells and 50 piped water systems, and installation of approximately 18,000 pit latrines and 14,000 water-sealed latrines.
- Establishing functioning subproject maintenance systems.
- Developing and implementing educational activities to promote community participation, improved health behavior related to water and sanitation facility use, and systems maintenance.
- Training promoters and field agents to improve subproject implementation, supervision, and overall project monitoring.

The program includes:

- Recognition of outstanding village health workers.
- Recognition of active community projects.
- Announcement of local meetings and continuing education programs in which village health workers should participate.
- Radio programs broadcast directly to target audiences to promote selected health practices and to provide general support to the primary health care workers.
- Simple print materials for the target population which function as reminders of key concepts.
- Modulerized pamphlets for the primary health care workers and target population which function as a rural health library and reference guide.

The program is coordinated through the efforts of field promoters who are responsible for all phases of activities, including making initial community contacts, promoting the project, and obtaining assurance that the community provides the required volunteer labor, construction, and health education. The community participates in the decision to initiate the project, the selection of the technology, the scheduling of labor-intensive activities, instruction on system operation, and training for maintenance. A health education component is included in the project design to encourage adoption of improved hygiene practices.

The instructional development process relies upon past experience in mass communication and combines systematic preprogram research with experience drawn from such fields as social marketing and behavioral analysis. This process rests upon a clear understanding of the behaviors to be promoted; the personal, family, and community context in which these behaviors are elicited; and the ability of the instructional tools to promote widespread adoption of the selected behaviors.

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AED

Rural Water-Borne Disease Control Education

OBJECTIVE: To establish and strengthen the capability of the Government of Swaziland to design, implement, and evaluate programs aimed at influencing the behavior of rural people regarding the proper use of water and sanitary facilities.

DURATION: 1980 to 1985

SPONSOR: Ministry of Health, Government of Swaziland; U.S. Agency for International Development/Swaziland.

In 1980 the Academy for Educational Development began a comprehensive five-year health education project in Swaziland to combat diseases related to water and poor sanitation. Like many developing countries, Swaziland suffers from a number of diseases resulting from poor environmental sanitation, improper excreta disposal, and contaminated water supplies—a situation that has led to a high morbidity and mortality rate. Rural health care clinics provide basic curative services, but preventive health care services are minimal and geographically dispersed, and little has been done to address the causes of these health problems. In addition, proposed new improved irrigation and other water projects may increase the prevalence of water-related diseases such as schistosomiasis. The Swaziland Rural Water-Borne Disease Control Project evolved to address this situation and to provide the necessary impetus and capacity for change.

To achieve the basic goal of influencing the behavior of people regarding the improved protection of water and use of sanitation facilities, the project is assisting the Ministry of Health in expanding and developing its capability to deliver effective preventive services. The existing Health Education Unit (HEU) within the Ministry is being upgraded, and in-country training programs have been conducted for rural health personnel. Based on the results of a comprehensive knowledge, attitudes, and practices (KAP) survey of the health and sanitation habits of rural people, the HEU is developing a national health education strategy.

The project also has two other major components: sanitation and an epidemiological survey of schistosomiasis and other water-related diseases. The sanitation component has accelerated the Ministry's latrine construction program and has provided engineering guidelines for water works construction. Under this component, the project also provides in-country training programs and funding for 2,000 demonstration latrines. Within the first two years of the project, the American Public Health Association, under a subcontract to the Academy, conducted an epidemiological survey of water-related diseases. This survey was conducted as an essential first step in revealing the prevalence and distribution of water-related diseases in the country and has enabled the Ministry of Health to plan, monitor, and evaluate the progress of programs to control schistosomiasis and other water-borne diseases and to facilitate longitudinal disease surveillance. The overall Rural Water-Borne Disease Control Project already has funded the expansion and equipment of the Ministry's schistosomiasis laboratory.

In the second half of the project, focus is being intensified on the prevention of diarrheal diseases and the treatment of dehydration that often results from these diseases. A radio-based health education campaign has been launched to reach rural families with information about the use of household bleaches for the disinfection of water, the methods of rehydration, and other health education messages. Communicators from the various development ministries are being trained in the design of mediated health campaigns.

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Academy for Educational Development

AED

Clearinghouse on Development Communication

OBJECTIVE: To provide information and services to foster the application of appropriate communications technology to Third World development programs.

DURATION: 1972 - ongoing

SPONSOR: Office of Education, Bureau for Science & Technology, Agency for International Development.

