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HEALTHCOM Briefing Paper

INSTITUTIONALIZATION OF HEALTH COMMUNICATIONS

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INSTITUTIONALIZATION OF HEALTH COMMUNICATIONS

Stanford University's findings to date on the success of the (MMHP) Project reflect the project methodology's ability to effect changes in attitudes, knowledge, practices, and health status. Stanford reports, for example, that diarrhea-related infant mortality decreased by some 40 percent in Honduras as a result of the MMHP Project. A wide range of supporting data shows impressive knowledge gains, attitude shifts, and behavior changes related to the intervention. The researchers at Stanford concluded:

The overall picture that emerges of the project in Honduras is one of an intensive, well-integrated campaign that is achieving impressive successes in teaching people health information and getting them to change specific behaviors related to infant diarrhea.

Successful media effects, however, were only half of the MMHP challenge. The other primary question was, "Will it survive?" In the developing country bureaucracy and a world of budget cuts, over-burdened and constantly reorganized staffs, and ever-changing political priorities, can successful media/communication efforts survive? Further, are successful projects in one country picked up by other countries? Are these concepts and techniques diffused through a wide community of development professionals?

Recently in Honduras the Ministry of Health expanded the Project from Health Region 1 to a national program. The original methodology was refined and simplified and applied to other health objectives related to diarrhea control in a water and sanitation project. More recently it has been applied to a large health sector program encompassing malaria, tuberculosis, immunization, and family planning along with diarrhea. Communication costs have become a regular part of the Ministry's budget. The Health Education Unit has been merged with an audiovisual unit to create a single health communications office with a professional staff of nine. Two new positions (for radio and graphics specialists) have been added. The status of the Health Education Unit has improved, and the unit now functions as a minimarketing agency within the Ministry of Health and relates to the technical offices as though they were clients.

Despite the accomplishments serious threats to institutionalization have been identified. They are not unique to the countries in which they appear. Following is a description of these threats and possible means of overcoming them in future.

A. What is to be Institutionalized?

To understand why institutionalization represents such a challenge, it is important first to understand what must take place for it to occur. The following elements are key to successful health communications:

- o A commitment to **formative research**, including research on the health problem, the audience, the potential delivery systems, testing of products, messages and systems, and regular monitoring to make needed mid-course corrections

- o A fundamental orientation toward the consumer that assumes that consumer satisfaction is central to success
- o A comprehensive marketing plan that goes beyond mere promotion to include product development, price analysis, and distribution systems in their broadest sense
- o A promotion strategy with focused instructional goals established around a narrow set of health objectives
- o Specific messages selected to maximize the feasibility, practicality, and reliability of audience adoption
- o Broadcast media, print, and face-to-face support designed as integrated, mutually supportive, and interactive components, and significant use made of broadcast media for direct instruction as well as information dissemination and popular mobilization.

The success of health communications in reaching mothers, training health workers, producing and coordinating effective posters, flyers, and radio programs, however, will have been little more than another "interesting experiment," unless the issue of institutionalization. Institutionalizing within the MMHP methodology means leaving more than posters and radio spots, leaving more than two years of reduced infant mortality after the formal project has concluded. It means that the ministry modifies and incorporates some minimal threshold of the communications process described above as part of its overall strategy in health delivery.

B. Threats to Institutionalization

The following threats to institutionalization have emerged as particularly salient. These represent serious obstacles to the achievement of this broader goal, and they are generalizable to other communications projects, particularly to those supported by external assistance. This type of assistance provides special resources which ultimately prevent effective institutionalization.

1. The prestige of donor support
2. Flexibility in use of funds
3. Outside technical assistance availability
4. Absence of communication slots or budget items
5. Fear of failure.
6. Paucity of resources
7. Scarcity of communications expertise
8. Resistance to setting priorities
9. The need for visible success

10. Lack of political commitment
11. General resistance to change
12. Print prejudice and the fear of media

Donor Prestige. Well-financed, donor projects receive special attention within most developing country bureaucracies. This attention helps overcome obstacles to implementation as they occur, but the positive effects of this prestige are impossible to replicate when the project loses its "donor support" status. As the project becomes institutionalized it is just one more "boy on the block," unable to command the special concessions needed to make the experiment work. To the donor, these "special concessions" are essential, but they threaten institutionalization.

