MASS MEDIA & HEALTH PRACTICES

PROJECT IMPLEMENTATION

Academy for Educational Development, Inc.

Sponsored by the Office of Health and Office of Education
Development Support Bureau
UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

TRIP REPORT

HONDURAS

FEBRUARY 5 to 13, 1981

Project Director

Dr. William A. Smith

Project Field Coordinators

Dr. Reynaldo Pareja
Ms. Elizabeth Booth

37

CONTENTS

OBJECTIVE

PERSONS INTERVIEWED

A. PRINCIPAL ACCOMPLISHMENTS

B. MAJOR ISSUES AND POTENTIAL PROBLEMS

1. Packet Production
2. Packet Design
3. Counterpart and Broadcast Contribution of the MOH

C. STATUS OF PROJECT IMPLEMENTATION

1. Radio Program Production
2. Graphic Materials
3. Training
4. Campaign Administration

D. OVERALL EVALUATION OF PROGRAM AT THIS STAGE OF DEVELOPMENT

APPENDICES

A. Number of Packets of Litrosol Required by Oral Therapy Program

B. Hoja de Apoyo

C. Posters

D. Outline of Training Design for Auxiliar Nurses

TRIP REPORT
MASS MEDIA AND HEALTH PRACTICES PROJECT: HONDURAS
FEBRUARY 5 to 13, 1981

Objective

- Review Implementation Plan for Mass Media and Health Practices project with field team to ensure that all campaign components are in place.
- Discuss details of packet production and distribution system with MOH and PAHO officials.
- Discuss counterpart funding and provision of broadcast time by MOH.
- Prepare plans for initiation of the Water and Sanitation Health Education components through discussion with personnel at AID, SANA, and MOH.

Persons Interviewed

Dr. Reynaldo Pareja
Ms. Elizabeth Booth
Mr. John Massey, Health Officer
Mr. Ray Baum, Program Officer
Ministry of Health
Director General of Health

Sr. Jiron, Director, PROSABA, MOH
Dr. Zelaya, Health Education Chief, MOH
Luis Sarimiento, Health Educator, MOH
Dr. Carillo, Assistant to the Director, MOH of Child Care Division, MOH
Rural Health Auxiliar Nurse
Director of PANE
Ms. Miriam Martinez, Project Nurse, MOH
Mr. Hector Valladares, Graphic Specialist

A. PRINCIPAL ACCOMPLISHMENTS

1. Reached agreement with AID, PAHO, and Ministry of Health (MOH) to provide 100,000 emergency oral rehydration packets upon approval of amendment to AED Contract.

2. Through discussion with the MOH, it was agreed that the MOH would send a letter to the Ministry of Finance requesting that terms of Project Agreement be respected and that the three counterpart positions taken out of MOH budget be restored.

3. Visited laboratories of PANE, the national drug producer, and discussed production difficulties. With their help, some 50 sample packets with new triangular design were produced.

4. Visited a rural clinic and tested six poster designs, the new packet labels, and a new packet shape.

5. Reviewed status of each project component and developed the following materials:

- Distribution norms for packets and graphic materials..
- Designs for second phase poster materials, including a characteristic symbol for LITROSOL promotion: a large red heart with a red rose.
- Developed a training plan for auxiliar nurses and guardianes using dolls to simulate the clinical rehydration regimen.
- With Dr. Carillo and Miriam Martinez, developed the rehydration norms for the MOH and translated them into specialized posters for distribution to fixed facilities and to be used as a basis for training of health professionals.
- Developed plan and pilot designs of materials for school program including three specialized graphic products.
- Developed plans for a monitoring system, relying on regular monthly telegrams and summary control sheets for each health worker receiving materials.

B. MAJOR ISSUES AND POTENTIAL PROBLEMS

1. Packet Production

Using estimates developed during this trip, it is anticipated that some 96,000 packets a month will be needed during the months of May, June, and July if a fully operational marketing campaign is in place. This suggests that something like 600,000 packets are needed a year for Health Region No. I alone, or some 3,200,000 packets a year once the program becomes truly national (see Appendix D,1.)

At present, PANE, is producing 2,500 packets a day, approximately 50,000 packets a month, or approximately 600,000 packets a year. This production is presently limited by the capacity of the mixing/filling machine and by the number of work shifts a day. Conceivably, PANE could double production by putting on an extra shift and making minor improvements in production speed, but it does not seem reasonable that PANE will be able to maintain an accelerated production rhythm for extended periods of time.

For the moment, the 96,000 packets a month appears beyond the project's capacity to distribute. In Health Region No. 4, which has a fully implemented oral therapy program, at best without large scale public promotion, they managed to use only 38,000 packets during all of 1980. It simply does not appear reasonable to assume that the MOH will triple that rate of annual packet use for one month only.

