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COMBATting CHILDHOOD COMMUNICABLE DISEASES

HEALTH EDUCATION COMPONENT

FINAL REPORT

Prepared for the
AFRICAN REGIONAL AFFAIRS OFFICE
under contract #AID/I-C-1473
with the
BUREAU FOR SCIENCE AND TECHNOLOGY
AGENCY FOR INTERNATIONAL DEVELOPMENT
by the
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Regional Health Education Component
CCCD Project
Combatting Childhood Communicable Diseases

Prepared by
Academy for Educational Development
for the
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U.S. Agency for International Development
under
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A very special acknowledgement goes to the workshop personnel, consultants, AID, and Peace Corps personnel who shared their time, experiences, and opinions with us. Again, this contribution helped shape this report in significant ways.

Finally, we wish to express our sincere appreciation to Noel Marsh and Joe Davis for their substantive guidance and direction in the project. It was their clear commitment to building viable African institutions and their willingness to establish priorities for the health education component of CCCD which made this report possible.

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Introduction

This final report has been prepared by The Academy for Educational Development and reviewed by Expand Associates in partial fulfillment of the requirement of contract #AID/ta-C-1473 with the Agency for International Development. The contract stipulates that the contractors will:

- 1) Review WHO primary health care documents to include the declaration of the Alma ATTA Conference on primary health care and current policy documents implementing that declaration, the CCCD project paper, and work programs, and conduct a brief literature search and review of current health education technology and its application in lesser developed countries resulting in an annotated bibliography.
- 2) Discuss with relevant AID officials, CDC, and WHO/AFRO the preferred objectives for health education in the CCCD Project and the most feasible and efficient means to achieve them, the inputs required to accomplish the objectives, and review current health education/promotion experiences in Africa in these same discussions.
- 3) Critically assess current health education practices and problems in two African countries selected by AID and AFRO. To achieve this goal the Academy and Expand conducted a 22-day survey trip to seven countries--United Kingdom, The Gambia, Togo, Congo, Zaire, Geneva, and France--to interview selected individuals and visit existing programs of health education in Africa.
- 4) Hold a two-day workshop convening a small group of health education experts, CDC personnel, and AID personnel to develop recommendations for health education in support of CCCD.

Participants at this workshop held on March 10 and 11, included:

Mr. Andrew Agle, International Health Programs, Centers for Disease Control

Ms. Alberta Brasfield, Staff Consultant, Expand Associates, Inc.

Ms. Renee Brown-Bryant, Project Manager, Expand Associates, Inc.

Ms. Stephanie Cook, Program Associate, Expand Associates, Inc.

Dr. William Darity, School of Public Health, Health Sciences Center, University of Massachusetts at Amherst

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Mr. William Griggs, Chief, International Health Programs, Centers for Disease Control.

Dr. Robert Hornick, Annenberg School of Communications, University of Pennsylvania

Dr. Reid E. Jackson, II, Project Director, Expand Associates, Inc.

Dr. Donald Johnson, Health Education Centre, Institute of Public Health, University of Ibadan, Nigeria

Ms. Linda Lankenau, Science and Technology Division of Health, U.S. Agency for International Development

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Ms. Arlene Mitchell, Chief of Operations for Africa, Peace Corps
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for International Development
Dr. Frances Saunders, School of Public Health, University of
California at Berkeley and the National Center for Health Education
Dr. James Sheppard, Chief, Division of Health and Nutrition, Africa
Regional Bureau, U.S. Agency for International Development
Dr. William Smith, Vice President and Associate Director,
International Programs, Academy for Educational Development

- 5) Develop a report containing a project description, verifiable objectives, schedule of activities, budget, and desirable implementation arrangements for a health education/promotion component of the Combatting Childhood Communicable Diseases Project. The level of effort proposed should be commensurate with the approximately \$2,000,000 scheduled for health education activities in the CCCD Project.

This paper represents the final report referenced in point 5 above. In addition to the specific report requirements, it includes summaries of the Literature Review, of the Survey Trip Report, and of the Workshop Report. While personnel for the Academy and Expand Associates have cooperated on all phases of this project, each institution was assigned specific tasks within the project.

Expand was responsible for:

- o The Literature Review.
- o The Survey Trip Report.
- o The Workshop Organization.

The Academy was responsible for:

- o Reviewing the Literature Review.
- o Participating in the Survey Trip.
- o Participating in the Workshop.
- o Preparing the final report.

The Academy bears final responsibility for all opinions and views expressed in this report. While the workshop was tremendously useful to us in providing a review of the preliminary health education proposal, and many ideas have been incorporated into this final version of the report, this document should not be constructed to represent the views and opinions of all workshop participants.

Background

There are 47 countries in sub-Saharan Africa. Many of these countries lack the resources to address the childhood communicable disease problems they are facing. External resources are required. Under the CCCD Project, the U.S. Government will extend bilateral technical cooperation to as many as 12 countries of sub-Saharan Africa. While significant, the CCCD response will not begin to meet the totality of resource needs. The CCCD program comprises a major effort by CDA (Cooperation for Development in Africa) to work with African countries to reduce three of the major causes of mortality in infancy and childhood (i.e., diseases preventable by immunization, diarrheal diseases, and malaria). It is expected that the CCCD initiative will promote increased involvement in Africa by CDA and non-CDA countries.

Evaluation of immunization services in several African countries has documented their feasibility and effectiveness. Expansion is limited by constraints in management, training, cold chain, supervision, and resources. CCCD will address these constraints.

Control of diarrheal disease mortality has been improved by the recent development of oral rehydration treatment of diarrhea and dehydration, and the recognition of the importance of continuation of feeding during diarrhea. CCCD will assist countries in the introduction and expansion of these new technologies.

Studies of malaria in Africa have identified two population groups with a high risk of mortality--children under five and pregnant women. Presumptive treatment of child fever cases with chloroquine is proposed as a priority intervention to reduce malaria mortality. Because malaria during pregnancy adversely affects the mother, the fetus, birth weight, and infant survival, malaria prophylaxis and/or presumptive treatment of fever in pregnant women will also improve infant health.

AID support of the CCCD Project consists of two closely related components.

- o A Regional Support Element - providing overall intercountry training, health information system, health education system, operations research, and epidemiological backstopping. It will provide support to all CDA country-specific activities.
- o A Country-Specific Project Element - structured to provide more extensive country-specific assistance to approximately 12 countries over the seven-year life of the project. Such assistance consists of technical assistance, principally by a resident technical officer, provision of supplies and commodities, in-country training, development of health information systems, and health education.

Field implementation of the CCCD Project began in the fourth quarter of 1982 for all project components. AFR/RA has entered into a PASA with HHS/CDC (Centers for Disease Control) to implement portions of the regional project, as well as country-specific activities.

Health Education and CCCD

The objectives of the health education component as defined in the CCCD project paper include:

- 1) Identifying and ameliorating attitudes and behavioral patterns of parents that preclude the use of services designed to combat childhood communicable disease.
- 2) Developing community groups and organizations which can influence health-seeking behavior of parents, coordinating and assisting government public health programs, and organizing and directing community efforts to improve conditions leading to high levels of communicable disease mortality and morbidity.
- 3) Strengthening and improving private and indigenous responses to childhood communicable disease.

The specific activities which will be considered as potential health education activities of CCCD include:

- 1) Formal education in schools.
- 2) Informal education of parents by various means, including mass media, mothers' groups, and community organizations.
- 3) Formal and informal training of private and indigenous health care providers.
- 4) Development of community organizations to carry out health education activities, coordinate governmental programs, and to mobilize local resources to finance or carry out activities designed to combat childhood communicable diseases.
- 5) Activities designed to influence and commit policy makers and personnel responsible for resource allocation to make national resources available to CCCD activities.

I. EXECUTIVE SUMMARY

Health education in the CCCD context is defined as any organized activity designed to affect positively the knowledge, attitudes, and behavior of child caretakers and those who influence them towards the effective use of services being provided by the CCCD program. The primary goal is to create an agile and efficient health education program capable of producing in a relatively short period of time (3-4 years), high usage rates for the new CCCD services being promoted (EPI, ORT, and fever treatment). To achieve these goals, it is recommended that special emphasis be given to a particular form of health education known as the Public Communication Campaign. This approach emphasizes improved face-to-face education; expanded coverage through the systematic integration of mass media, print, and face-to-face channels; and, where possible, the development of community organizations to carry out and control village health education.

All three CCCD components—EPI, diarrhea, and malaria—will require significant, yet slightly different health education support. While the patient population for each component is the same (children under 5 years of age), each area is somewhat different in complexity and approach. Health education for EPI should foster increased clinic and health post usage through regular reminders of vaccination schedules, and should promote a general understanding and support for disease prevention. In addition to increased use of ORT in clinics, the diarrhea program may require widespread instruction in ORT mixing and/or administration skills, as well as changes in some traditional childcare practices at the home level. The malaria program will focus on clinic-administered chloroquine as the preferred treatment of all fevers in children under five. The primary goals of all these programs is to ensure that mothers of young children arrive at the nearest health center at the proper time, be it when a vaccination is needed, or when a child is ill with fever or prolonged diarrhea. Each program will be tailored to the specific needs of, and resources available in each of the 12 cooperating countries and will be part of a coherent and integrated program strategy which strengthens existing rural health care priorities and systems in the cooperating countries.

It is recommended that the CCCD regional health education component be used to provide substantive support to 12 bilateral programs, and additional consulting and advisory services to other CDA country programs to implement a public education approach to achieve the high usage rates required. At the same time, it is proposed that CCCD expand the capacity of selected African institutions to train and support health education planners in specific communication planning skills that are currently lacking.

At the regional level, health education should focus on:

- 1) Development of **model health education assessment and intervention strategies** which can be tailored to each participating country's needs.
- 2) Use of **Peace Corps specialist volunteers to provide 10-24 person-years of long-term technical assistance** to the 12 countries selected for bilateral programs.
- 3) **Specialized short-term technical assistance** to the 12 bilateral programs in the area of health education planning, audience and channel research, materials testing, and program monitoring systems.
- 4) Creation of **tailored short courses** for cooperating country health education specialists for CCCD program managers, as well as for Peace Corps specialists and generalist volunteers.

Bilateral assistance in health education should include resources for country-specific health education research and materials production, and short-term participant training funds to support cooperating country personnel training at two African centers. Additional resources from AID missions and other centrally-funded AID programs should be explored and used as appropriate.

PROPOSED ACTION AGENDA

1. Contact the following African institutions to determine officially their willingness and ability to provide the long-term and short-term technical assistance, as well as the training and coordination resources, required.
 - o University of Ibadan - Nigeria
 - o WHO Centre - LOME, Togo
 - o PAD Centre Douala, Cameroon
 - o Centre in Cotonou
 - o Centre in Dakar
 - o INEDES - Abidjan
2. Determine officially with the Peace Corps if and when 10-12 Peace Corps specialists could be provided.
3. Determine which of the health education activities proposed here are appropriate for the CCCD program.
4. Contract, through CDC, either an African or U.S.-based institution to coordinate and supervise the selected health education activities.

II. RATIONALE AND ASSUMPTIONS

What is the Role of CCCD and CCCD Health Education in Each Cooperating Country?

The CCCD program is viewed as a significant new contribution to the existing health program in each of the 12 cooperating countries. If successful, it will add a set of specialized resources to the existing programs that address three limited, but critical health problems common to all 12 countries (immunization, ORT, and presumptive treatment of fever).

The health education component is designed not to replace or absorb all existing health education activities in a cooperating country, but to add to existing systems a limited set of specialized health education resources which will contribute specifically to the fullest possible use of the three new CCCD services.

CCCD program managers both within AID and CDC are fully aware that the relatively narrow focus of the activity supported by CCCD, if carried out in isolation, is likely to result in only short-term gains. But the CCCD program does not propose to work in isolation. CCCD will become one fundamental new element in a growing system of improved health services delivery.