Flexibility in the Use of Funds. All governments have tight restrictions on the use of money. Money is not only unavailable, but procedures for spending money are cumbersome and result in delays. Donor-funded projects go around these obstacles; they short-circuit the system, often in simple but important ways. For example, when it was necessary for three ministry staff to conduct immediately needed testing in rural areas, a small per diem "loan" from the MMHP Project allowed government personnel to travel when necessary. Without this loan, the whole program would have been delayed for weeks. The loan was paid back, but it was the immediate availability of money which proved difficult to replicate once outside support was withdrawn.

Outside Technical Assistance. Outside experts, because they are able to focus on a single task, because they are well-paid, because they have special status as outsiders, and because they are driven by explicit project-related measures of success, create a special thrust--or "overdrive"--in this type of project. This acts as a catalyst for action, a regular reminder of tasks to be done, and a constant agenda-setter for the program. Unfortunately, the overdrive disappears when the advisors leave. It is not necessarily that the advisor is more capable or dedicated. He or she is simply more single-minded than governmental counterparts are ever allowed to be.

The Absence of Communications Slots or Budget Items. "Slots," or administrative staff positions, drive bureaucracies. If there is no slot for a communications expert (and there rarely is in most development ministries), then either one has to be created, or some other slot has to be given the additional communications responsibilities. In the first instance, it is typical in a program like MMHP to spend two or three years creating the new slots only to find that when they are created, training resources have been depleted. There are new slots, and new people but no way to train them. If existing slots are tapped, the problem is equally difficult. Curriculum expert, or epidemiologists, although they may be attracted to communications, do not see "success in communication" as part of their career path. They may work hard for a year or so and learn a great deal, but sustained communication support tends to dissipate as the program becomes routine.

Equally difficult is the problem of communication costs. Many governmental institutions have no budgetary line item for air time, actors, field research, or promotional materials. To create a new budget line item in a

government ministry is almost impossible, yet without resources to cover these costs the job will not get done.

Fear of Failure. The type of formative methodology which lies at the heart of health communication project success requires an empirical view of the world--a love of uncovering mistakes, particularly one's own mistakes, and fixing them. "Mistakes" within bureaucracies, however, are anathema. Health communication's empirical methodology is often translated into meaningless routine. Many people now pretest materials, for example, but how many changes are made in materials as a result of those tests? There is a tendency to say, "oh yes, we tested the materials and everyone loved them!" This response reflects not a naive understanding of pretesting but a cogent understanding of the world of rewards and punishments in which public employees live. The fear of admitting failure constitutes a major stumbling block to successful adoption of this type of methodology.

In sum, it is difficult to change habitual procedures within any bureaucracy. External prestige, new relationships among vertical programs, autonomy in decision-making, and fear of failure--these tax the usual way of doing things in most ministries today. In addition to these constraints, there are also more obvious constraints such as:

An Absolute Paucity of Resources. In the poorest countries, such as The Gambia, Swaziland, and Lesotho, there are chronic shortages of trained counterpart personnel with whom to work. The best are often required to serve as counterparts on several foreign aid projects and frequently called out of the country for training courses, conferences, and so forth. Moreover, ministry budgets are so spartan that there are often insufficient funds for such essential operational commodities as paper, audio tapes, gasoline, and per diem for field trips. In such situations, aid projects are used by governments to finance these basic operational costs. The ability of these governments to absorb and institutionalize project methodologies is obviously at risk.

A Scarcity of Communications Expertise. Even in countries with greater resources, there is often a shortage of the skills necessary to implement effective communications programs. Sometimes the skills are present in individuals, but the management and organizational experience to tie them together is absent. Many well-trained health educators continue to hold very traditional views of health education. They may resist the systematic use of mass media in addition to interpersonal communication, for example, or to an approach which focuses intensively on only one or two educational priorities at a time. Public health education, as developed by AID, differs strikingly from what most health educators are now accustomed to. It requires not only new skills, but new management processes to organize those skills into an effective whole.