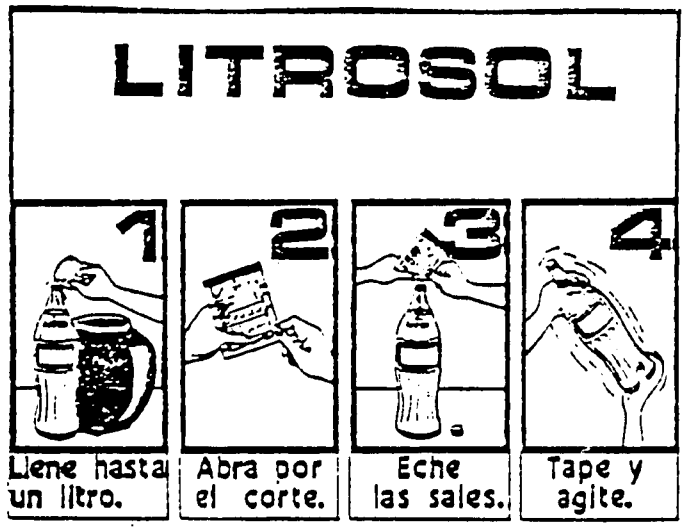
An agreement was reached with the MOH to provide the entire production of PANE, some 150,000 packets during the next three months, to Health Region No. I (the project's target region) alone, and to obtain an emergency stock of some 100,000 packets from UNICEF to meet the needs of the rest of the country during 1981. This will ensure that in Health Region No. I, one style of packet will be used and that the Ministry will have an excellent test of how that packet is best distributed, received, and used before making a national commitment to a specific design.

It will also permit the MOH to gauge the effects of a large-scale promotion on packet demand and may suggest the necessity for additional investment in production equipment. Until the MOH has proof that demand will increase considerably, they are unwilling to make additional investments in equipment and staff. This seems a reasonable position on their part as skepticism about the project's ability to distribute such large quantities of packets continue to be strong within the MOH.

2. Packet Design

In 1980, PANE purchased one million aluminum foil packets very similar in design and structure to the UNICEF packets. The foil is a bit thicker, and the labeling much simpler, but the packet holds the same volume and mixture of ingredients and is shaped the same way. During the first months of field tests several problems with the PANE packets were detected. First, the glucose had not been properly dried before being mixed and the salts were caking severely. This interferred seriously with the ability to pour and dissolve them. Secondly, the ink used on the packets came off with only minimal handling. Third, the foil was so heavy that it was impossible to tear open without using a knife or some other sharp instrument. And fourth, spillage of salts was common when they were poured into narrow-necked bottles.

We believe that the drying problem has been solved. Humidity standards in the laboratories are still a few degrees higher than optimal. This problem is being addressed by the addition of several dehumidifiers. New package labels have been designed which provide a brand name, LITROSOL, and a four picture instruction on how to mix the packet (see following page).



Three hundred thousand labels were printed to test their durability under field conditions and their instructional efficacy. They are being added by hand to the already printed PANE packets. In an effort to address the packet-opening difficulty, a small slit (see photograph A on following page) is being made in the upper corner of the packet which permits easy tearing of the corner. This also helps solve an earlier problem with pouring the salts into narrow-neck bottles which are the most common liter size available in rural Honduras. Opening at the corner provides an easier means of inserting salts into the small bottle opening.

Early field trials of the instructions and the slit indicate that without direct guidance, mothers do not notice the instructions on the packet. They are particularly unaware of visual instructions. In one case for example, a mother simply turned the packet to the side where the ingredients were printed and tried to use this as a mixing instruction. Mothers tended to wash their hands before opening the packets without any suggestion from the instructor to do so. Because their hands were wet, the packet opening was wet also. This caused the salts to clog at the opening and made pouring difficult, but not impossible (see photograph B). Several mothers used their teeth or a knife to open the packet. None of the mothers could find the slit, even after being asked to look for it on the packet. However, once the mothers were shown the visual instructions--step-by-step, and shown physically where the slit was--they learned very quickly and seemed pleased to have the information. The instructions took less than a minute and mothers made virtually no mistakes in opening the packet after the simple instruction period.