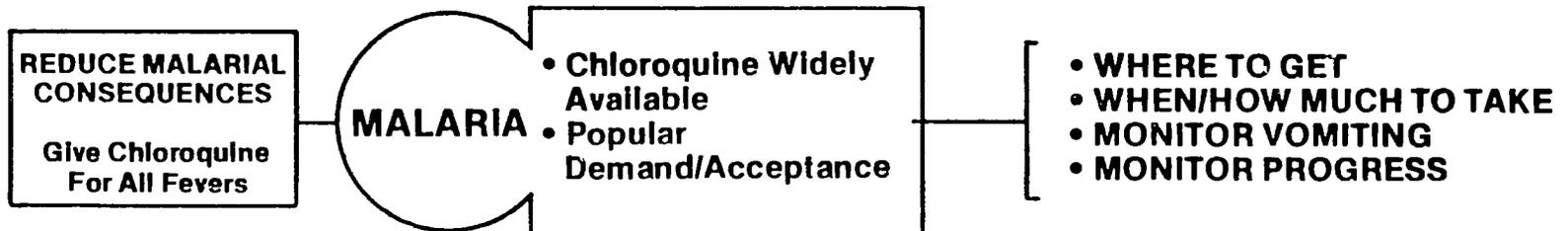
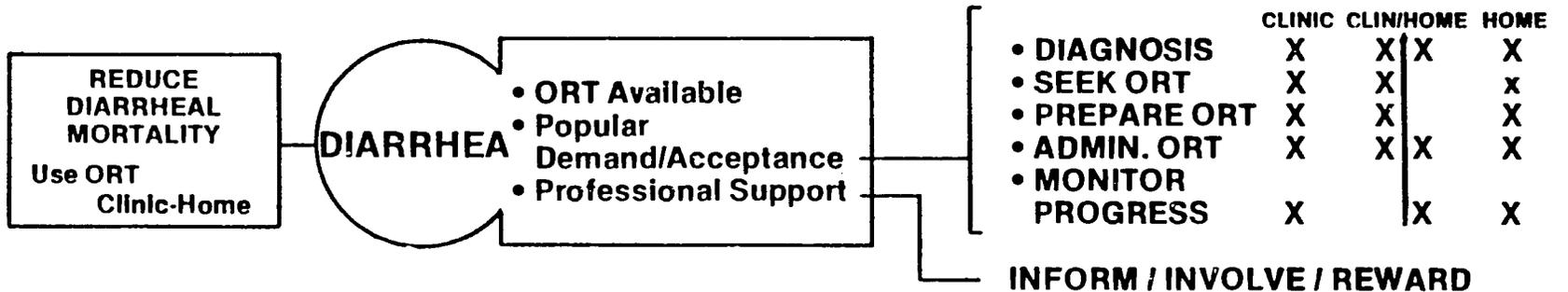
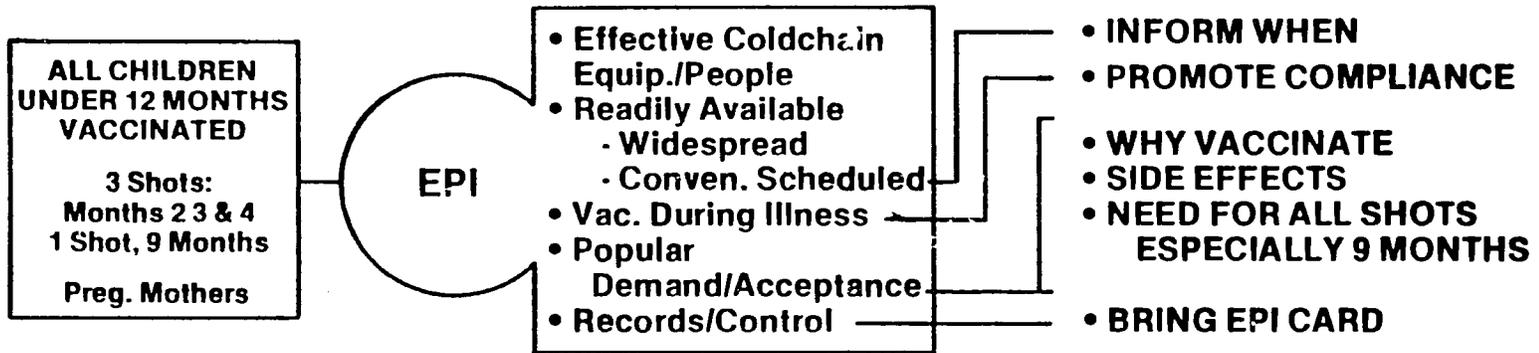
The primary conclusion to be drawn is that health education in the CCCD Project should focus on the goals of increased use and should not be judged against the broader objective of developing a comprehensive health education delivery system. Clearly, CCCD intends to contribute to the development of such systems by adding complementary skills and approaches, but the program will not take full responsibility for fundamental health education development.

The health education component has been included as part of the regional rather than the bilateral assistance. The resulting economies of scale permit the program's resources to be used more broadly and to influence and assist a larger number of health education activities. Significant emphasis is being given to regional African-based training programs, regional short-term consultation, and the development of regional models for the assessment and implementation of relevant health education programs.

What Behavioral Changes are Needed to Ensure Widespread Use of the New CCCD Services?

Each of the target areas--EPI, diarrhea, and malaria--represent significantly different health education problems. Primary messages proposed for each area are illustrated in Chart I and are described subsequently.

1 KEY HEALTH EDUCATION ROLES



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EPI

- o Bring child to clinic once a month for 3 months starting when child is 1 month old.
- o Bring child to clinic between 9 and 12 months of age.
- o Always bring child's health card to clinic.
- o Pregnant mothers should visit clinic (time to be determined).

Diarrhea

- o Give ORT (regime to be defined locally) everytime child has diarrhea. ORT helps child (to be defined).
- o Get ORT packets from (to be defined).
- o Mix ORT in one litre of cleanest water, making sure to dissolve all the salts (container and mixing instructions to be determined).
- o Give (amount to be determined) every (to be determined).
- o If child is not improving (signs to be determined), take child to clinic.
- o Continue breastfeeding during bouts of diarrhea, and give as much liquid and soft foods as child will take.

Malaria

- o Chloroquine fights malaria.
- o Chloroquine is especially important for pregnant mothers and small children under 5 years of age.
- o Pregnant mothers should take chloroquine once a week all during pregnancy.
- o Children under 5 years should take (amount) chloroquine every time they have a fever.
- o If child vomits after taking chloroquine, give him/her another tablet.
- o If the child's fever continues for more than (to be defined), take child to clinic.

Additional Messages Concept

- o Child spacing--more than 18 months apart.
- o Keep feeding children during illness. Feed the child all the food he/she will take. Be sure he/she eats as much as possible.

The greatest number of questions which have to be defined in the local context relate to diarrheal disease. It also requires the most difficult and complex maternal response. While the EPI program requires mothers to be at the right place at the right time, and the malaria program requires mothers to administer a relatively simple and recognized medication for a clearly defined set of symptoms, the diarrhea program requires mothers to acquire, prepare, administer, and monitor a treatment which is often counter-intuitive and does not result in a dramatic improvement in the child's diarrhea. Much greater potential for significant confusion exists with this disease, thus an argument can be made for a somewhat greater health education investment.

Effective health education activities, however, are critical to all three topics. Some common problems which health education will need to address include:

EPI

- o Mothers' resistance to, or lack of understanding of prevention may inhibit their bringing healthy children for vaccination.
- o Mothers forgetting vaccination schedule, particularly the 9-12 month target for measles which is the most critical of the injections.
- o Resulting fever and the vaccination side effects may discourage mothers from returning for second and third doses.

Diarrhea

- o Totally new behaviors may need to be learned and applied in unsupervised settings.
- o Potential is high for forgetting volume and administration instructions and signs of diarrhea.
- o Traditional beliefs are well developed and often counter-productive.
- o Inherent benefits of ORT are not readily visible to mothers. The greatest challenge is uncovering some perceivable benefit for mothers.

Malaria

- o Chloroquine is not generally recognized by the target population to be especially important for pregnant mothers and children under 5 years of age.
- o Cost factors will inhibit use unless health education can create a powerful incentive.
- o If chloroquine is distributed free, mother will still need to know how much to give, when, and when to seek outside help. Two concerns are primary:
 1. Widespread unsupervised use of the single dose presumptive treatment may lead to drug resistant strains.

2. Widespread unsupervised use of the three-day regimen may be unreliable because of the mother's tendency to give less than the full three-day treatment unless she receives face-to-face supervision.

What is Known about Producing These Kinds of Changes in a Short Period of Time with a Large, Dispersed, Often Illiterate, and Economically Poor Audience?

At least two concrete experiences in Africa, both in The Gambia, provide information on this issue. The EPI program there, without any explicit or large-scale emphasis on health education, has achieved over 80 percent coverage. The diarrhea program has entailed a large-scale, coherent program of public education and has also had remarkable success in the short period of one year. The reason for these results is not completely understood. The Gambia represents a special environment in some respects, but at the same time villages in The Gambia are not dramatically different from those found throughout Africa. Aside from the Tanzanian health campaigns of the '70s, there are few examples of rapid, widespread adoption of even simple new health practices in Africa. Programs of long-term fundamental change are even more difficult to identify, understand, and replicate.

Programming effective health worker support under any circumstances is difficult in the rural areas of Africa. The lack of a physical infrastructure from which to operate, often impossible terrain and inaccessible villages, difficult climate and resultant deterioration of physical communications systems, lack of adequate funds, a small professional pool from which to select personnel, lack of appropriate supervision, class, caste, and racial differences between agent and client...all of these factors and more impede the functioning of an effective rural health system.

As much as extension workers in theory are the key elements in the behavioral change process, in practice they seldom are. As much as in theory they provide the interpersonal, credible link between external information sources and community receivers, they frequently cannot. And as much as many educational programs have been criticized for not using rural extension workers, an equal number have failed by expecting too much from those workers that have been used.

The success of health education activity is dependent upon two external factors:

- o Health system personnel who are committed to and capable of providing the services being promoted.
- o The availability of materials and supplies needed to provide the services being promoted at a reasonable distance (5-10 kil.) from the audience's residence.

For the narrow goals of CCCD, health education is generally most successful when:

- o The number of messages is limited to a few key areas.
- o The messages selected are actionable, relevant, salient, and rewarding to a specific audience segment.
- o A comprehensive plan is developed based upon targeted audience research, including information on existing knowledge, attitudes,

practices; on channel significance (broadcast, print, face-to-face); on decision-making processes; and on incentives and obstacles to compliance.

- o Multiple channels are integrated to deliver the same message at the same time.
- o The program is monitored at regular intervals and mid-course corrections are made to correct errors.
- o A program is guided by a stable, coherent, and explicit framework.
- o A program is tied to specific resources and programs which can apply the assistance immediately. Assistance to programs without adequate funding or support is likely to be wasted.

These principles come together in a form of health education popularly known as the public communication or public education campaign. (See Appendix A) While this approach represents a relatively small segment of the traditional health education literature, it has demonstrated its fundamental viability in programs like the Stanford Heart Disease Prevention Program. Recent experiments with public education in developing countries, specifically Africa, such as the Mass Media and Health Practices program and Tanzania's "Man is Health Campaign," have added important insights to how these principles can be applied in the context of Third World countries.

Public education is considered particularly suited to the needs of CCCD because the proposed messages are relatively simple and because they must reach a large number of people in a short period of time to be effective. Public education has proven especially adept at this process. (See Appendix A for a review and description of Public Education.)

What Kind of Institutional and Human Resources are Necessary to Implement Such a Program?

Health Education Planning and Management: Technical personnel are needed to prepare a comprehensive health education plan including definition of objectives, message strategy, pre-program research, audience segmentation, channel strength and importance, materials production schedules, monitoring plan, and program budgets. Special emphasis needs to be given to ways of integrating channels like radio, health workers, schools, community groups, and print material to maximize their outreach and effectiveness. These individuals must then have the practical skills to manage these plans in real-world settings.

Audience and Channel Research: A small group of individuals must be able to develop practical research instruments including targeted KAP studies, village observation guides, focus group and central location intercept interview guides, and specialized behavioral measures such as ORT mixing trials. The outreach, credibility, and practicality of different health education channels (broadcast, print, and fact-to-face) must be assessed. These techniques need to be adapted to local African conditions to provide practical information to program planners on what messages are appropriate and salient, what channels should be used and how they should be used together; to whom should specific messages be addressed; and how can these particular audiences be influenced.

Materials Testing: In addition to baseline research described above, specific materials testing procedures need to be strengthened in African settings. These procedures should include message development, concept testing, comparative tests and model testing. Fields such as social marketing and communication research should be tapped for appropriate specialists.

Program Monitoring & Evaluation System: Once in place, health education activities need regular monitoring to determine if the logical chain of consequences which relates knowledge, attitude, practice, availability, first trial, continued compliance, and benefit is in fact operational. These monitoring systems can measure aspects as simple as broadcast reception and as complex as obstacles to compliance. These should provide regular information to program directors on needed mid-course corrections.

Do These Resources Exist Now in Africa?

Health education is presently one of the weakest components of existing health programs in Africa. This is true despite the fact that in many settings, particularly in the area of diarrheal disease control, health education may be of critical importance to the program's success. Many existing health education units in Africa are understaffed, underbudgeted, over extended, poorly trained, ill defined and often nonexistent.

The most needed health education skills that are related specifically to public education in Africa are audience research, audience segmentation, channel integration and interaction, pretesting, and monitoring systems. Channel integration includes determining ways in which different channels such as radio, print, schools, health workers, traditional leaders, spouses, etc., can be used to deliver a single set of coherent messages to a given audience during a specific period.