Specific areas of importance are marketing, formative (particularly behavioral and qualitative) research techniques, creativity, and program management. Personnel training is a double problem. First there are few trained people now, and, second, once trained they are likely to be reassigned--or leave government positions.

The Resistance to Setting Priorities. Most developing country public sector professionals feel compelled to address the whole range of health

problems facing their countries. Dental hygiene often has an equal voice with diarrheal disease and immunization. Officials are reluctant to set priorities, thereby excluding other colleagues' specialties. Consensus decision-making, rather than vertical authority often leads to programs with too many objectives.

The Need for Visible Success and the Lack of Continuity. Governments need to demonstrate success--often when it does not in fact exist. Governments fear too much attention on a single area: it not only breeds resentment but it suggests favoritism. At the first signs of success there is a tendency to say, "OK, we've done diarrhea, let's now go on to respiratory disease."

In addition to creating too many objectives at once, this tendency often leads to selecting health problems for which there is no good intervention, no useful information, or at least none that an audience could reasonably be expected to take. Yet, officials feel compelled to waste scarce resources on their topics to demonstrate balance and fairness.

The temptation is to go for the "flashy campaign" rather than the long haul. Health communications programs are implemented within political, as well as cultural, settings. Flashy television or radio spots are good public relations for a government. Systematic health communications programs, however, have little chance to be institutionalized if the product and the delivery systems, including training health workers and opinion-leaders, are not developed at the same time as the promotion strategy. Decision-makers must understand and be committed to public health education as a continuing, reiterative process which has a single coherent strategy yet develops and changes over time.

Lack of Policy-Maker Commitment. Health communications also requires commitment from top level policy-makers as well as middle level practitioners. Institutionalization in Honduras, for example, was jeopardized when a new Director General, unfamiliar with the AID-funded health project, wanted to do away with the Division of Education and disperse staff among various divisions. This action would have made the communications management and planning necessary for a single coherent strategy impossible. Once the Director General understood the value of the new approach, he became an important advocate for the Division and provided additional staff and resources. The key to his conversion was the realization that the Division could meet his needs for better a program and increased public visibility.

General Resistance to Change. In the public sector in many developing countries, creativity or innovation is unrewarded. Indeed, it is often discouraged. Public sector institutions are particularly susceptible to this problem, because the measure of success is cooperation and survival, not competition or rising above your colleagues. Yet, it is frequently creativity that makes the difference between an average program and one that changes health related behavior. To succeed the health communications model requires creativity to succeed and the resistance to change represents a significant obstacle to its true institutionalization.

The Print Prejudice and the Fear of Media. Everyone wants a nice poster and pamphlet. They are tangible. You can show them to your boss. You can point to them in the health center; they are hard evidence that a health

educator (much like "Kilroy") was there. Often program planning begins by designing a poster--and ends with printing it. Channel strategies are not well understood, and, more importantly, not easily tolerated. Broadcast media are threatening. A single angry call from the minister's cousin can ruin a bureaucrat's career. Why take the chance? There is a sense, not without foundation, that broadcast media are not only expensive and unfamiliar but also risky. At the same time, there is a belief that it is a "miracle drug." If diarrhea was mentioned on TV or radio, then diarrhea has been dealt with. Health educators are often asked, "Do you use TV or radio in your diarrhea program?" The answer is almost invariably, "Yes, we mentioned it on our program three months ago."

C. The Measure of Success

How do we know if institutionalization is occurring--what measures of success and intermediate progress are useful? Success means more than just an effective reduction in infant mortality. The following measure of institutional success should be carefully monitored throughout the program:

- o The number of trained personnel, particularly in the areas of:
 - social marketing
 - behavioral analysis
 - qualitative research
 - creativity
 - program management.

- o Changes in administrative norms and procedures which:
 - provide incentives for detecting and correcting program laws
 - organize personnel to their rolls in research, creating messages, and programs and management
 - link public- and private-sector institutions
 - promote prioritization of health communication topics
 - support message continuity over time
 - permit real costs, particularly formative research and media costs, to be financed.