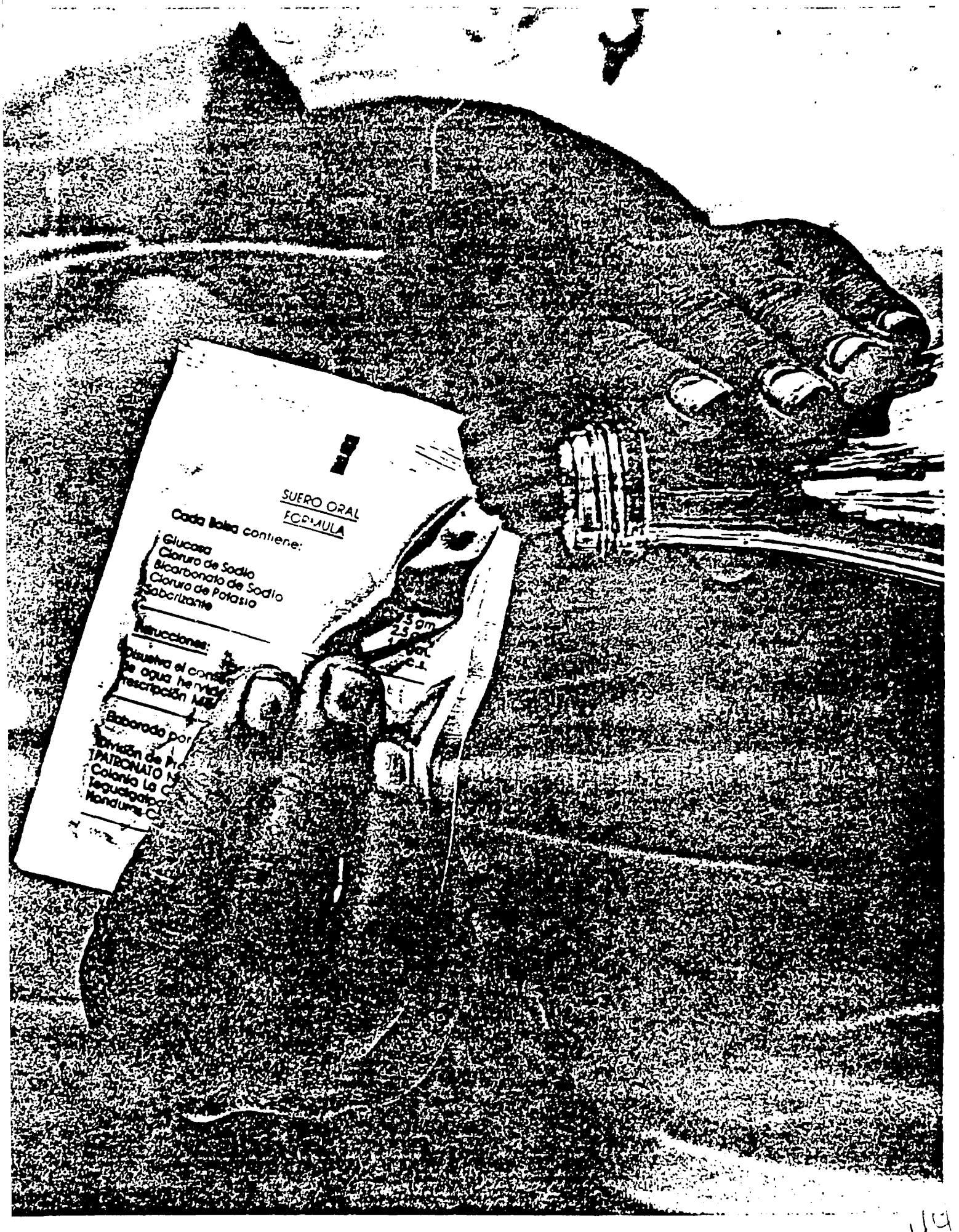
Taking this experience into account, a support leaflet (see Appendix D,2.) has been designed which uses the exact drawing on the packet label coupled with additional simple drawings of the principal administration steps and dehydration signs. These support leaflets will be distributed with every packet and used as a teaching guide for the auxiliar nurses, providing them a simple, but systematic way to review all the important mixing and administration points. These materials are now being tested with auxiliar nurses.

Finally, one additional packet experiment is being tried. A new packet shape has been designed. This shape allows the same volume of salts to be packed, but provides a single, narrow point. This point, when opened with a knife, converts into a funnel, which fits perfectly into the narrow-neck bottles commonly available, and virtually eliminates spillage.

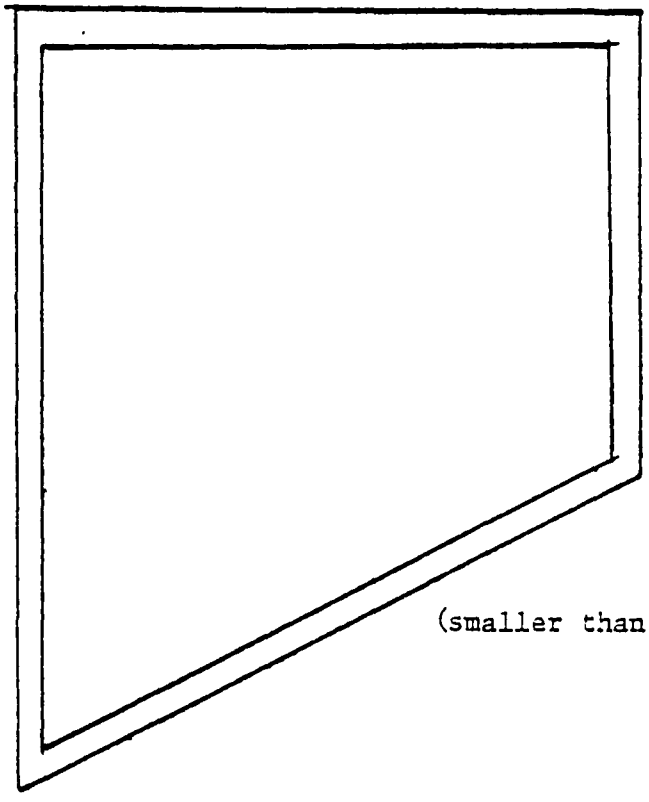
47

PHOTOGRAPH A

PHOTOGRAPH B



Mothers, when given a choice between the two packet shapes—and after having used both, chose the triangular packet as "much easier." This design will not be incorporated into large scale production until further field trials have been conducted, and if it proves successful will be used for the next bulk order of packets.



(smaller than actual size)

3. Counterpart and Broadcast Contribution of the MOH

The project agreement stipulates that the MOH will assume the financial responsibility for three counterparts and one-half the cost of air-time required by the project. The MOH is fulfilling its commitment in terms of air-time but is facing a difficult situation as regards the counterparts. Due to the project's late start-up in Honduras, the MOH missed the 1980 budget cycle and was unable to include the three counterpart salaries in the 1980 budget. The project, under special agreement with AID, agreed to pay those salaries for one-year on condition that the MOH assume them from that point on. The MOH included the three positions in its 1981 budget request to the Ministry of Finance. Honduras however, is undergoing a financial austerity program, and budgets are being severely cut at all levels. The MOH received dramatically less money than requested and the three new positions for counterparts were denied. We have reached agreement with the Minister that he will make a special plea for these three positions.