At the same time, it must be recognized that African institutions such as the University of Ibadan in Nigeria, as well as numerous universities and training centers in the U.S. and Europe, have trained hundreds of African health educators over the past two decades. The dilemma for CCCD, therefore, is twofold: finding and recruiting these individuals to provide technical assistance and training; and then reorienting them to the highly focused objectives of the CCCD program.

Priority should be given to identifying African professionals able and willing to provide long- and short-term technical assistance as well as African training institutions for Francophone and Anglophone personnel in the areas previously defined.

The Academy believes it will be possible to identify a few highly qualified African professionals who meet the requirements mentioned above. These individuals are likely to be heavily committed to other responsibilities, however, and may not be readily available on a regular basis to the CCCD program. A large number of other well-prepared African health educators can be identified, but these individuals will require re-orientation to new, practical methods of achieving the focused CCCD goals. Public education, as being proposed here, is very new in Africa. It is not reasonable to assume that cadres of African professionals with these skills can be readily identified.

What Other Resources are Available to the CCCD?

The United States Peace Corps has demonstrated a clear willingness to cooperate with USAID in the CCCD program. Two specific areas have been mentioned and each offers the opportunity to increase considerably the impact of CCCD. First, the Peace Corps can recruit, train, and place up to 12 specialist volunteers, one for each of the 12 cooperating countries. These specialists would work directly with the host country health education director for periods of up to 24 person-months to plan, manage, monitor, and evaluate the proposed public education model. They would serve for two years, providing both technical continuity and direct substantive support to the health education activities.

Additionally, the Peace Corps could recruit, train, and place groups of generalist volunteers in selected countries to work at the grassroots level as community health education agents. These needs would be determined on a country-by-country basis.

Issues of particular concern are:

- o The lead time (approximately 18 months) required by the Peace Corps to field specialist volunteers may cause a problem. This delay can be reduced in two ways: 1) identify experienced one- or two-year volunteers willing to extend their tour of service and provide them with special intensive training; or 2) use a contractor to identify one to three long-term specialists who could begin work immediately in the countries of most urgent priority.
- o Immediate detailed conversations with Peace Corps in Washington, D.C., and involvement of Peace Corps missions in programming generalist volunteers for selected countries is necessary.

Related AID Projects in Africa such as the WASH program, the Population Office's I.E.C. contractor, the Johns Hopkins University, the Mass Media and Health Practices Project, as well as specific mission projects, should be contacted to determine how resources for health education such as research, material production, and evaluation costs can be shared.

A private contractor, either African or U.S.-based, should be identified to oversee the development of the health education component. This contractor could be managed through a subcontract with CDC, but would be responsible for developing a coherent health education strategy, identifying and managing the cadre of relevant short-term technical assistants, identifying and placing one to three long-term experts, if necessary, and coordinating the specialized short-term training required by the project in cooperation with the selected African institutions.

III. PROJECT DESCRIPTION

This section attempts to describe how the needs identified in Section II can be met.

A. OVERALL GOALS

- 1) Provide specialized technical assistance and training to at least 12 CCCD programs in the areas of health education planning, emphasizing ways to integrate several viable communication channels in a single coherent program targeted at a limited set of tightly defined educational goals. Attention should be given to pre-program, audience and communication channel research, materials testing, and program monitoring and evaluation systems.
- 2) Strengthen the long-term capacity of at least two African institutions to provide specialized health education training and technical assistance in the above mentioned areas.

B. PROGRAMMATIC OBJECTIVES

Goal #1 - Provide Assistance to Bilateral Programs

Provide to the 12 cooperating CCCD countries:

- 1) 24 person-years of long-term technical assistance (approximately 1-2 person years each)*
- 2) Approximately 1,000 p/d of short-term technical assistance.
- 3) Short-term training of :
 - o Three to five days for 30 CCCD Cooperating Country Program Managers.
 - o Three months for 60-120 cooperating country health education specialists.
 - o Three to six weeks for 12 Peace Corps specialists.*
 - o One to three weeks for 100 Peace Corps generalists* (20 Volunteers in each of five countries).
- 4) A regional health education assessment and implementation model for adaptation to country-specific needs.

*Costs for recruiting, fielding, and administrating volunteers would be covered by Peace Corps. Costs for training volunteers would be covered by CCCD.

Goal #2 - Strengthen African Training Institution

Develop cooperative agreements with at least two African Health Education Training Institutions (one Anglophone and one Francophone) to:

- 1) Provide part or all of short-term technical assistance specified above.
- 2) Provide part or all of long-term technical assistance specified above.
- 3) Provide part or all of short-term technical training specified above.
- 4) Develop a public education campaign curriculum and training materials and incorporate as part of the institution's regular training programs in health education.

C. PROJECT COMPONENTS

Goal #1 - Provide Assistance to Bilateral Programs

1) Country-Specific Long-term Technical Assistance

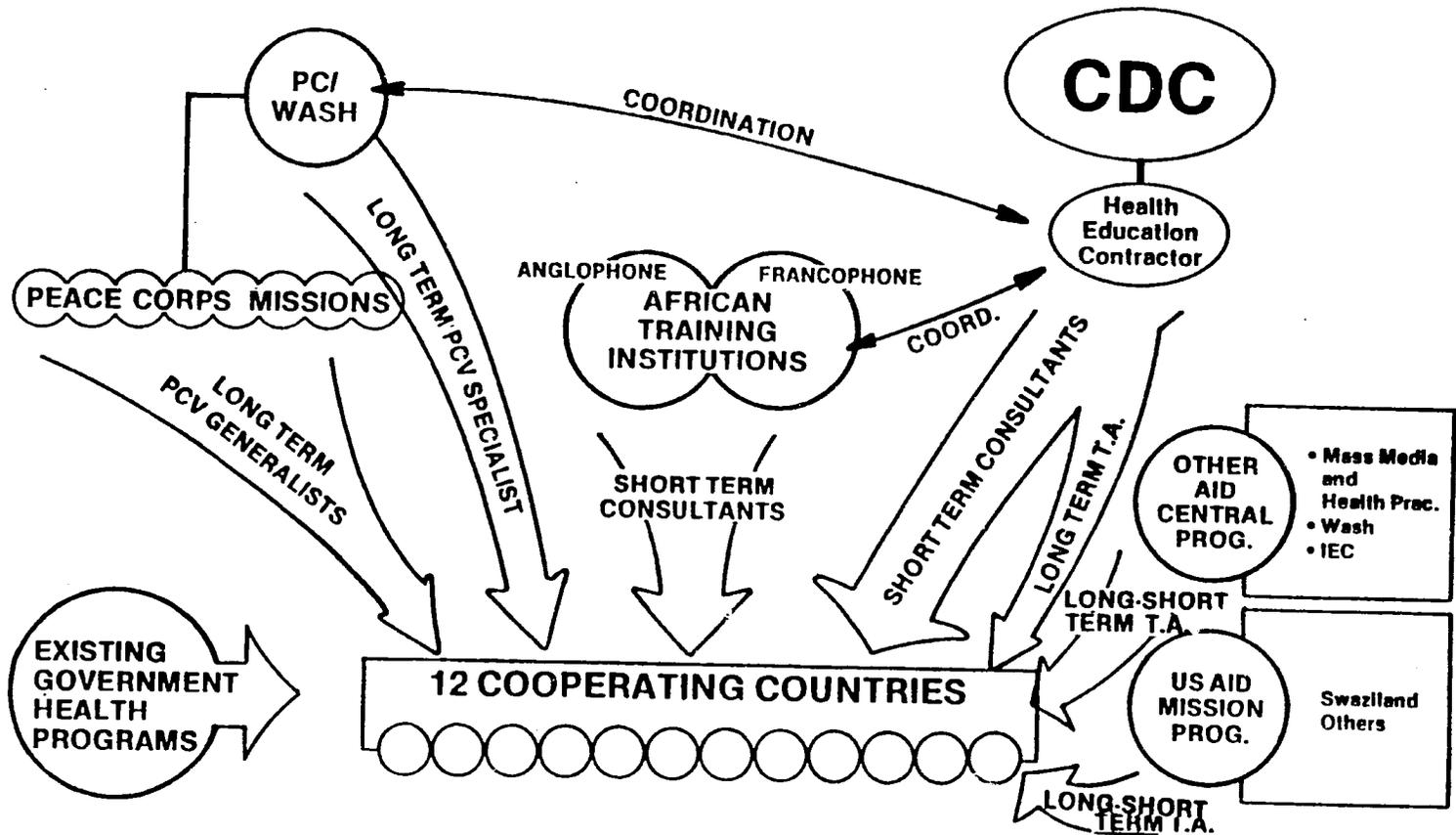
Long-term technical assistance (LTTA), while not originally contemplated as part of the regional program, has taken on greater significance as the real limitations of existing health education resources in Africa have been acknowledged. Not only does LTTA offer regular on-site assistance to the development of a specific program, it provides a real opportunity for targeted in-service training to key cooperating country personnel and helps guarantee the institutionalization of new health education techniques within the cooperating government.

For these reasons, it is proposed that one Peace Corps specialist act as long-term (12-24 month) technical advisor in health education to each of the 12 cooperating countries. This individual will be responsible for assisting in the design and supervision of required pre-program research, and development of a detailed health education plan specifying objectives, audiences, messages, channels, and monitoring systems. The 12 countries should be those that will have bilateral CCCD programs. Candidates now include, but are not limited to: Swaziland, Lesotho, Zimbabwe, Congo, Liberia, Zaire, Togo, Senegal, Guinea, Sierra Leone, Central African Republic, Rwanda, and Burundi. In the case of small countries like Swaziland/Lesotho and Rwanda/Burundi, a single individual could provide assistance to each cluster, reducing the number of long-term technical assistants from 12 to 10.

Costs of long-term technical assistance are generally high. To maximize CCCD resources, two groups of six to 10 Peace Corps volunteer specialists should be recruited especially for the CCCD health education program to provide the needed long-term assistance. The CCCD program would provide technical training during the regular Peace Corps training program. The actual costs of such an arrangement would be negotiated with Peace Corps personnel, but approximate costs have been estimated in the proposed budget.

2 TECHNICAL ASSISTANCE

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The two groups should be scheduled at three-month intervals, resulting in one group prepared by November of 1984 and one group by March 1985. (See Appendix B for scheduling assumptions.) Training volunteers in two groups would ensure that countries would be ready for the second group's assistance.

The long delay (approximately 18 months) in recruiting, training and placing Peace Corps volunteers makes it essential to explore two supplemental alternatives. First, existing Peace Corps volunteers could be recruited for specialist training. These volunteers would receive three to five weeks of intensive training in Africa in the techniques of public communication campaigns. They could then be assigned by August and September of 1983 to countries of most urgent need.

Secondly, if existing volunteers cannot be identified quickly enough, a contractor should be asked to provide one or two specialists in those countries of most urgent need, and/or provide short-term consultants to begin the early health education planning in those countries.

2) Regional Long-Term Technical Assistance

In addition to the long-term technical assistance proposed for each of the 12 cooperating countries, a single focus for overall supervision of health education is required. It is proposed that a contractor, either Africa or U.S.-based, be identified to perform the following functions: (See Chart 2)

- o Planning the overall health education strategy to be used by CCCD.
- o Coordinating all health education inputs with CDC, the Peace Corps and the other cooperating African training institutions.
- o Providing assistance to countries with immediate needs (Togo and Zaire).
- o Cooperating with African training institutions to prepare the training curriculum for all health education courses.
- o Developing a consultant resource bank for short-term specialists in the required areas.
- o Assisting the Peace Corps by conducting the tailored technical training for specialists and generalists, and through regular visitation and consultation with participating volunteers.

3) Short-Term Technical Assistance

Short-term technical assistance for CCCD is designed to achieve three broad goals:

- o Provide specialized assistance at key points in the development of a bilateral program to supplement the existing long-term assistance.

- o Provide regular follow-up assistance to the 12 cooperating countries after the long-term assistance has been completed.
- o Provide specialized assistance to other countries without bilateral CCCD programs.

To achieve these goals, the following specific activities are proposed:

- o A cadre of short-term experts available for periods of 3-12 weeks in :
 - Preprogram planning
 - Audience and communication research
 - Protocol development
 - Materials testing and development
 - Audience segmentation strategies
 - Training design and program monitoring
- o Short-term consultants should be provided primarily to those countries with bilateral programs that are able to use the short-term assistance as part of a broader comprehensive program.
- o Consultants should be able to assess program needs as well as advise and train host country personnel.
- o Consultants must have language proficiency in French or English, as required by the country.
- o Short-term consultant requirements should be defined by the bilateral programs staff based upon a consultant catalogue provided to each bilateral program. The catalogue will provide a list of available consultants and define professional experience felt to be appropriate for the CCCD program.