D. Overcoming the Constraints to Institutionalization

Overcoming these constraints is the central challenge of institutionalization. No easy answers exist--at least no generic ones. In each case, the problems vary in intensity and character, and, more importantly, each situation presents unique opportunities which must be exploited.

There are several principles, however, which can help address the problem, and if not ensure success at least increase its likelihood. They are:

- o **Attend to the issue constantly.** Do not leave institutionalization to the last 12 weeks of the contract. Start on day one to discuss it, build it into letters of agreement, constantly look for ways to exploit opportunities, and constantly seek USAID Mission support.
- o **Do not depend too much on training.** Training alone is not institutionalization. Norms and policies also have to be changed if health communications methods are to be continued.
- o **Train more people than needed.** (When you do training, however, train numerous people.) Use seminars to train people at all levels and as many as possible. It is likely that today's director of EPI will be tomorrow's health education director or vice versa. The way to beat staff turnover is not to insist that the government agree never to change people, but to train so many people it does not matter if turnover happens or not.
- o **Do not be too dogmatic.** Test what is necessary and what is not. Little is really known about what can be done without. Testing should begin early.
- o **Plan on success from day one.** Assume you are going to succeed--create an atmosphere of success. Make the difficult decisions that managers have to take seem worthwhile.
- o **Study institutions.** Look at policies, procedures, and norms. Be more of an expert on how to get a budget approved than anyone in the ministry. Learn to work the system--it is more important ultimately than writing an effective radio spot.
- o **Provide assistance over enough time.** Short-term assistance, except in rare cases, will not provide sufficient support for institutionalization. You need at least two years. Three and a half years is more realistic. But six months is not enough time. It might be enough time to design a program, maybe but not for learning a new approach in a complex institution.
- o **Finally and most importantly, look for new institutional linkages.** Find skills in the private sector and then emphasize new relationships--these investments can have huge pay-offs in long-term self-sufficiency. Exploration of these institutions' delivery systems is a fundamental goal of AID's continued development of the health communications methodology.

E. Expanding Institutional Delivery Systems

A special focus of future child survival communication projects must be the development of new institutional approaches to service delivery, both to increase program coverage and to enhance prospects for methodology transfer and institutionalization. Each of the different child survival technologies

offers slightly different opportunities for institutional delivery. Below are various institutional delivery models and a discussion of each of the five principal technologies in relation to their potential for institutional delivery.

Public and Private Sectors: Strengths and Weaknesses

Public sector institutions in developing countries--ministries of health, information, agriculture, and broadcasting, and so forth--offer certain opportunities to project implementers. These institutions provide access to extensive service delivery systems, centralized policy and decision-making bodies, and, in some cases, substantial program resources. A ministry can also give a program visibility, credibility, and prestige as well as the official authorization necessary to conduct a national public health program. On the other hand, public sector services suffer from serious constraints. Governmental budgets are increasingly limited, and government personnel are frequently underpaid, undermotivated, and lacking in necessary program skills. High turnover rates at the decision-making levels often require constant renegotiation of program objectives.

The private sector has economic mechanisms--price incentives--for promoting efficiency in the production of goods and services and for attracting talented personnel. The profit motive, however, does not always operate for goods and services which are affordable for those most in need. Health promotion and communications produced by the private sector are often superficial and product-oriented, focusing on product sale with less emphasis on effective product use. In the case of health services delivery, the product and profit orientation of the private health sector should be seriously examined when considering socially equitable outcomes.

In discussing the consumer education and health communications responsibility, a fundamental question emerges: Whose responsibility is it? Where should this function be placed within the institutional structures of a developing country? The answer will vary from one country to another and will almost never be a simple one. The following is an attempt to outline various models for the organization of communications and marketing systems within both public and private sector institutions and suggests several innovative ways that private and public sector resources can be maximized through joint planning and cooperation.