We are hopeful, but not overly optimistic, that the situation will be favorably resolved. Discussion with USAID mission personnel indicated that the austerity program is genuine and pervasive, affecting the implementation of large loan agreements with several Ministries. A number of avenues are being explored. Without the counterparts we now have, it will be virtually impossible to implement the present campaign plans. Their absence would severely eliminate the project's ability to develop a Honduran capacity to integrate systematic communication planning in future health programs. This is an issue of great concern to us at the moment.

C. STATUS OF PROJECT IMPLEMENTATION

During my visit, a thorough review of the project's present status was conducted involving both project personnel and MOH counterparts. The following is a brief report on the status of each component.

1. Radio Program Production

a. Spots

The central themes of this phase of the campaign are: to introduce the concept of dehydration; to provide messages which reward and praise mothers for doing the right thing, such as breast-feeding; and to introduce the link between children who need special care and parasites. Twenty-one radio spots have been pretested, revised, and produced. These twenty-one are now ready for final MOH approval and distribution to radio stations. Broadcasts are scheduled to begin the last week of February. The programs break down in the following ways: by content there are four programs on "special care for young infants;" four programs on "how to avoid parasite contamination;" four programs on "the importance of breast-feeding;" and 9 programs on "the significance of dehydration in children."

From a format perspective: there are three programs which have a news style; four programs which use a single narrator; and 14 programs which use a dramatic setting. These dramatic programs include a midwife character, a school class, a learned doctor, two mothers congratulating themselves, two parasites talking to each other about the things they like most, and a happy mother who learns how to kill parasites. In addition, two songs have been written for the project, one which is a lovely melody stressing the importance of child care, and a second which is a memorable jingle about dehydration.

In my view the radio programs are very well produced, technically excellent, and should be both memorable and relevant. I was very pleased with the quality of the production.

b. Mother of the Week (MOW)

The field taping of ten MOW programs will be conducted the first week of March. Five villages will be visited and two auxiliares, ten mothers, and several guardianes will be interviewed. These materials will be edited into ten final programs. MOW broadcasts will begin the end of March. A ventriloquist has been contracted and a special dummy made to animate the large community sessions. Graphic materials will not be distributed during this first field taping, but additional pretesting of new graphic materials will be conducted during the community visits.

c. News Items

Four news items are now being written for broadcast at regular intervals during Phase I. The first two items will stress Honduras' role in implementing oral therapy in the Maternal Child Hospital and in developing local production of oral rehydration salts. In addition, the latest studies of the importance of breast-feeding and feeding during diarrhea will be stressed in the two additional programs.

d. Mini-Radio-Novelas

This program is now being reconsidered in light of the lack of an MOH radio counterpart. Without a full-time person to write, produce, and distribute these programs, it is impossible for a quality program to be produced. The cost of hiring actors, along with taping and editing costs, makes this format relatively expensive. For these reasons, the radio novela is being reconsidered and probably will be eliminated as part of Phase I programming.

2. Graphic Materials

a. Posters

Three posters have been pretested, redesigned, and are now in final production. Copies of each have been provided in Appendix D.3. The first poster focuses on the benefits of breastfeeding. Additional field testing showed that a little pizzazz needed to be added to the original design. This was done by encircling the mother in a large red heart, adding a rose to her hand, and crowning her with a laurel leaf. An initial trial of using a halo was rejected because of opposition from evangelical groups in rural communities. The heart, rose, and crown were well received and the poster proved popular with the test audience. Coincidentally, red is a color associated with curing and adds impact to the overall visual message. These three elements: heart, rose, and crown are being considered as a characteristic trademark for the program, combining them with images of a healthy child holding a LITROSOL packet, and a LITROSOL packet by itself.

A second poster shows a mother providing special care for her infant while her other children play in the background. And a third shows the negative consequences of keeping water from a child with diarrhea. The third is somewhat controversial. The death scene was considered to be very strong by most of the test audience. They clearly said the "didn't like the picture" and it appeared clear they were referring to the content. At the same time, they recognized the consequences of lack of water. Only 1,000 copies of this poster are being made, while some 5,000 initial copies of the other two are being produced.

Draft posters for Phase II are also included in Appendix D.3. They show how the same visual themes are expanded to relate LITROSOL to child care and to avoid death from dehydration. The phrases being used on the posters are picked up in the radio programs and provide an identifying characteristic for the campaign. One poster is being designed which replicates the label on the LITROSOL packet. This poster will be widely distributed throughout the region during Phase II.

One specialized poster has been designed for fixed health facilities including doctor's offices, hospitals, clinics, and health centers. This graphic provides clear instructions on administration of oral therapy in fixed facilities and additional information on the importance of breast-feeding, avoidance of antibiotics, and feeding during bouts of diarrhea. This poster is being printed in the U.S. so that it will have the maximum professional quality. This is considered critical to convincing the medical professionals that oral therapy is a serious and "high-class" treatment. The chart has been designed especially for a literate and sophisticated audience. It will be used in the training sessions for all health professionals and distributed at the end of each training course.

b. Support Visuals

A slide tape presentation on the administration of oral rehydration therapy has been prepared for use with professional medical personnel. The seven-minute presentation uses pictures from the oral rehydration ward in Tegucigalpa and photographs taken during field mixing trials to illustrate the overall administration and instructional problems related to oral therapy. Finally, a manual for auxilar nurses and another on official MOH norms for oral therapy are being prepared and structured into separate documents. These documents will be used as a reference, supporting the large wall graph and the training sessions.