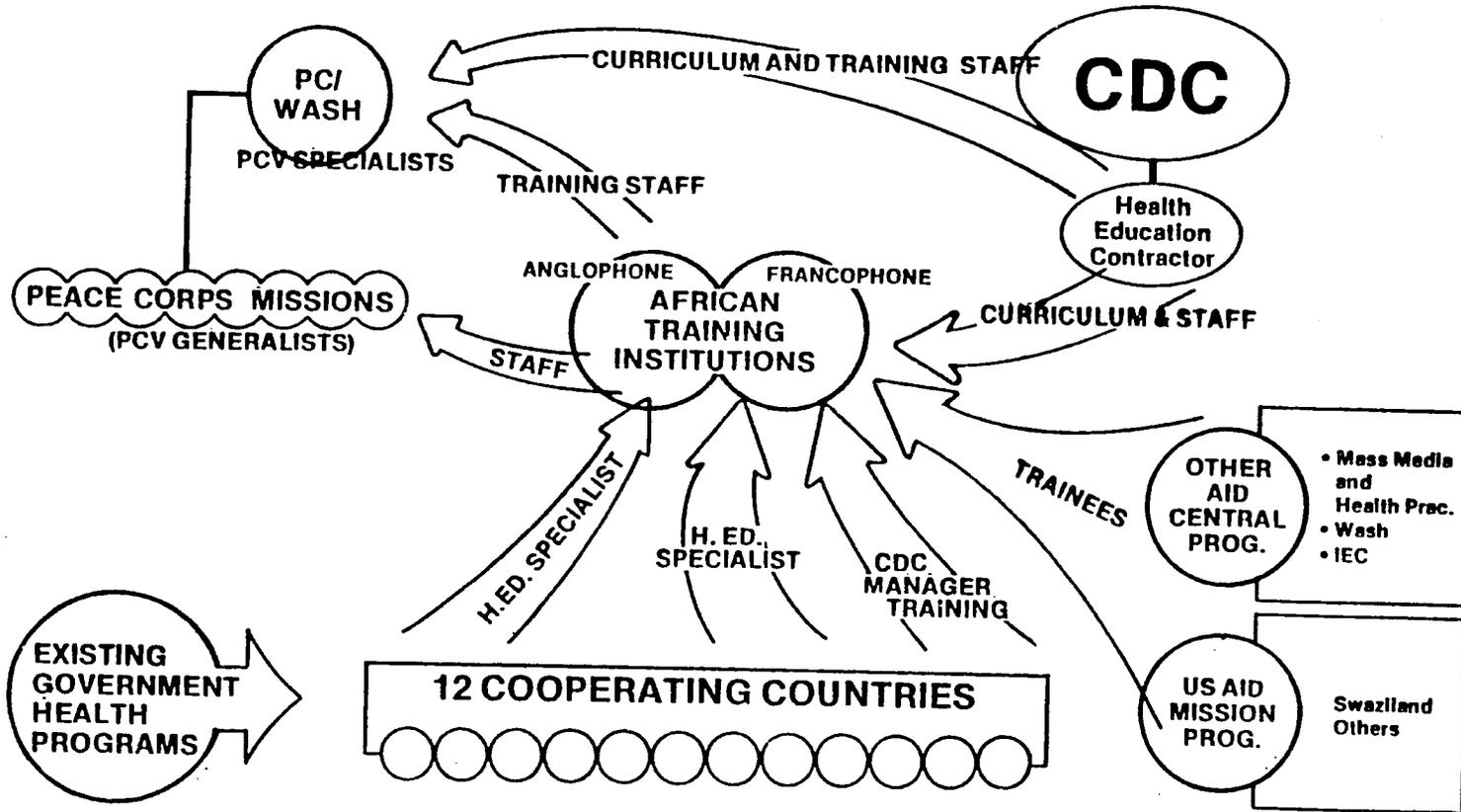
4) Short-Term Training

To ensure maximum use of CCCD resources, regional training courses will be organized for various levels of health education managers required in the program. Training will either take place at African training institutions like the University of Ibadan, or will use regional training personnel at a country-specific training site. It is proposed that four basic training activities be conducted: (See Chart 3.)

- o **A 3-5 day health education management module** should be developed and included as part of the CDC management training courses, EPI Management I and II, and CDC Management I and II. The module should stress message selection, channel integration, and audience segmentation strategies along with some practical guidelines for administering and managing public communication campaign activities.
- o **Short training courses**, ranging from three to six months, will be developed and offered to approximately 60-120 cooperating country health education personnel, in the areas of health

3 TRAINING

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education planning, preprogramming audience and channel research, materials testing and program monitoring system. (See Appendix C for detailed curriculum outline.)

Existing staff at the two African training institutions will be strengthened by short-term consultants working as peer teachers. Existing health education specialists in WHO and UNICEF will be encouraged to participate as co-trainers in the course, thus strengthening the overall available resources.

One fundamental purpose of this training is to strengthen and support the existing capacity of the two African institutions to provide long-term assistance to African countries in the area of public education campaigns. Several African institutions now have excellent general health education programs. This CCCD support will strengthen the use of modern media and increase the visibility and viability of the two institutions as African training resources for the future. A set of audiovisual and small format printing supplies should be provided to each center to be used during the training courses and in the development of training materials.

- o **Two training modules** should be prepared for Peace Corps volunteers. The first would be for generalist volunteers associated with country programs to prepare these volunteers to support health education activities planned for that country. A second module, three to five weeks in duration and much more technical in nature, is needed for the specialist group of volunteers being recruited to function as national level health education advisors. Special attention should be given in the second module to detailed message selection, audience research, channel integration, and audience segmentation strategies. Additional content should include community participation activities.
- o In addition to these regional training resources, it is recognized that country-specific training for middle level and peripheral personnel will be needed. These costs have not, however, been budgeted as part of the regional health education component.

The general curriculum for each training activity described above is outlined in the following Graph 4, and a detailed curriculum outline is included in Appendix C.

4

FORMAL TRAINING CURRICULUM

	CCCD Program Managers	Peace Corps Vol. Health Special.	Coop. Countries Special.	Health Specialist Generalist
Understanding the Health Problems and the Specific Audience	5 hrs.	10 hrs.	30 hrs.	50 hrs.
Conducting Preprogram Investigation	3 hrs.	30 hrs.	25 hrs.	100 hrs.
Developing a Public Education Program	4 hrs.	10 hrs.	5 hrs.	50 hrs.
Managing the Inputs	8 hrs.	30 hrs.	10 hrs.	100 hrs.
Monitoring, Evaluating, and Making Changes	4 hrs.	10 hrs.	20 hrs.	60 hrs.
Total	24 hrs. (3 days)	90 hrs. (3 weeks)	90 hrs. (3 weeks)	360 hrs. (12 weeks)

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5) Health Education Assessment and Intervention Models

A health education assessment model needs to be developed as part of the overall country assessment strategy. This model would provide information on possible health education channels (broadcast, print, face-to-face), possible audience segmentation strategies, existing local capacity in health education, and country-specific characteristics that might affect health education delivery. The assessment model would provide a framework for an initial health education plan and should be completed as an integral part of the overall country assessment, occurring simultaneously with that assessment.

A coherent health education intervention model is also needed to provide an overall framework for CCCD health education. The present ambiguity as to the purpose and particular means of health education represents a major obstacle to success. The model should be flexible and adapted to meet special local characteristics, but it must set limits and define an overall approach. A possible module is described in Appendix A. (See Graph 5.)

6) **Additional Bilateral Activities**

- o Preprogram research, materials development, and material distribution costs should be covered in large part by bilateral resources, relying on existing local personnel and transport where possible to supplement external support. Priority should be given to funding operations research--travel, per diem, interviewer fees, analysis time--which leads to the selection of specific messages, audience strategy, channels and distribution systems. It is estimated that from six weeks to six months would be required to develop a comprehensive health education plan in each country. This will vary depending on the amount of existing information, the degree of access to rural areas, and the inherent complexity of the sociocultural environment. See Appendix G for detailed cost estimate.
- o Modest resources also should be programmed in the bilateral program for third-country participant training in one of the two proposed African training institutions. Levels of participant training will be defined largely by the size of each country. Anticipated levels would range from perhaps 10 people a year in short courses of six to 18 weeks, to as few as two people a year in similar courses.

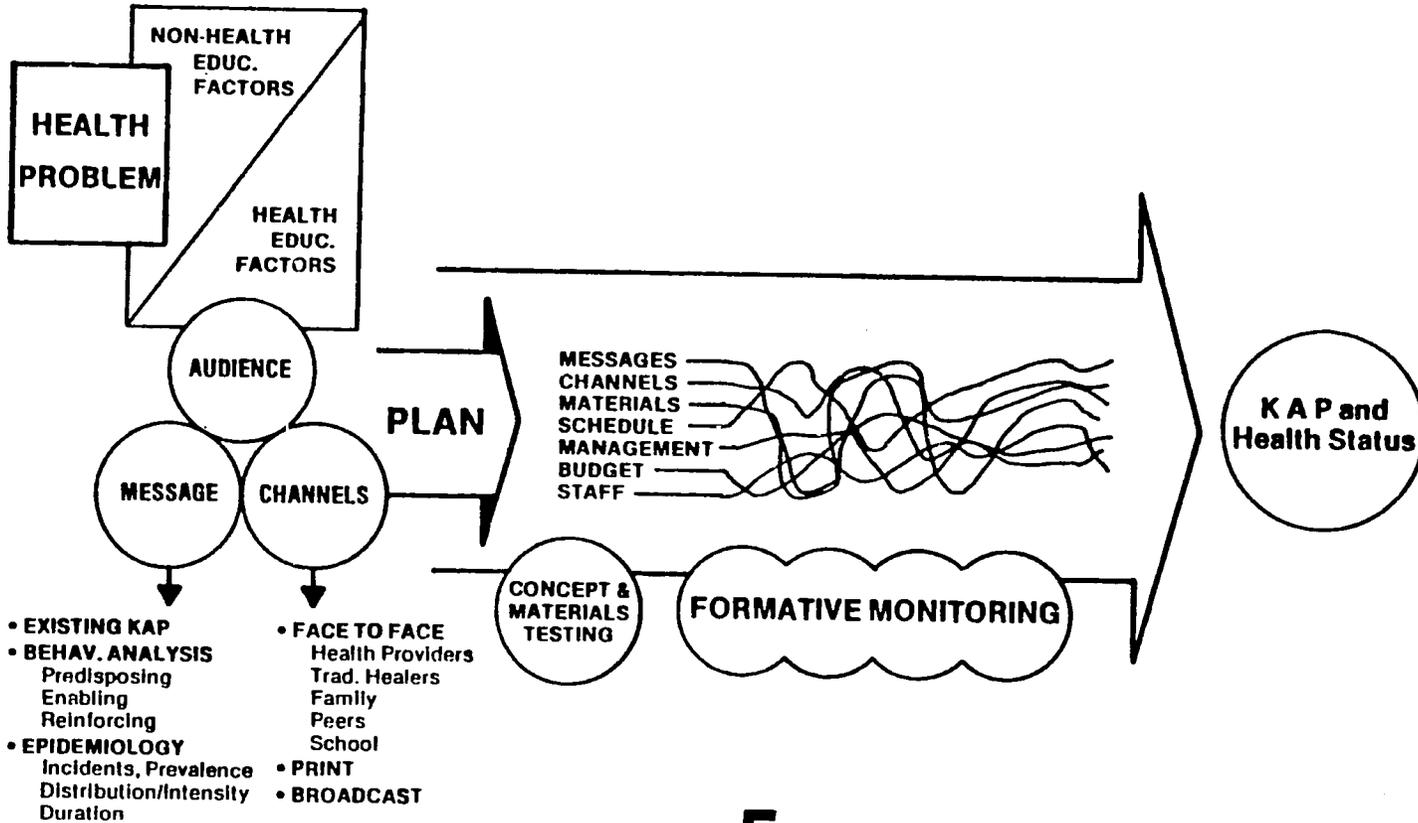
Goal #2 - Strengthen African Training Institutions

There is a strong commitment to using African training institutions to provide as much of the technical assistance and training as possible. Currently, however, only one institution has been visited--the WHO training center at Lome, Togo. Clearly, the center does not now have the capacity in personnel and experience to provide even a significant percent of the assistance required by the CCCD program. A second center, at the University of Ibadan, Nigeria, has been considered but not visited. Although no direct contact has been made, facilities, personnel, and experience appear to be greater at this institution than at Lome. Countries in which other centers exist include Cameroon, Senegal, Benin, Kenya, and Tanzania. Again, none have been contacted by CCCD staff.