Public Sector Communication Models

Most child survival communications projects to date have worked primarily with public sector institutions. The service delivery responsibility rests within the ministry of health, but the communication function appears in different settings. Three viable settings have emerged from this experience:

Ministry of Health Alone. Health communications research, planning, implementation, and evaluation are conducted by the Ministry of Health itself, often within a specialized Health Education Unit. Servicing of this model requires a strong commitment to innovative health communications and ample resources committed to the Health Education Division's personnel and operational budget. This is rarely the case; most health education units are understaffed, lack prestige and leverage, and have limited budgets.

Collaboration between Ministries (Health and Broadcasting). In this model, the ministry of broadcasting--for example, the national broadcasting service--shares operational responsibility for the program, providing technical skills in broadcast planning and production which may be lacking in the Ministry of Health as well as valuable broadcast time on a complimentary or discounted basis. While maximizing skills, it diffuses authority and adds inter-ministerial cooperation as an added obstacle.

Integrated Ministry Approach. A number of governmental entities work together in implementing a project. This model could apply both to countries where the requisite skills and resources for running a communications project can only be found in different ministries--for example, print in the ministry of education or government printing office, broadcast in the ministry of information, research in the statistics or surveys office--or in a large country such as Indonesia, where interministerial coordination is a program management imperative. Working with a number of ministries increases the opportunities for transferring project methodologies but poses a formidable management task for the project director.

Private Sector Marketing Models

There are a large number of private-sector institutions offering opportunities for marketing child survival technologies, which are only beginning to be tapped:

Commercial Marketing. The marketing systems of pharmaceutical companies and other commercial enterprises are obviously targets of opportunity for promotion of child survival technologies, such as oral rehydration salts. Retail sale of ORS is taking place in a growing number of countries--Bangladesh, Ecuador, Peru, Pakistan, Indonesia, Thailand, and the Philippines--but on a relatively limited basis. Pharmaceutical companies often favor the sale of more profit-making antibiotics and antidiarrheal medications and remain unconvinced of the marketability of ORS.

Private Health and Delivery Systems. There is a wide and growing range of private health delivery systems in developing countries. These include both private hospitals and physicians and a variety of employment-related benefit plans, such as social security schemes, health maintenance organizations, and health plans run by industries or cooperatives. Typically, these services are financed by contributions of the employer and the employee with governments also sometimes contributing. Because of their growth--for example, the social security system is the largest provider of health services in Mexico and nearly half the population of Uruguay is covered by HMO services--these systems represent an important opportunity for child survival marketing. They tend to be highly professional in the marketing and communications activities and are receptive to child survival technologies because preventive effects help keep rising curative costs down.

Private Voluntary Organizations. There are a large number of both indigenous and international PVOs such as Caritas, Catholic Relief Services, CARE, Save the Children, etc., working in health service delivery programs in developing countries. In many countries these organizations have developed extensive and effective grass-roots systems, and in some of the poorer developing countries their coverage may actually exceed that of the public health system. Several AID programs are already undertaking significant ORT delivery and education projects through PVOs in Africa and Latin America, such as PRITECH's collaboration with Caritas in Bolivia and with Africare in Chad. In 1985 AID set aside some 15 million in child survival funds to support these activities. At present, their communication strategies stress face-to-face models with little effective use of broadcast channels. PVOs are highly motivated and well-organized and represent a target of opportunity for improved health communications.

Public and Private Sector Mixes

The most interesting and promising possibilities for rapidly expanding the coverage and institutionalization of child survival programs lie in the development of creative mixes of public and private sector systems and resources. The possibilities include:

Publicly Subsidized Commercial Marketing. To stimulate commercial marketing for oral rehydration salts, a government may subsidize a pharmaceutical company's sale of ORS so that it is both affordable to target consumers and profitable to the company. This is a strategy currently under consideration in the Philippines, for example, where the Ministry of Health may subsidize both the production and distribution of an ORS packet by a local pharmaceutical company by guaranteeing Ministry purchase of x number packets annually from the company.

Product Social Marketing. Similar to the preceding model in that a product is sold at a state subsidized price, social marketing differs in that a new organization is usually established for the sole purpose of marketing a socially desired product. Most international product social marketing has been through AID's contraceptive retail sales projects in a number of countries. There are currently several promising efforts underway, in Nepal, Jamaica, and Bangladesh, to add ORS to the product line of successful existing contraceptive social marketing programs.