A Hoja de Apoyo para Madres support leaflet for rural mothers is being prepared (see Appendix D,2).This leaflet details the critical points in administration and mixing of the oral solutions.

A similar sheet is being prepared for midwives and primary health workers to emphasize the signs of dehydration and decision points when children must be taken to a fixed facility.

Three materials are being prepared for use in rural schools. The first is a children's story, abundantly illustrated, which has as the central character a young boy who helps save his sister's life by recognizing the early signs of dehydration. The story emphasizes the role that young children can play in such a program and gives the boy praise from both his mother and the local health nurse for being such a hero. The second is a comic book using two parasites as central characters. The parasites build upon the story from the radio spot to explore how unsanitary conditions help them propagate. The comic features a little girl who learns how to destroy parasites and guard against parasite invasion. The third is an exercise called La Casa Sana.* Like the fire prevention checklist that many schoolchildren in the U.S. take home to evaluate the home fire hazards, this checklist is an exercise which allows the rural teacher to first discuss diarrhea hazards around the home, to motivate the child to do an individual evaluation of his own home, and then to adopt one of the behaviors which is not presently practiced. Care has been taken to include several aspects which we know now exist in rural homes to avoid embarrassing children who come back to school with a zero health score. One activity has been included especially for follow-up purposes. That activity is the use of a special box, or place in the home, to store dirty diapers. It

* The Healthy House

is considered that this is very rare now; that it would be a contribution towards home cleanliness; and that it is something that a school age child (second- to third-grade) could effectively manage. The exercise includes a monitoring function and a reward for children who do arrange a special place for dirty diapers.

3. Training

One training course has been completed for 37 nationwide nursing supervisors. This course emphasizes both the theoretical and practical aspects of oral therapy. Initial skepticism among project personnel about the worth of theoretical sessions proved to be unfounded. The nurses are accustomed to theoretical presentations, particularly from respected doctors, and would have felt cheated if only practice sessions had been included. The purpose of this early training was to introduce the oral rehydration therapy concept to an influential group of supervisors working at the national level.

The next major training experience will be for 125 medical students preparing for their first year of field service. A similar emphasis on theory combined with practice will highlight the training design. The wall chart will be used as the basis of the training structure and will be distributed along with a paper prepared by Dr. Edwin Parker which has been translated into Spanish for this purpose.

In April the full-scale training of auxiliar nurses in Region I will begin using a training design which emphasizes simulated practice of therapy administration (see Appendix D). In May and June training of primary health care workers and midwives will begin.

The basis for this training approach was developed after a five-week field test of the training format. Miriam Martinez, the project counterpart nurse, first spent one week in the Maternal Child Care Hospital observing doctor's, nurse's, and mother's responses to the oral therapy regimen. These experiences pointed out clear difference between rural and urban mothers who came to the hospital. Rural mothers had much greater difficulty in keeping the scheduled administration times. They were oblivious to the work. They were more reluctant to wake their children to administer the solution, as sleep for them represented an important improvement in their child's condition.

It was also clear from these experiences that neither doctors nor nurses gave very good instructions to mothers, nor did they provide regular supervision of mothers. This was particularly true during those times when the nursing shifts were changed. In a few cases, mothers were left without oral solution for up to three hours. Vomiting was frequent. It was rarely severe, but it did concern mothers greatly and seemed to be related to rapid administration of the solution. The instructions which nurses and doctors gave to mothers on how to prepare and administer the packets in their homes were also insufficient. There was little or no checking with mothers to determine if they understood the instruction and a very rapid review of the most important points was made. A common question which mothers asked was whether they should "cook" the solution before giving it to infants. This questioning has prompted doctors to dwell on the point and insist that the solution not be boiled, but that the water in which it is prepared be boiled. Mothers were also concerned that the solution had not stopped the diarrhea. The

doctor's response was to focus on the child's improvement and to say that the solution had stopped the vomiting. This proved to be an effective argument with most mothers, although their concern about receiving medicine for the diarrhea continued.

The second stage of the trial was a field test of an auxiliar's ability to teach the basic steps of mixing to rural mothers. Miriam spent one day in Talanga, a rural area several hours from the capitol. She first taught the local auxiliar during a three-minute demonstration, how to prepare the solution. The auxiliar then taught 11 mothers, individually, with no intervention from Miriam. She then established a follow-up schedule; visiting the first four mothers after one week; another four mothers after two weeks; one mother after three weeks; and a final mother after four weeks. There was essentially no loss in learning the critical mixing steps. Mothers, even after three and four weeks, made no notable mixing mistakes and seemed to remember very well how much water to use; when to add water and salts; and how to give, and over what period of time to administer, solution. This was both surprising and encouraging to the project staff. It suggests that nurses may be effective educators even if they are pressed for time and may suggest that opinion leadership, the transfer of mixing and administration instruction from one mother to another, should be aggressively encouraged.

4. Campaign Administration

A number of specific administrative decisions are now being made. First, a broadcast schedule is being finalized which will specify each radio broadcast time and station. This design will be used to monitor the station's compliance with scheduled plans. A local commercial firm which specializes in this service will conduct the monitoring activity.

A distribution system has been designed to control what materials are distributed to whom. A combination of distribution during training sessions, distribution to difficult areas through the Mother of the Week program, and regular monthly cables from 10 selected sites will be used to ensure that at least minimal supplies of packets and print materials are available.