The Clearinghouse on Development Communication is an international center for information and materials on communication technology supporting programs throughout the developing world in education, health, family planning, nutrition, agriculture, and community development. The Clearinghouse originally began in 1972 as the Information Center on Instructional Technology. From this beginning, it expanded the scope and nature of its activities to reflect the widening interest of development professionals in applying communication technologies not only in the classroom, but in all sectors of development.

Today the Clearinghouse on Development Communication links a worldwide network of over 5,000 development professionals, and provides regular, up-to-date analysis, reporting, reference, and referral services.

The ongoing information services range from a quarterly topical newsletter to technical information packages compiled in response to individual queries. The publications and services described below are made possible through contract support from the Agency for International Development.

- **Development Communication Report:** A quarterly newsletter that highlights issues and trends in communication applications for development.
- **Project Profiles:** Concise information provided to project planners on the use of communication technologies in development projects; available in English, French, Spanish, and Arabic. Currently over 100 projects are included and cross-referenced.
- **Information Bulletins:** Published on major development communication topics.
- **State-of-the-Art Reviews:** The latest and best thinking in a given area, resulting in:
  - Information packages and design services for seminars in development communication.
  - Media productions illustrating the role of communications in education, agriculture, health, etc.
  - Synthesis of research papers and planning documents relevant to a specific topic.
- **Referral List:** Institutions and individuals in the area of communications and development, categorized by country and professional interest.
- **Technical Information Service:** Tailored information packages provided in response to individual queries.
- **Resource Center:** 15,000 documents on communications, education, and development, as well as films, videotapes, and other illustrative materials on international development and communication. Outstanding features of the resource center are a selection of country-specific materials on communication, unpublished project research, and reports rarely found in other libraries or bibliographies. New materials on communications are added daily to the collection. A partial overview of the collection's organization follows:

Media

Radio	Computers
Satellites	Folk Media
Films	Video
Television	Audio Cassettes
Audio-visual Aids	

Content

Agriculture	Education/Nonformal Education
Nutrition	Health
Training	Population/Family Planning
Information Management	Research and Evaluation
Women in Development	Urban/Rural Development

Geographic Areas

By country or by region:

Africa	Asia
Latin America	Middle East

Audio-visual Library

Films | Videotapes

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SERVICES

The Academy offers a variety of specific services to meet the needs of individual programs. These services are provided directly to participating governments, or often through assistance from international donor agencies.

The Academy is able to:

Select, relocate, and supervise long-term resident and short-term consultant personnel.

Organize and manage major institutional consortia.

Prepare tailored planning and evaluation studies on selected projects and programs.

Coordinate the placement and supervise the academic programs of foreign students in top-level American institutions.

Identify and coordinate external review panels and oversight committees.

Produce film and video documentaries and develop and print technical reports and studies.

Organize specialized conferences, workshops, seminars, and in-service technical training programs.

Plan and implement programs of specialized visitor and cross-cultural exchange.

Develop technical information access and exchange systems.

Develop technical equipment specifications and provide complete procurement services.

Supervise and manage engineering subcontractors.

Design management and organizational communications systems.

Design tailored educational software.

For information concerning the International Division contact:
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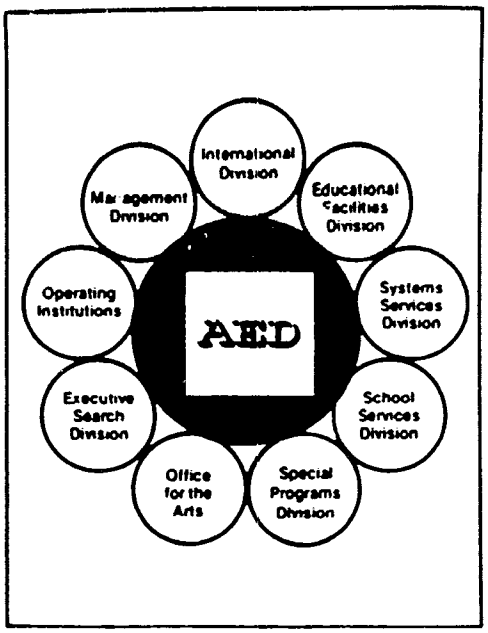
ORGANIZATION



The Academy is organized into nine major divisions: International, Management, Educational Facilities, Systems Services, Operating Institutions, School Services, Executive Search, Special Programs, and the Office for the Arts. Although each division is structured to allow for individual leadership, the Academy has always operated in a manner that promotes substantive contact and cooperation among the divisions.

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