Public Promotion of Private Products. There are some countries in which socially sought goods or services are available in the private sector but for which there is inadequate consumer demand. Public resources may be used to stimulate demand, as when a ministry of health conducts a campaign for family spacing or ORT which increases consumer demand for contraceptives or ORS products available in the private-sector. Egypt's "missionary" promotion of family planning of the early 1980's is a good example. The Haitian national ORT program is currently using international donor funds for a promotional campaign designed to stimulate demand for the ORS packet produced and distributed in the private commercial sector.

Private Promotion of Public Products. The converse of the foregoing model, here a public sector program is supported by goods or services donated by or contracted from the private sector. Recent child survival program examples include AID's ORT campaign in Peru and the newly planned Ecuador and Indonesian programs in which private market research and advertising firms are contracted (sometimes at a discounted rate) by the Ministry of Health to do research and design promotional activities. In Brazil, several private broadcast networks donated millions of dollars worth of broadcast time to a UNICEF/Ministry of Health breastfeeding campaign. In Colombia, the networks worked closely with the government's immunization program.

Joint Marketing. Both public and private sectors are engaged in promoting the same product or products in their respective markets. This model has successfully served a number of national family planning programs, including programs in which the same contraceptive line is being sold commercially and distributed at no cost through public health facilities. It is also currently being followed in the ORT program in Peru, where the Ministry of Health is promoting and distributing the same ORT packets through the public health system that the local pharmaceutical companies market commercially.

Complementary Marketing. Public and private sectors market different products to different market segments as part of an overall unified strategy. Such is the case, for example, in Pakistan where a public health service distributes at little or no cost a product produced locally while the commercial sector sells a more expensive product to a more affluent segment of the market.

Competitive Marketing. Public and private-sectors, using different strategies, promote different products to the same market segments. This model runs the danger of promoting conflicting, confusing, and potentially dangerous messages for the audiences, but if the basis can be agreed upon (mixing volume for example) competitive marketing can stimulate market demand of products such as ORS over less effective antibiotics and antidiarrheals.

Real World Mixes

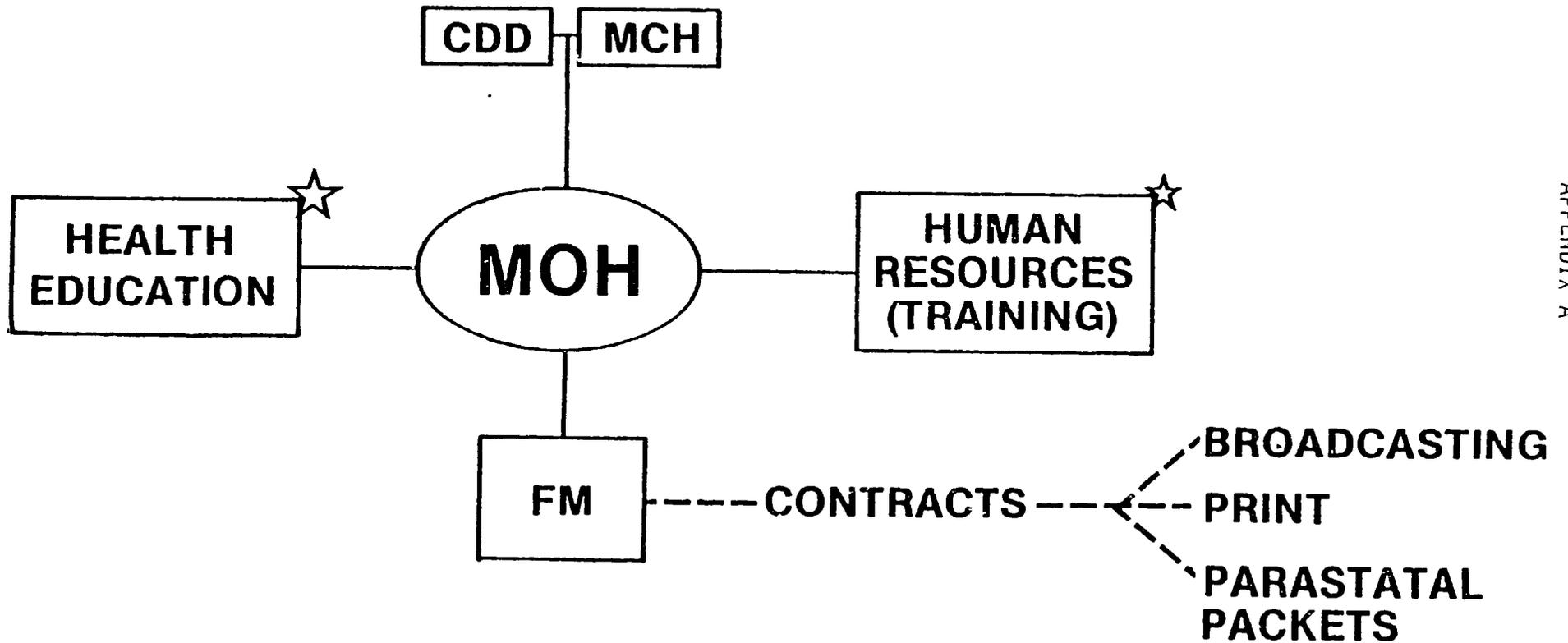
A few examples will illustrate how these models operate in real life situations:

In the **Honduran Diarrheal Disease Control Program** (see Appendix A) the government Ministry of Health (MOH) has two coordinating units--Diarrheal Disease Control (CDD) and Maternal and Child Health (MCH)--and two implementing agencies, Health Education for the promotion strategy and Human Resources for health-worker training. The Ministry's Accounting Office signs agreements with private firms to air radio programs, print materials, and produce ORS packets. Private sector involvement here is purely incidental, leaving all functions within the government.

In the Peru model (see Appendix B) an expatriate social marketing firm (AED) provides overall strategy and design assistance, which links a local advertising firm and the MOH pharmaceutical and health service system.

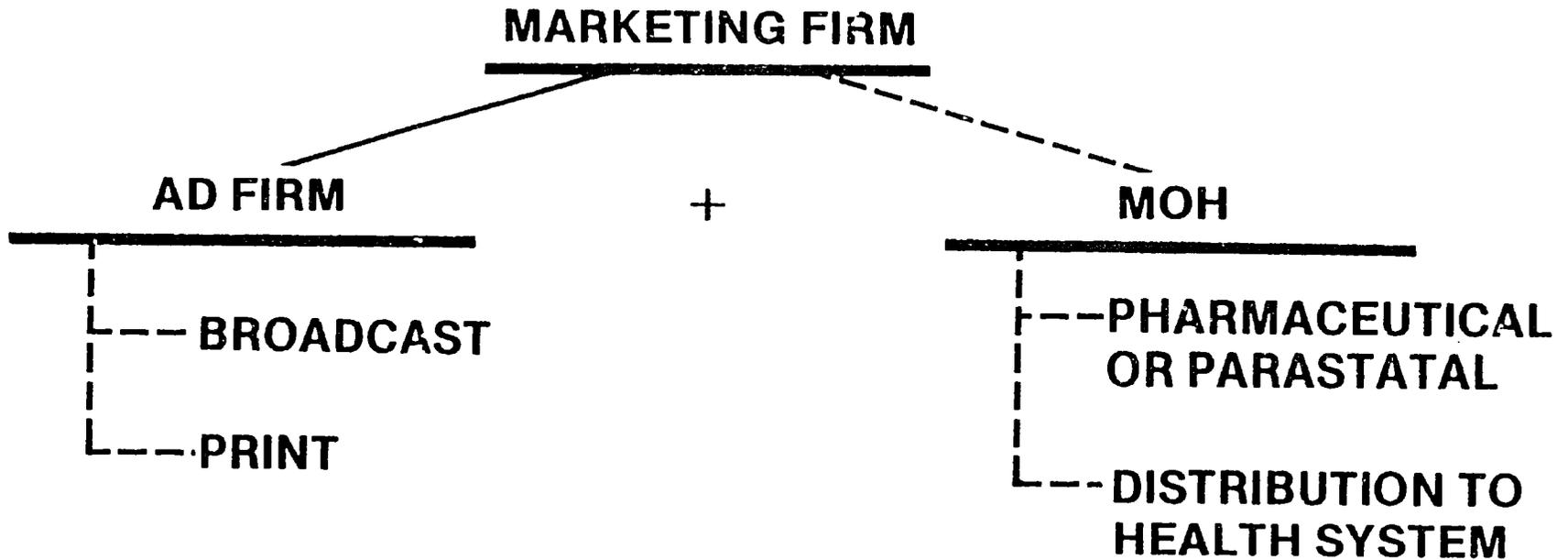
In Indonesia (see Appendix C) an advertising firm, the Ministry of Health, and a private pharmaceutical firm work together to provide wider ORT coverage and a more sophisticated marketing strategy than the public sector alone is able to provide. The advertising agency develops a promotion campaign consistent with technical recommendations of the MOH. This strategy is altered by the private pharmaceutical company to be more appropriate for their intended market. However, the core technical messages remain consistent throughout all materials.