Distribution of packets through commercial pulperias (stores) is still being discussed. Noone in the MOH has explicitly forbidden it, but all authorities have expressed serious concern. They feel it would set a precedent which the MOH does not want to establish and would blur the lines between commercial and public distribution of patent medicines. In the absence of a clear prohibition project staff continue to explore ways in which the commercial sector can be involved, including commercial production of oral salts to compliment the MOH's own program. Optimism is tempered in this regard, but project personnel continue to be hopeful. At this point, it is doubtful that packets will be widely available through local stores during Phase II of the project.

D. OVERALL EVALUATION OF PROGRAM AT THIS STAGE OF DEVELOPMENT

Enormous progress has been made toward the development of some very exciting instructional materials, including the radio programs and several interesting graphic support materials. The support leaflet offers an instructional axis around which the principal educational points can be organized, taught, reinforced, and evaluated.

The biggest problem continues to be effective supply and distribution of packets. While steps are being taken to address this problem, its solution continues to depend on a variety of factors beyond the project's control. It appears clear now that the project will have an effective first phase campaign and that the potential demand for LITROSOL will be high. We continue to be hopeful that a break-through on the production of packets, the use of commercial distribution facilities, and assured access to training courses will be forthcoming.

Finally, the concern over the continued availability of counterpart personnel is very critical. Not only will the absence of counterparts weaken the ability of the project to become an operational part of the MOH, but it threatens the project's ability to conduct training sessions, design materials, and generally carry-on with the campaign.

NUMBER OF PACKETS OF LITROSOL REQUIRED BY ORAL THERAPY PROGRAM

SYSTEM I:

Calculated by number of distribution points during rainy season:			LITROSOL
No. of health centers; 63 x 10 episodes of diarrhea daily x 20 days in a month x 2 packets		=	25,200 per month
No. of guardianes; 164 x 2 episodes of diarrhea daily x 20 days in a month x 2 packets		=	13,120 per month
No. of midwives; 559 x 0.5 episodes of diarrhea daily x 20 days in a month x 2 packets		=	11,180 per month
Hospital Materno Infantil		=	10,000 per month
Hospital Danli		=	5,000 per month
	Subtotal		64,500 per month
250 large stores x 50 packets (per month)		=	12,500 per month
650 small stores x 30 packets (per month)		=	19,500 per month
	Subtotal		32,000 per month
(No. of packets during rainy season (per month)	Total		96,500 per month

---

No. of packets needed during rainy season: 4 x 96,500		=	386,000 per month
No. of packets needed during dry season: 8 x 24,125 (1/4 of rainy season)		=	193,000 per month
Packets needed for Region I annually	Total		579,000 per month
Packets needed nationally (annually) (Considering Region I has 18 percent of total population)			3,216,666 per month

D,1-1

Best Available Document

SYSTEM II:

Calculated by number of children:

64,000 families of Region I x 1,5 children less-than-5-years-old	=	96,000 children
96,000 children x 4 episodes of diarrhea annually	=	384,000 episodes
384,000 episodes x 2 LITROSOLS	=	768,000 LITROSOLS annually
No. of LITROSOLS during rainy season (128,000 x 4)	=	512,000 LITROSOLS
No. of LITROSOLS during dry season (32,000 x 8)	=	256,000 LITROSOLS
Total		768,000 LITROSOLS

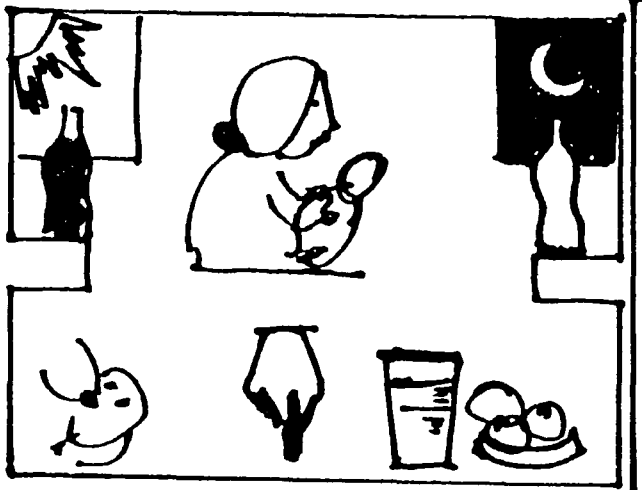
(System I represents 75 percent of this total)

SYSTEM III:

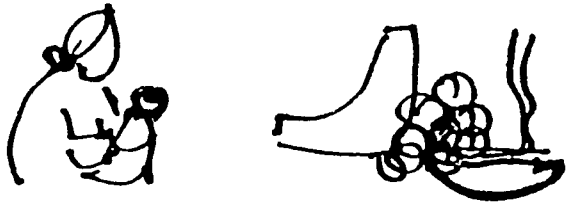
18,000 episodes of diarrhea reported in 1980	=	36,000 LITROSOLS

1	2	3	4
(same a		label)	

Mix LITROSOL in a 1 litre bottle of Water

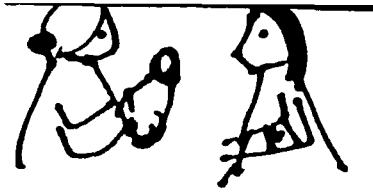


Give ALL the bottle in 1 full day plus Breastmilk, Water & Juice

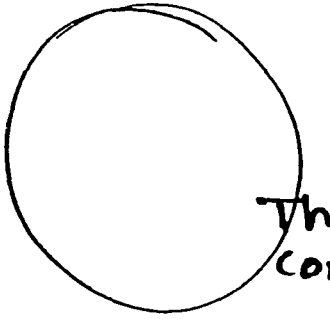


Give soft foods like rice water,

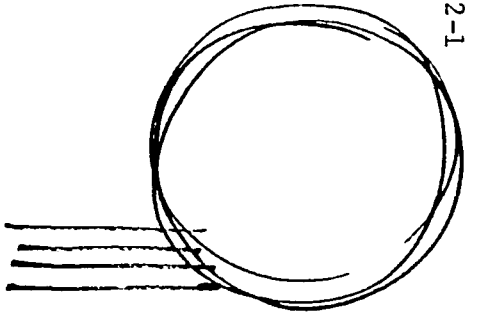
DONT give Purges like teas, —, —.