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HEALTH EDUCATION MODEL

It is not unreasonable to assume, however, that whatever center is selected, their experience with focused public communication approaches will be limited. This whole genre of health education is relatively new, particularly in Africa. Of all the centers considered, Tanzania has the most concrete field experience in running a large-scale public communication campaign. But personnel at the Adult Education Institute in Dar es Salaam are few in number and highly overworked. It is unlikely that they would be able to supply more than a fraction of the resources required.

Talented and well-trained African health education specialists do exist. Many of these individuals are potentially available to the program and could be recruited to work on peer consulting teams, together with expatriate experts more familiar with the specific approaches to public communication being proposed by CCCD. During the first two years, these teams could provide the bulk of short-term technical assistance. During the last two years, the African experts would work alone.

The existing African training institutions would become a second focus of public communication training. Working with existing facilities, expatriate experts in social marketing and communication planning would develop and implement new short-term training programs in areas of special interest to CCCD. These course materials would then become part of the institution's overall health education program.

The management of such a program of peer consultation and peer teaching is not easy. It would require exceptional individuals, expatriates, and Africans alike. It would demand careful timing and considerable preprogram orientation. It also would increase the initial costs of providing short-term technical assistance and training, but would probably cost about the same as using only expatriates for the full four-year program.

It is felt that the investment in creating a regional health education resource in two African countries is fully justified by several factors, including:

- o The presence of existing underused facilities.
- o The relative homogeneity of many African health education planning needs.
- o The need for continued health education assistance after the CCCD Project ends.
- o The need to train a relatively large number of CCCD program managers and their staff in health education planning, research, and design skills, and the need to incorporate public education approaches to existing health education systems.

The final decision on how to best use existing African resources will stem from direct contact with the African institutions mentioned previously.

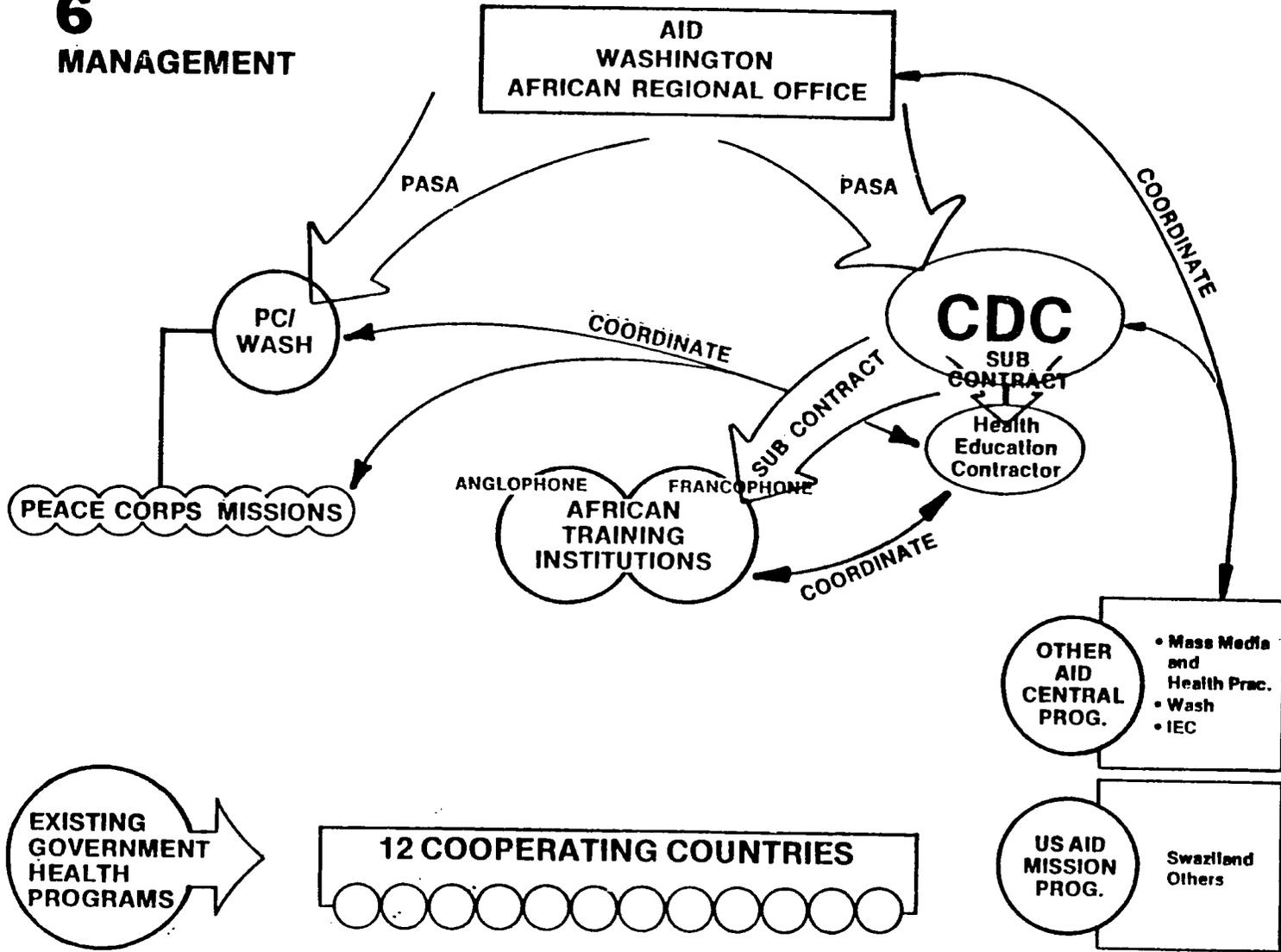
D. MANAGEMENT STRUCTURE (See Graph 6.)

It is proposed that the regional assistance be administered through a subcontractor to CDC with experience in health education in Africa. The group would be responsible for:

- o Identifying, monitoring, contracting, and supporting one or two long-term advisors.

6 MANAGEMENT

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- o Liaison with the Peace Corps in recruiting and training the groups of specialist and generalist volunteers.
- o Maintaining a short-term consultant resource bank and providing regular, consistent, and relevant information to all participating countries on the qualification and availability of the selected consultants.
- o Creating the assessment and intervention models and monitoring their adaptations to country-specific programs.
- o Coordinating directly with CDC and AID to administer the regional health education activities, and to support the bilateral programs.

AID will contract directly with the Peace Corps through a PASA to provide funds to support the full training of 12 Peace Corps specialists and the technical training component of approximately 60 additional Peace Corps generalists.

AID will contract directly with two African training institutions to provide the three-month short courses for cooperating country health education specialists.

I. Alternative Management Approaches

Several alternative management structures are viable to achieve the above mentioned design. The alternatives hinge on the selection of the proposed subcontractor and the availability of long-term technical assistance. (See Graph 7.)

Model 1 proposes to use an African training institution as the subcontractor. The institution would have full responsibility through their subcontract with CDC for management of the short-term consultant and training activities. They would be free to contract expatriate consultants as they saw fit.

Model 2 proposes a joint management structure between a U.S.-based firm and an African institution. The U.S. firm would provide overall conceptual coordination, develop the intervention and assessment models, and maintain a list of short-term consultant resources relying heavily on African personnel. Short-term teams composed of African and expatriates would work together in the field as short-term consultants. The U.S. firm would field two expatriate long-term advisors to provide immediate assistance to countries unserved by Peace Corps specialists, if required. The African institutions would design and conduct the three-month health specialist training program.

E. IMPLEMENTATION SCHEDULE

This section of the report is divided into two subsections. The first describes how health education would be developed in a single country. The second provides an overview of how all project activities would be scheduled.

I. Country-Specific Schedule

It is assumed that each country intervention will last approximately four years. During the first six to 18 months, CDC personnel will focus on planning and developing the specific infrastructure elements (ORT packets, coldchain equipment, chloroquine supplies, etc.) necessary to make the program successful. During this period, CCCD managers will receive the three-to five-day health education management training as

		MODEL 1			MODEL 2		
Long-Term TA		P.C.	African Institute	Subcontract	P.C.	African Institute	Subcontract
	Technical Coord.						●
	2p/y needed immed.		●				●
	24p/y	●			●		
Short-Term			●			○—○	
Training	CDC Managers		●			○—●	
	H. Educ. Specialists		●			●—○	
	Peace Corps	Specialists		●			○—●
		Generalists	●—●	●		●	●—●

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7 MANAGEMENT ALTERNATIVES

● Primary Responsibility
○ Secondary Responsibility

part of their overall management training. Selected health educators will participate in the three-month courses conducted at the African training center.

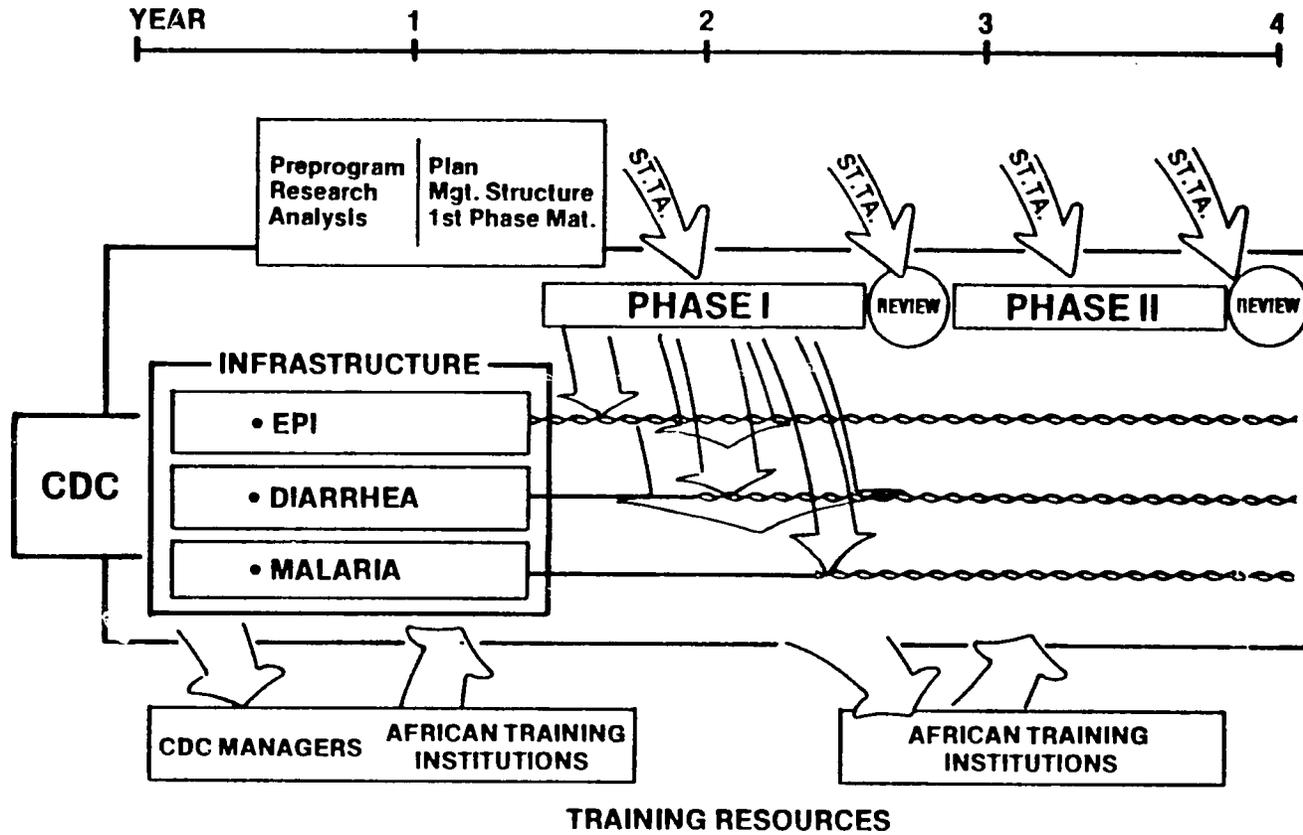
Near the end of this period, the health education advisor will work with local health education specialists to develop and apply an initial investigation protocol, to analyze the resulting data, and to prepare a one-year public communication plan. This plan would describe the primary message strategy, the channels to be used, and the training curriculum. The plan itself will consist of two 12-month phases, with explicit review periods of one month following each phase. It is expected that the three CCCD subprojects--EPI, diarrhea, and malaria--will be implemented in a phased fashion. The health education intervention model will adjust to this phased implementation. The development of specific materials, (print, radio, and face-to-face intervention) will require three months for the initial phase, including pretesting, revision, and final production. Regular formative evaluation activities should occur at three-month intervals to provide program planners with the ability to make mid-course adjustments. (See Graph 8.)