PUBLIC HEALTH COMMUNICATION THE MOH MODEL (Honduras)



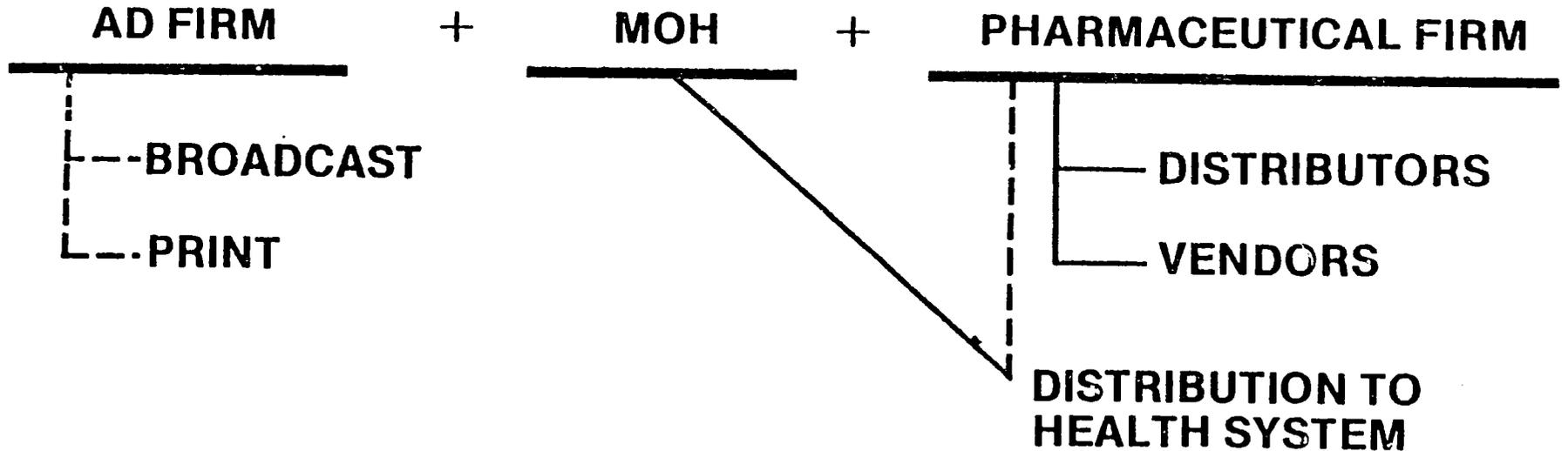
(Product Problem)

**PUBLIC HEALTH COMMUNICATION
MIXED MODEL #1
(Peru)**



(Coordination Problem)

PUBLIC HEALTH COMMUNICATION MIXED MODEL #2 (Indonesia)



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APPENDIX C

(Coordination Problem)