Take your child to the ~~for~~ clinic if:



The diarrea continues



D,2-1

54

Hoia de Apoio

Madre que pecho da..

¡Es Madre de Verdad...!

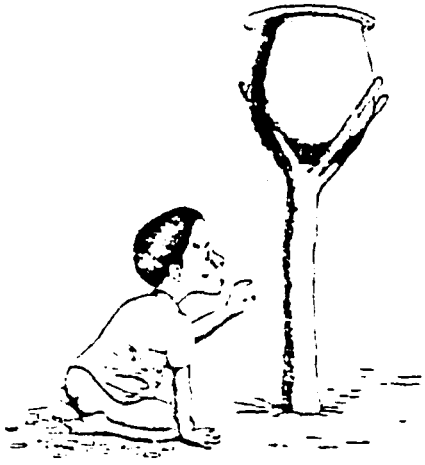
D,3-1

EL TIERNO ES MAS
DELICADO
¡ DELE MAS CUIDADO !

EL TIERNO ES MAS
DELICADO
¡ DELE MAS CUIDADO !

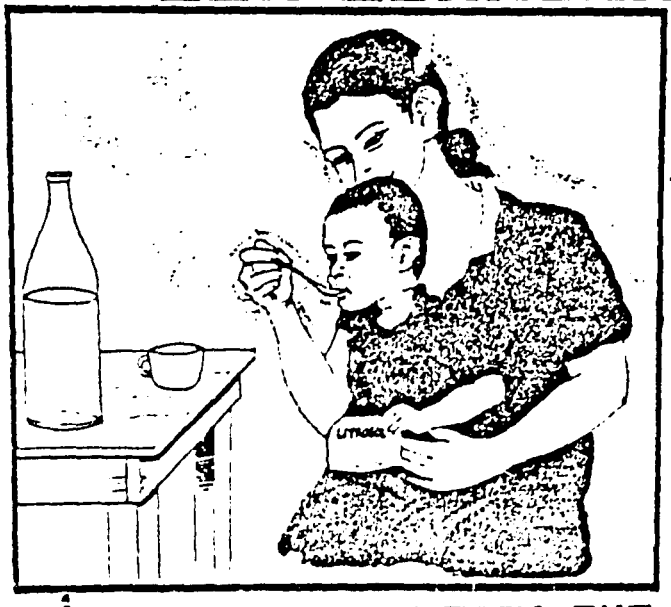
D 3-2

¿ CON OBRADERA...?



¡ DELE LIQUIDOS PARA QUE NO MUERA !

¿ CON OBRADERA...?



¡ DELE LIQUIDOS PARA QUE NO MUERA !

OUTLINE OF TRAINING DESIGN FOR AUXILIAR NURSES

Principal Objective: Train auxiliar nurses to effectively use the Support Leaflet with rural mothers.

Secondary Objective: Train auxiliar nurses to properly administer oral rehydration therapy in fixed facilities to dehydrated children.

A. Introduction: A brief presentation of who the trainers are and why they have come.

B. Audiovisual presentation: A seven-minute slide-tape which summarizes the major aspects of oral rehydration therapy.

C. Theoretical presentation of how oral rehydration therapy works.

This 20-minute presentation by a respected local physician discusses the physiology of oral rehydration therapy and sets a professional tone for the remaining training. This was included to counter claims by many nurses that oral rehydration therapy was a household remedy used for years and not really as good as application of the therapy in a center. The presentation deals with their principal concerns: does it work; what happens if vomiting occurs; and does it stop the diarrhea?

D. Demonstration by Miriam Martinez of the full application of the therapy in a center.

This ten-minute demonstration provides a model for the nurses who will then be asked to simulate the full administration cycle themselves during the training.

E. Small group practice before the large group.

The large group of 20 to 30 nurses will be broken down into 10 groups of two to three people each. Each group will be numbered and one member of the group will take the role of an auxiliar nurse, while the other members play the role of family members. One of these groups will be asked to repeat the administration demonstrated by Miriam. Miriam will provide feedback to the small group on their performance and ask the large group to make suggestions as well.

F. Practice in individual small groups.

At this point the small groups will separate and each will be asked to conduct one practice session using dolls, common measures, the wall chart, packets, etc. Each group will have the same materials which can be found in their clinic. They will first determine the severity of the diarrhea and look for signs of other serious problems. They will use the weight-for-age chart to establish their child's (doll) actual weight and prepare the correct volume of mixture for that child (doll). They will then use a cardboard clock to simulate administration time and discuss what they would do if vomiting occurred. They will reevaluate the child's condition and assume that improvement has taken place. At this point, they will use the Support Leaflet for mothers to teach the other members of their group how to mix and administer the solution in their homes, receiving feedback on their teaching behavior. Each member of the group will have the opportunity to simulate the role of auxiliar at least once. The trainers will pass from group to group giving advice, noting problems and providing support.