2. Overall Project Timing

The following graph demonstrates how long- and short-term technical assistance and training inputs are scheduled to support the phased initiation of country activity. The principal training activities precede the health education intervention in each country. The delay in the first group of Peace Corps volunteers is compensated by the two person-years of contractor long-term technical assistance, and the short-term technical assistance scheduled to support the actual intervention as well as provide a substantive follow-up once the long-term assistance has ended. (See Graph 9.)

8 TIMING

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BUDGET

BUDGET

	PASA w/ PEACE CORPS	CONTRACT : AF. INSTITUTIONS	SUBCONTRACTOR AFRICAN OR U.S.
I. Regional Training Center Equipment, Materials, Supplies		\$ 80,000	
II. Technical Assistance			
A. Long-term Technical Assistance			
1. Salary \$40,000 x 2	16-24 p/y		\$ 80,000
2. Benefits \$10,000 x 2	provided by		20,000
3. Travel & Transportation 6 RT x 6,000	Peace Corps		36,000
4. Allowances			
Post Diff. \$8,000 x 2			16,000*
Housing \$15,000 x 2			30,000*
Education \$2,000 x 2			4,000*
5. Shipping \$10,000 x 2			20,000*
Subtotal			206,000
Indirect Cost Subtotal			46,800
Long-term T.A. Subtotal			\$ 252,800
B. Short-term Technical Assistance			
1. Consultant Fees			
21 days x 12 countries x 5 trips x \$180/day			226,800
2. Travel 26 trips x \$ 4,000			104,000
34 trips x \$ 2,000			68,000
3. Per Diem \$1,260/day x 100			126,000
Subtotal			524,800
Indirect Cost Subtotal			157,440
Short-term T.A. Subtotal			\$ 682,240
C. Health Education Research			
\$25,000 x 12 countries			300,000
Indirect Costs			90,000
Research Subtotal			\$ 390,000
D. Management & Technical Direction			
1. Project Director 48 p/m @ \$40,000			192,000
2. 1/4 time Ass. Dir. 12 p/m @ \$35,000			42,000
3. Direct Costs @ \$30,000/yr. x 4 yrs.			120,000
Subtotal			354,000
Indirect Cost Subtotal			106,200
Mgt. & Tech. Direction Subtotal			\$ 460,200

* Excluded from Indirect Costs

III. Peace Corps Participation

- A. Specialist Volunteers
12 p. x \$750 x 12 weeks
- B. Generalist Training
12 countries x 10 volunteers x
2 weeks x \$500
- Peace Corps Subtotal

PROGRAM TOTAL

PASA w/ PEACE CORPS	CONTRACT: AF. INSTITUTIONS	SUB-CONTRACTOR AFRICAN OR U.S.
\$ 108,000		
120,000		
\$ 228,000		
<u>\$ 228,000</u>	<u>\$ 80,000</u>	<u>\$ 1,785,240</u>

The budget alternatives presented in Graph 10, following, hinge on the decision to provide two person-years of expatriate technical assistance or not.

Budget alternative 1 assumes the worst-case scenario, namely, that no existing Peace Corps volunteers can be identified and that an agreement is reached that short-term consultants alone will not suffice. Two person-years of long-term technical assistance costs approximately \$252,800.

Budget alternative 2 assumes that all other costs remain the same and that the savings in long-term technical assistance are applied to increasing the number of short-term person-days available by approximately 467.

Budget alternative 3 again assumes all other basic costs remain the same, but reallocates the long-term technical assistance savings to the African training institutions, either for staff, materials, or to pay the costs of participant travel and support costs.

All alternatives assume that the health education research and project costs remain stable.

The prime budget has been structured so that a variety of budget alternatives can be considered. An obvious and infinite number of alternatives could be constructed, allocating the savings in any number of ways.

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BUDGET ALTERNATIVES

	1 Proposed Budget	2 No Contractor Long-Term TA	3 No Contractor Long-Term TA
Long-Term			
Contractor	2p/y	0	0
P.C.	16-20 p/y	16-24 p/y	16-24p/y
Short-Term	1260p/d	2 +467p/d	—
African Training Institutions	\$80,000	\$80,000	3 +\$252,800
Health Education Research	\$25,000	\$25,000	—
Project Management	\$115,000 year	\$115,000	—

APPENDIX A

THE PUBLIC EDUCATION HEALTH CAMPAIGN
A MODEL APPROACH TO HEALTH EDUCATION IN CCCD

THE PUBLIC EDUCATION HEALTH CAMPAIGN

A. DEFINITIONS AND ORIGIN

The public education or public communication campaign is an approach to large-scale health education that attempts, in a predefined period of time, to change a particular set of behaviors in a large-scale target audience with regard to a specified health problem. During the past two decades, dozens of programs on topics as varied as forest fires, mental retardation, energy conservation, smoking, alcoholism, littering, seat belts, venereal disease, malaria, breastfeeding, latrine construction, population control and infant diarrhea have attempted to inform, motivate, and often to educate a wide audience in a short time.

Not all of these experiences have been positive, indeed much has been disappointing. In a recent review of public education, entitled Public Communication Campaign, Dr. Ronald Rice concludes:

After the early belief in the power of the media to persuade any audience faded, communication researchers were generally pessimistic about the probable success of such campaigns. But the mood of communication researchers has, for the most part, changed, as indicated by the title of the journal article, "Some Reasons Why Information Campaigns Can Succeed. (Mendelsohn, 1979).*

This change in mood is a result of two factors. First, we now have several documented successes. Secondly, we have a growing realization that public education is no "quickfix," but rather a useful, if complex and not well understood, new tool in the overall armory of health educators.

The scientific evaluation of public education applied to diarrheal disease control, malaria, or EPI in developing countries is almost nonexistent. Of 27 oral rehydration programs recently reviewed in Population Reports 1/1/81 for example, only one program reported using any mass media, and that was a narrow use of radio alone. Several governments in Latin America and Asia have implemented national programs of public education for ORT promotion, most significantly Indonesia, Nicaragua, Costa Rica, Ecuador, and Colombia. None of these experiences have been evaluated independently, however, and only subjective anecdotal information is now available. A comprehensive program of public education applied to diarrheal disease control is now being supported by USAID in Honduras and The Gambia, and while the program is not yet completed early evaluation data is encouraging.

But experience with public education in other sectors and with other health programs is considerably more extensive. In the population area, at least half a dozen projects with three years' experience or more have improved contraceptive availability, increased sales of contraceptive products, spread knowledge and stimulated wider use of the methods promoted, and provided a substantial measure of protection against unwanted pregnancy at a cost below that of most other programs.

Mendelsohn, H. (1973) "Some reasons why information campaigns can succeed." Public Opinion Quarterly 37:50-61.

The following list of selected programs, in the U.S. and internationally, have contributed to our understanding of public education, and have demonstrated both the inherent problem and real potential of the approach. These experiences form the basis for the model recommended in this paper.

In the U.S.

- o Stanford Heart Disease Prevention Program
- o National High Blood Pressure Education Program
- o Breast Self-Examination Program
- o National Cancer Institute's Asbestos Awareness Alert
- o Drug Abuse Prevention Campaign
- o Driver Safety Education Campaign
- o Forest Fire Prevention Campaign
- o Residential Energy Conservation Program

Internationally

- o Man Is Health Campaign - Tanzania
- o Masagana 99 - Philippines
- o Have a Heart Campaign - Jamaica
- o Model Family Planning Program - Iran
- o Jamu Project - Indonesia
- o Preeth's Marketing Program - Sri Lanka
- o Aprofam Family Planning - Guatemala
- o Mass Media vs Direct Education Program - Mexico
- o Dr. Hakim Program - Tunisia
- o Mass Media Nutrition Education Campaign - Phillipines
- o Nutrition Mass Communication Project - India
- o Breastfeeding Campaign - Trinidad and Tobago
- o Soybean Utilization Program - Bolivia
- o Mass Media and Health Practices Project - Honduras and The Gambia

B. OVERALL CAMPAIGN STRUCTURE

The success of a public education campaign depends upon its ability to provide a sufficiently large number of people with practical and important new information. 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. It must change what people do as well as what they think and believe. 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 educational messages which are both useful and practical, and a coordinated distribution network which reaches each individual through various channels simultaneously. In essence, the planners of such a campaign will need answers to the following questions:

1. Which of the many behaviors that we could advocate changing are important enough to make a difference and are also susceptible to change? Susceptible to change means people must:

- o Have ready access to any new resources required to adopt the behavior.

- o See positive benefits from adopting the behavior.
 - o See no serious negative effects from adopting the behavior.
2. What must we do to ensure that people:
 - o Believe that the behavior we are advocating is the best alternative to solving a problem which they perceive as important?
 - o Understand how to perform accurately the behaviors so that the positive rewards we are predicting come about?
 3. How will enough people become exposed to the advocated behaviors to make a difference in the problem?
 4. How will we provide long-term reinforcement of the behaviors to ensure continued adoption?
 5. How do we know what level of success we have achieved?
 6. How can all this be done at a cost we can afford?

The campaign structure being proposed (See Graph 5.) here reflects the importance of these elements. It includes a preprogram planning and development phase, an instructional intervention, and an ongoing monitoring and evaluation system with clear results in knowledge, attitude, behavior, and health status.

The planning and development stage emphasizes the collection of critical information needed to prepare an effective campaign 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 should be advocated? (d) What resources are needed to conduct the campaign? The final campaign planning, including budget and resource requirements, is based upon the results of this investigation.

While it is impossible to predict the results of the preprogram research, it is possible to suggest certain basic features that might be included in any effective public education campaign. In order to reach large numbers of people, mass media, particularly broadcast media like television and radio, will play a central role. By using radio and TV spot announcements and exciting mini-programs, it is possible to capture national attention and focus it on specific health problems. Broadcast media can also perform specific instructional tasks by actually teaching listeners/viewers important skills, thus reducing the need for expensive interpersonal methods.

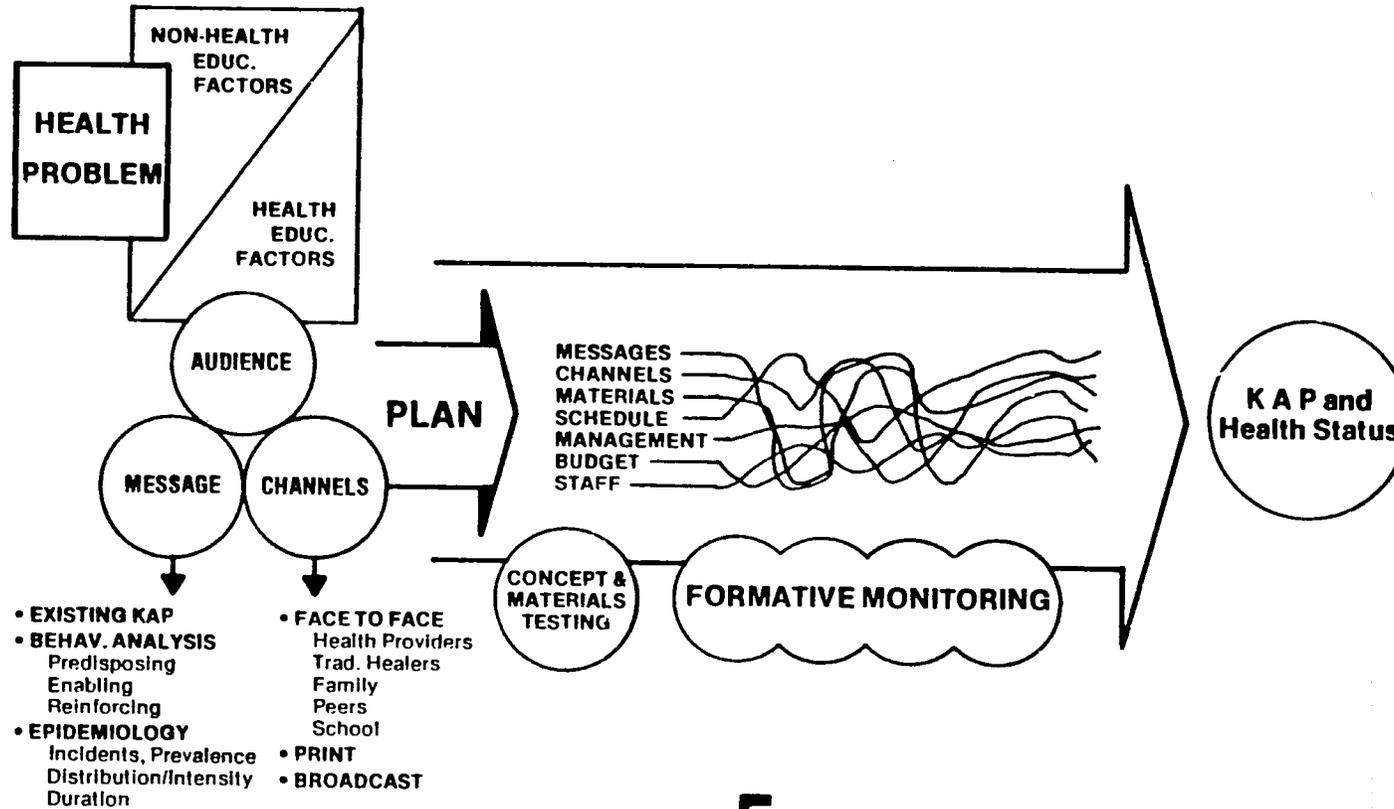
These broadcast efforts must be supported by print materials using both fixed and mobile distribution points: billboards, buses, vans, etc. The public schools offer a unique opportunity for raising community health issues and for disseminating information and practical skills to a large percentage of the population. Through the schools, thousands of families can receive regular, structured information on how to address critical health issues. Teacher's guides, printed pamphlets, games, and other learning resources can be channelled through the schools to provide an effective network of information exchange.