G. Large group discussion of problems encountered.

The large group will convene once again and discuss how this system might be used in the congested, noisy environment of their rural clinic. Possibilities for group teaching of mothers and the use of expert mothers as assistants will be discussed. Essentially, the point here is to give the group a chance to compare reality with the artificial environment of the training course.

H. The radio programs will be played during the training course and nurses asked to comment on them, making sure that the messages are clear. They will then be asked to remind mothers that such programs are on the air, mentioning specific characters like Dona Chela, Dr. Salustiano, etc.

I. Materials, including a wall chart, the manual, multiple copies of posters and a guide on where posters should be placed in the community, along with a two months supply of packets, will be distributed.

J. A written test will be administered to determine what information was lost and these tests reviewed and "graded" by the auxiliar herself to ensure that mistaken concepts are corrected. Special attention will be given to emphasize that: LITROSOL is a medicine, not just a vitamin; it does not stop diarrhea, but it helps make the child stronger so that the child can fight the diarrhea better; the solution replaces the water which the child has lost and helps restore the child's appetite; if vomiting occurs, the mother is to let the child rest, and then continue administering slowly; mothers should give all the solution; mothers should stop giving purges, and instead, feed the child breast milk and soft foods, and, finally, mothers should return if the diarrhea continues, or the child appears worst.

MASS MEDIA & HEALTH PRACTICES: RURAL WATER & SANITATION

OBJECTIVE:	To design and execute a community health education component for a rural water and sanitation project
LOCATION:	Tegucigalpa, Honduras
TARGET POPULATION:	247,000 rural Hondurans living in communities with populations under 2,000
PROJECT DURATION:	33 months
SPONSORS:	United States Agency for International Development; Government of Honduras
CONTACT PERSON:	Dr. William A. Smith Academy for Educational Development 1414 22nd Street, N.W. Washington, D.C. 20037

Ministry of Health (MOH) 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 by INCAP in Guatemala found a synergistic relationship between malnutrition and diarrhea. The findings suggest that an intervention such as 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 the rural areas. Some 78 percent of the urban population has access to drinking water facilities and 49.7 percent has access to some means of human waste disposal. Comparatively, only 30.3 percent of the rural population has reasonable access to safe drinking water, and only 18.4 percent of the population has access to basic waste disposal facilities.

The project will pursue four major activities: (1) expansion of construction capabilities to permit self-help installation of approximately 180 gravity-flow aqueducts, excavation of 3,000 hand-dug wells to be furnished with hand pumps, rehabilitation of 800 wells and 50 piped water systems, and installation of approximately 18,000 pit latrines and 14,000 water sealed latrines; (2) establishment of functioning sub-project maintenance systems; (3) development and implementation of education activities to promote community participation, improved health behavior related to water and sanitation facility use, and systems maintenance; and (4) training of promoters and field agents to improve sub-project implementation, supervision, and overall project monitoring.

60

The program will be coordinated through the efforts of field promoters who are responsible for all phases of activities, including the initial community contact, obtaining assurance that the community will provide the required volunteer labor, construction, and health education. If a protected water source exists within a reasonable distance above the village that will serve the community's water needs, a gravity-flow aqueduct will probably be the appropriate solution. If the prerequisites are not present for a piped water system, the possibility of installing community wells will be investigated. The motivation for adoption of the water and sanitation facilities is to be stimulated by community participation in: the decision to initiate the project, 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 health education activity relies upon past experience in mass communication and combines systematic pre-program research with experience drawn from such fields as social marketing and behavioral analysis. This process rests upon a clear understanding of three principal areas: 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 the widespread adoption of the selected behaviors.

RESOURCES USED

People:

The health education component provides one full-time expatriate technical assistant for 33 months in Honduras.

In addition, there are resources for short-term expatriate consultants in behavioral modification, social marketing, and formative education, as well as local assistance for field interviewing, village observation, and program monitoring.

Buildings:

Facilities of the Ministry of Health and the National Sewer and Water Agency (SANA).

Material Aids:

Open broadcast radio programs.
Tailored graphic materials including posters, pamphlets, flipcharts and training support materials.
16mm film and slides.

Costs:

Approximately $500,000 for the health education component.

THE JOHNS HOPKINS UNIVERSITY

SCHOOL OF HYGIENE AND PUBLIC HEALTH

DEPARTMENT OF
HEALTH SERVICES ADMINISTRATION
DIVISION OF HEALTH EDUCATION

615 North Wolfe Street • Baltimore, Maryland 21205

February 24, 1981

TO: Dr. William Smith
Project Director
Mass Media and Health Practices

FROM: Members, Institutional Review Board of The Academy for Educational Development RF

It is our view that two aspects of your project - the mass media campaign and the distribution of oral rehydration therapy - are not research activities according to the definition of research provided in the current DHHS regulations (published 1/23/81) and therefore do not require our review and approval. We also doubt that your monitoring of village women's reactions to the media campaign is a research activity. However, because no identifying information is to be collected, even if this monitoring constitutes research with human subjects, it is exempted from review under the current regulations (see 46.101, b-3, p. 3386).

Thank you for this opportunity to consider your project. We appreciate the thoroughness of the materials you prepared for our review.

IRB Members: Maurice Imhoof
Jill Merrick
Joel Teitelbaum
Ruth Faden RF
Mary Lou Clements
Gayla Kraetch