Finally, innovative ideas particularly tailored to the individual country environment, will be developed to reach those segments of the population most in need

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of, and least susceptible to, broadcast and school-based distribution channels. The feasibility study will be central to selecting which of these ideas are most appropriate. Some examples might include: traditional healers, local opinion leaders, songs, rural lotteries telephone exchanges, storefront distribution points, village support committees, popular literature like phonovels, and traveling health fairs.

These three components--broadcast media, print materials, and community outreach activities--will be structured in a coordinated whole so that one reinforces the information provided by another. The rural woman hearing health messages on the radio should also hear the same advice from a health worker, receive printed information from her child's school, participate in a community health fair, and see related posters.

The intervention will be divided into discrete cycles. Each cycle will cover the same basic information but with slightly different approaches. These cyclical changes will reduce audience fatigue and permit a continued renewal of audience involvement. From an administrative perspective, the cycle approach is important because it permits program planners to design segments of the campaign sequentially. They do not need to design the entire campaign at once. This means they can work with fewer production facilities over a longer period of time; more importantly, they can incorporate results of the earlier phases into the planning of later phases. In essence, it permits the planner to make important ongoing changes in educational strategy.

These changes must be made in response to information on the acceptance and efficacy of project activities. It is the purpose of the monitoring and evaluation component to ensure that this information be available at relevant and timely intervals. A monitoring system which permits the random sampling of selected segments of the audience will be developed. Planners will 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 up important logistics problems such as a breakdown in delivery of printed matter or use of inappropriate broadcast times to meet audience needs. This type of ongoing evaluation is essential in making corrective changes in future cycles, as well as providing program administrators with a clear idea of their overall potential success.

C. FEASIBILITY STUDY

The success of the proposed intervention will depend significantly on the project implementors' adequate knowledge and assessment of:

- o The target population's correct health and nutrition knowledge, attitudes, and practices, especially as they relate to the specific health problem.
- o The constraints--whether social, economic, physical, or political--which limit the opportunity for the populations to change their knowledge, attitudes, and practices in response to project intervention.

This project will require a significant investment in pre-campaign research. Development communications experts, drawing heavily on a variety of social science survey techniques, and more recently, from social advertising and marketing strategies, have made significant advances in such developmental investigations.

I. Investigation Topics

Project designers will conduct investigations and surveys that provide both broad and specific information in the following areas:

a. Problem Definition

- o What are the measurable effects of the present health conditions on people's lives?
- o What are the perceived effects of the present state of these conditions?
- o What are the principal causes for the problem?
- o What are the major solutions being proposed?
- o Who in the total community is best equipped to solve the problem?
- o What are the major constraints limiting the solution of the problem?
- o Which of the alternative solutions being discussed is most susceptible to educational influence?
- o What has been the history of development efforts in this area?

b. Audience Characteristics

- o Who is affected by the present conditions?
- o How can these individuals be grouped into audiences which share significant common characteristics such as language, socioeconomic level, family structure, decision-making patterns, family mobility, etc.
- o What is the expectation of each group in relation to the solution of the chosen health problem?
- o What are the detailed characteristics of each group's present health topic behaviors?
- o What characteristics of the cultural reward system can be associated with the selected behaviors?
- o What examples exist of each audience group's ability to make significant adaptation with simple behaviors?

c. Distribution Channels

o Opinion leadership

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

- o Mediated Communications

What forms of mediated communication are particularly acceptable to the target audience?

- o Institutional Delivery

What institutions would be accepted by the target audiences as viable sources of information on the health topic?

How can these organizations be coordinated most effectively?

- d. Outcome Expectations

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

- o How could these changes best be measured?

2. Instruments To Be Used

In order to collect this information, a range of instruments is proposed. Each instrument is tailored to the type of information being sought, and is designed to combine both reliability and efficiency. The first source of information should be existing anthropological and ethnographic studies. A thorough review of existing literature should be undertaken.

Focused group interviews will bring together selected members of the target population in groups of five to eight. Each group will be led by a trained interviewer who will use a prepared list of probing questions. The principal objective of this activity will be to collect broad information on vocabulary, attitudes, and concepts related to the intended health problem.

Individual interview questions will build upon the information collected during the group sessions. A new set of respondents will be selected who have characteristics similar to those of the previous group. The objective of the individual interviews is to probe deeper into individual attitudes of selected individuals.

A series of home observation visits will be planned to identify the existence of commodities, conditions, or behaviors which might inhibit or reinforce the behaviors being advocated. Trained observers will visit some 1,000 homes in conjunction with the individual interviews.

Finally, a short survey questionnaire will be developed, based upon the results of the previous four activities. These will help quantify critical areas of concern identified in the previous stages.

An effective public education program must include the important step of testing the recommended action or instruction by actually observing the behavior of the audience to determine what occurs as the product is acted upon. This systematic observation procedure results in a behavioral profile. The product-testing step provides the program implementor with the opportunity to test the appropriateness and acceptability of the product before additional and significant investment is made in the media design.

Each instructional package will be prepared by establishing discrete and sequenced behavioral objectives for which the implementor anticipates particular actions in that sequence by the target population. It is important to observe behaviors that precede and follow the target behavior, identifying critical reinforcers that surround and support the specific behavior. As the sample group or individuals are observed, intermediate behaviors and unanticipated behaviors can be identified and, as appropriate, included in the instructional package.

D. CAMPAIGN IMPLEMENTATION

Information collected and analyzed during the feasibility study will then be transformed into a specific workplan. This plan will define who is to be identified as the target audience, what instructional advice will be advocated, how the audience will be reached, who will be involved in and responsible for specific activities, how the program will be monitored, and how much the enterprise will cost.

It will be essential to segment, or divide, the audience into clusters sharing similar characteristics. On an a priority basis, seven variables appear particularly important as segmentation devices. They are: (1) language, (2) socioeconomic level, (3) family structure, (4) decision-making structure, (5) specific health attitudes and behaviors, (6) access to health facilities, and (7) family mobility. Others may be added as more is learned about specific conditions in each country.

Once the audience has been segmented and critical characteristics have been identified, it is possible to define the specific instructional content of the campaign. The most important consideration here is that the advocated behavior be actionable—that is, that it be something the audience can indeed perform. If new resources are needed, if some major change in traditional behavior is proposed, if investment is required, then each of these factors must be dealt with in the campaign.

From a behavioralist point of view, there are five circumstances which singly or in combination, account for absent behavior. If one takes the example of a large-scale program promoting the use of oral rehydration therapy, the necessary materials or implements, such as ORT packets, may be unavailable. Second, prerequisite skills, discriminations, or knowledge may be lacking. For example, rural mothers may know that boiling water is good but not understand that it actually kills the parasites they fear. Third, there may be no incentives, such as immediate improvement in their child's health, to engage them in the behavior. Fourth, there may be incentives to engage in incompatible behavior, such as giving kaolin or purges. And fifth, there may be punishing consequences which discourage the desired pattern. A child may vomit, for example, or his diarrhea may actually appear to increase. An understanding of these factors is absolutely critical in the development of an effective instructional intervention.

Behavioral analysis also makes an important contribution to our understanding of how to change behavior patterns, whether it be altering an existing pattern, or creating a new one. Many health messages, for example, carry an implicit or explicit threat. This approach has been shown to be less effective than providing rewards to approximations of the desired behavior. Use of approximations require that we identify a relevant existing behavior to reinforce and may mean including a few behaviors in the instructional campaign which we know rural mothers are now performing correctly. Rather than telling mothers to stop bottle-feeding, for example, we may want to reward mothers when they do breastfeed.

These concepts are critical to selecting messages which are salient, appropriate, and actionable. Once the content has been selected, these concepts must be transformed into specific materials, radio and TV scripts, draft print materials, etc. This essentially a creative function, but not an isolated creative function. The artist must assimilate the insight gained in the previous stages into simple messages which communicate powerfully.

Continue to believe that some form Pretesting materials has been shown to be useful, particularly when a totally new media approach is being tried. This belief is supported by experience in many development settings. The recently created Health Message Testing Service (HMTS), sponsored by the U.S. Department of Health Education and Welfare, is an example of how systematic pretesting is becoming a regular part of public education programs in this country. The key to pretesting seems to be (1) get it done quickly so that the producers can make needed changes, (2) do it well so that the results are helpful, and (3) test draft and not final materials so producers will be willing to make necessary changes.

Once pilot materials have been tested and changes made, production facilities, either commercial or government-operated, will be contracted to produce the large number of needed materials.

The ultimate success of the program will depend on the complementarity of the three major program elements: broadcast media, print materials, and community outreach. The total information program should be greater than the sum of its parts. Each component should energize every other.

I. Community Outreach

Broadcast media and print materials will ensure that a large percentage of the target population will be exposed to some aspect of the program's information. But important groups of individuals may be excluded from effective contact with the project if only these two systems are used. The community outreach aspect of the campaign is designed to reach those individuals otherwise excluded, and to create community support groups which contribute additional energy to the total program. Community outreach will include the following activities:

- o Opinion leaders, including health workers, will be identified in selected villages. These individuals will be given specially prepared materials which will help them to inform other community members.
- o A series of promotional activities will be selected, based upon their local feasibility. Examples include a traveling health fair with puppet shows, music acts, printed materials to be distributed, and involvement of local celebrities. These fairs would travel from village to village, making presentations and stimulating interest in the programs. In urban settings, a telephone hotline might be established to provide specialized information and answer specific questions. Random telephone calling might be used to reinforce some behaviors so that every week a certain percentage of a given area would receive phone calls, reminding them of some selected behavior. In villages without telephone service, this information might be handled by wall posters or handbills, printed frequently on inexpensive paper and distributed regularly through some local commercial channels. Resource centers could be set up temporarily in stores and become

distribution points for information and advice, as well as places where people could go to get questions answered.

- o Buttons, bumper stickers, and even cash awards could be distributed to early adopters. These would function as motivation for more reluctant members of the community. Past experience will help determine which of these and other ideas are most appropriate.

While all of these "gimmicks" can add color and impact to a campaign, it must be remembered that they are no substitute for sound selection of practical behaviors and a clear understanding of what constraints are faced by people being asked to adopt new health behaviors. The best promotional ideas will not compensate for unreasonable advice or poorly constructed messages.

a. **Health Extension Workers: Special Considerations**

The programming of effective interpersonal contact under any circumstances is difficult in the rural areas of the Third World. The lack of a physical infrastructure from which to operate, often impossible terrain and inaccessible villages, difficult climate and resultant deterioration of physical communications infrastructure, lack of adequate funds, small professional pool from which to select personnel, lack of appropriate supervision, class, caste, and racial differences between agent and client...all of these factors and more impede the functioning of an effective rural extension system. When such a system is asked to function within yet another framework--that of a highly-organized, complex communications scheme--the need for practical planning is even more important.

As much as extension workers in theory are the key elements in the behavioral change process, in practice they seldom are. As much as in theory they provide the interpersonal, credible link between external information sources and community receivers, they frequently cannot. And as much as many communication campaigns have been criticized for not using rural extension workers, an equal number have failed by expecting too much from those workers they have used.

There is no easy solution or recommendation for the effective programming of health extension workers in a multi-intervention communications campaign. Amounts of budgeted money vary, as does political commitment to health, existence of severe and resistant disease, external, international pressures--all from country to country and region to region. Yet, there seem to be certain actions the communications planner can take to insure at least a modicum of effective health worker participation and impact:

- o Establish a clear line of administrative authority for project-related activities within the Health Ministry.
- o Involve Ministry personnel at all levels of extension-worker participation in the campaign.
- o Do not become financially committed to the payment of extension personnel for services rendered during the campaign.
- o Do not attempt to change existing health extension patterns.
- o Allow inter-Ministerial extension worker contact to develop gradually, and at the pace of the various Ministries involved.

- o Focus on training as the key element in the use of health extension workers in the campaign.

b. **The Public Schools : A Powerful Vehicle**

The public schools offer one of the few widespread organized and structured environments through which a large percentage of the total urban population can be reached. Students attending schools represent all economic levels and cultural backgrounds. They are not only potential targets of a public education campaign, but they are also a logical and powerful distribution vehicle for project information. Materials distributed in school can be shared with their families and friends, multiplying the impact of investment in school-based programs.

Schools represent a challenge for the public educator. Usually their curriculum requirements are rigid and their teachers resistant to the introduction of new ideas. Each teacher is already overburdened with tasks and often resents being asked to carry an even greater instructional load. It must also be recognized that many students perceive what they learn in schools as irrelevant to real life. It is important to convince them that schools can teach them immediately practical and useful things.

Three principles, age-specific content, colorful materials which students can use and take home, and simple, flexible teachers' guides can be adapted to many settings. The precise adaptation should be a topic for the feasibility study, but it appears clear that schools, and perhaps other institutions, can be asked to make an important contribution to the campaign's success.

2. **Broadcast Media: Radio and Television**

Broadcast media can be conceived as one central element in the communications campaign. Because of its reach and acceptability, it is the point from which less-universal and less-familiar communications interventions begin. It is the matrix of the campaign, for its messages will continue throughout, received regularly in every village while contact with schools and community facilities will be less frequent and less intense. It is the unifying element in the campaign which will relate community, school, and print material to the information it broadcasts. As suggested above, there are a number of possible radio formats which can be used to reach various audiences and to strengthen the understanding and acceptance of new information. These include spots, interviews, photonovels, and talks.

While the development of listening groups is not envisaged because of the high administrative cost, there are two ways in which existing group structures can be used in an efficient and potentially effective way:

- o **In-school programming.** If it is found that health is discussed in a particular primary or secondary school curriculum, and that teachers are familiar with the use of radio in a classroom situation; specially designed programs for students and teachers can be included at low costs.
- o **Ad hoc listening groups using cassetts.** If no financial constraints are involved, selected extension workers can be provided with inexpensive tape recorders and a series of taped radio programs to help motivate village learning groups.

3. **Graphic/Print Media**

Classically, graphic/print media are supportive communications tools, adding depth, range, and texture to an idea, informative message, or concept. They allow the viewer/reader to assimilate slowly, to reflect, to consider the information at greater length, to place that information more clearly within his/her own personal psycho-social environment, and act as a reminder of detail instructions.

Particularly interesting materials include posters, handbills, flyers, instructional labels, and displays at local pharmacies and rural stores. Different kinds of print material, if well designed, can perform different roles.

Health worker study guides can:

- o Repeat the message of the program in prose form.
- o Provide a short body of written material (400-500 words a unit) to be read aloud, normally by the leader.
- o Provide a copy of the discussion questions for each member.
- o Provide something for each member to take away and read (or have read to them) between meetings and after the campaign--a reference book and symbol of membership of a massive study program.

Village flipcharts or simple flyers can:

- o Reinforce aspects of the message contained in the radio program and study guide unit.
- o Illustrate the theme of the meeting through three or four large photos, maps, or drawings for each unit.
- o Serve as a reminder of specific information.
- o Help provide a focus for discussion.
- o Show aspects of the campaign subject that people may have heard about but have never actually seen.

4. **Integration of Radio, Graphic/Print Media, and Extension Agents**

There is a significant difference between the theoretical functional relationships among the three campaign elements and actual, practical, realizable relationships. In theory, graphic/print material should supplement radio, providing well-timed range, depth, and texture to audio messages. Extension agents should take the sum of those two external interventions and personalize them, make them locally relevant; add a credible cast to otherwise disinterestedly produced information. The most essential element in the success of a public education campaign is the coherent promotion of a limited set of clean, relevant, and actionable message through all reasonable channels, in such a way that one channel supports and supplements another.

E. EVALUATION

The evaluation component of the program is designed to fulfill two basic functions. First, it should monitor project success at each of the stages described above, and provide project planners with ongoing information needed to make corrections in program effectiveness. This function is called monitoring. Second, the evaluation should assume that the program's central task is behavior modification and should focus on behavior change in the target audience as the ultimate measure of project success. This is suggested for basic reasons. First, collecting reliable health-status information is very expensive and intrusive on the population being tested. Second, the measurable health benefits from the intervention may be long-term and highly influenced by other environmental and social conditions. A negative health status result might suggest to planners that the public education program failed, when, in fact, people did learn new behaviors, and applied these behaviors properly, but few measurable immediate benefits resulted.

It is proposed that the evaluation use two basic approaches. First, a broad survey of attitude and knowledge related to advocated behaviors with the target population will be prepared and applied at yearly intervals during the life of the project. Consequently, three repetitions of this survey will be conducted. Second, it is proposed that a panel design be developed for frequent sampling of selected behaviors over time during the life of the project. The panel will provide detailed information from a limited but representative sample of the target audience. Combined, the broad survey and panel designs will provide a mix of detail and breadth sufficient to demonstrate impact and identify critical deficiencies. These two evaluation approaches will be reinforced by regular interviews and materials-testing procedures.

APPENDIX B

SCHEDULING ASSUMPTION FOR PEACE CORPS PARTICIPATION

4/24

APPENDIX B
SCHEDULING OF PEACE CORPS SPECIALISTS

	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
83					Begin recruiting							
84								Training First Group			First Group Avail- able	
85	Training Second Group			Second Group Avail- able								

Assumes recruiting process will take approximately 18 months.

APPENDIX C

DETAILED CURRICULUM OUTLINE

Appendix C

Curriculum Outline

A. Understanding the Health Problem and the Audience

1. Preliminary Consultation: Identifying Consultants/Resources
2. Constructing Descriptive Models
3. Formulating Hypotheses
4. The Role of Audience - Channels - Messages

B. Conducting Preprogram and Materials Research

1. The Purpose of Preprogram Research
 - o What is Preprogram Research?
 - o What Does Preprogram Research Measure?
2. Preprogram Research and the Health Communication Process
 - o Stage 1. Planning and Strategy Selection
 - o Stage 2. Concept Development
 - o Stage 3. Message Execution
 - Assessing Comprehension
 - Assessing Recall
 - Identifying Strong and Weak Points
 - Determining Personal Relevance
 - Gauging Sensitive and Controversial Elements
 - o Stage 4. Implementation
 - o Stage 5. Assessing In-Market Effectiveness
 - o Stage 6. Feedback to Stage I Planning and Strategy Selection
3. Preprogram Research
 - o Methods
 - o Readability Testing
 - o Focus Group Interviews
 - o Individual In-Depth Interviews
 - o Central Location Intercept Interviews
 - o Self-Administered Questionnaires
 - o Gatekeeper Review
 - o Pretesting Methods Conclusion
4. Limitations of Preprogram Research
5. Planning and Conducting Preprogram Research
 - o Designing the Questionnaire
 - o Recruiting Respondents
 - o Recruiting Interviewers
 - o Facilities
 - o Obtaining Research Assistance
 - o Conclusion

C. Developing a Health Education Plan

1. Defining Audiences, Channel, Messages
2. Strategies to Integrate Each Element
3. Developing Distribution Schedules
4. Defining Personnel, Budget, Management Schedule
5. Identifying Key Milestones and Monitoring Plan

D. Managing the Inputs

1. Training
2. Print Material
3. Broadcast Materials
4. Coordinating with other Institutions
5. Costs

E. Monitoring, Evaluating, and Making Changes

1. What to Monitor
2. How to Decide What Makes a Difference
3. What to Change and How to Do It Without Major Disruptions

APPENDIX D

LITERATURE REVIEW

The full report is available from Expand Associates

expand

associates, inc.

Draft Literature Review Report

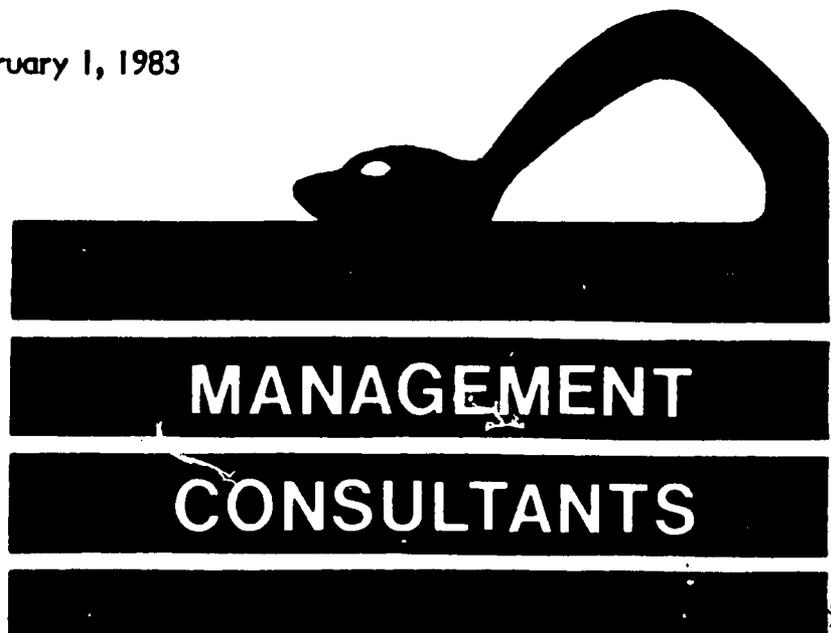
Prepared for

**AFRICAN REGIONAL AFFAIRS OFFICE
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT**

In Response To

**Contract Number AID-AFR-0421-C-00-2083-00
Project #698-0421**

February 1, 1983



APPENDIX E

FIELD STUDY REPORT

The full report is available from Expand Associates

expand

associates, inc.

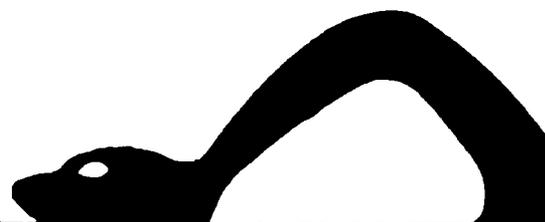
REPORT OF THE FIELD STUDY ON
HEALTH EDUCATION AND PROMOTION FOR THE
COMBATTING CHILDHOOD COMMUNICABLE DISEASES PROJECT

Prepared for

African Regional Affairs Office
U.S. Agency for International Development

Contract No. AFR-0421-C-00-2083-00
Project No. 698-0421

March 7, 1982



MANAGEMENT

CONSULTANTS

APPENDIX F

HEALTH EDUCATION RESEARCH BUDGET

APPENDIX G

Health Education Research Budget

(Per Country for 3 Years)

I. Preprogram Research and Monitoring

A. Local Interviews

Fee - 10p x 30dys x \$10 x 3 yrs.	\$ 9000
Travel - 10p x 3 trips x \$10 x 3 yrs.	900
Per Diem - 10p x 30 days x \$8 x 3 yrs.	2,200

B. Materials and Supplies

\$1,000 x 3 yrs.	3,000
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C. Tabulation and Analysis

Fee - 5p x 10days x \$10 x 3 yrs.	<u>1,500</u>
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Subtotal 21,600

II. Material Pre-testing

A. Local Interviewers

Fee - 5p x 10days x \$10 x 3 yrs.	1,500
Travel - 5p x 2 trips x \$10 x 3 yrs.	300
Per Diem - 5p x 10 days x \$8 x 3 yrs.	1,200

B. Materials and Supplies

Pilot radio program production \$20 x 5 prog. x 5 yrs.	500
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Pilot print material \$20 x 3 mat. x 3 yrs.	180
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C. Tabulation and Analysis

2p x 3 days x \$10 x 3 yrs.	<u>180</u>
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Subtotal \$3,860

Total \$25,460

GLOSSARY

Audience	a particular segment of the total population toward which messages are addressed.
CCCD Project Managers	those host government individuals within each cooperating CCCD country who have been assigned to direct the overall CCCD program.
Channel	the mean of delivering messages broadcast radio, TV, film, print, face-to-face, schools, health workers, peers, etc.
Channel research	research designed to investigate the relative importance of different channels and to determine how to best use a given channel.
Health Education Specialist	those host government individuals within each of the cooperating CCCD countries who have been assigned to direct the health education component of CCCD.
Intervention	the sum total of organized activities and materials designed to deliver the messages.
Messages	the specific health advice being offered a particular audience.
Program monitoring	specific means to determine if health education components are in place, being received, understood and accepted and being applied.
Public Communication Campaign	a specific form of health education which relies on detail pre-program research to define audience, channel, and appropriate messages, organizes this element into a coherent and integrated intervention, and modifies that intervention using regular formative evaluation information.