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Institutionalization of Health Communication Methodology in The Gambia

A Report to

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EXECUTIVE SUMMARY

The purpose of this report is to evaluate the extent to which the communication methodology introduced in the Mass Media for Health Practices (MMHP) project was institutionalized in The Gambia, and to draw conclusions from this case for use in institutionalizing the methodology in other countries. We describe what the Department of Medical and Health Services (DMHS) in The Gambia and the MMHP project staff did to institutionalize the methodology, and the results of those efforts.

Initiated in Honduras in 1981 and The Gambia in 1982, the MMHP project introduced a communication methodology for use in persuading rural mothers to use of oral rehydration therapy (ORT) in treating their infants' diarrhea. Later the project was expanded to apply the methodology to other health practices related to mothers' care of their children. It has been used in fifteen countries in Africa, Asia and Latin America.

The methodology integrates the use of mass media and interpersonal communication networks. It is based on two tenets:

- messages to mothers about health care are most effective when they stem from research on what will catch the attention of those mothers, and
- when the same messages are sent through both mass media and interpersonal communication channels, those messages will reinforce each other.

The major goals of the MMHP project in The Gambia were to reduce infant death and disease, and to test the use of the methodology for this purpose. A secondary goal, which was introduced in the third and final year of the project, was to institutionalize the methodology. Although the MMHP project ran for three years, it was designed as a research and development project, and it was not until the third year that the goal of institutionalizing the project was added. To accomplish this

latter goal, the project staff trained Health Education Unit staff members in the knowledge and skills they would need to continue to use the methodology once the project staff had departed.

The evaluation of the project included a follow-up survey of mothers and health workers conducted in mid-1987, five years after the project had commenced. At that time, data were collected on the extent to which the project had been institutionalized.

The evaluation demonstrated that, using the methodology, the project staff succeeded in getting mothers to use ORT to treat their children's diarrhea, and in reducing health problems related to diarrhea. However, when the staff left The Gambia after the three-year term of the project, the DMHS did not continue using the methodology to teach mothers about ORT or any other health practices.

The Gambians' reluctance to continue using the methodology once the MMHP project ended appears to result from:

- not enough time for transferring to DMHS-staff members the technical skills they needed to use the methodology;
- Department members' lack of confidence in their own capacity to use the methodology when limited to their own resources,
- the absence of organizational changes and resource allocations that would have facilitated use of the methodology.

The MMHP project was designed and funded by the Bureau of Science and Technology in the Agency for International Development (USAID/S&T/ED). The Bureau contracted with the Academy for Educational Development (AED) to assist the Ministry of Health, Labor and Social Welfare (MHLWS) in executing the project. The MMHP project was evaluated by Stanford University's Institute for Communication Research and Food Research Institute, and by Applied Communication Technology (ACT).

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We acknowledge with appreciation the authors of the reports on which we have relied for information about the institutionalization process and results: Dr. Peter Spain, Dr. Leslie Snyder, Dr. David Eckerson, Dr. Daniel Lissance, and Dr. Ellen Piwoz.

BACKGROUND

The Mass Media and Health Practices (MMHP) project. The Agency for International Development (USAID) initiated the MMHP program in 1978 as a research and development effort. The program was designed to develop and test a methodology for improved public health communication, applying what USAID had learned about development communication and social marketing as tools for helping people in developing countries change their health practices. These tools included the use of preliminary research such as focused analysis of people's radio-listening habits and health practices. The findings from this research were used to design messages to be sent through several channels (radio, print materials, and health-care workers), and to integrate the delivery of these messages through the various channels.

Within the MMHP program, projects were started at the same time in two countries so that USAID could learn about how the methodology works in different cultural and environmental contexts. Agreements with the governments of Honduras and The Gambia permitted the program staff to work with the ministries of health to introduce the methodology in support of the diarrheal disease programs of those two countries. Later, other countries also joined in the program.

In The Gambia, the Department of Medical and Health Services (DMHS) in the Ministry of Health, Labour and Social Welfare (MHLSW) initiated the MMHP project to strengthen its effort to reduce death and disease among mothers and children.

The Academy for Educational Development (AED) in Washington, D.C. worked with the DMHS for the three years between 1982 and 1985 to design and implement the project. From the outset, an accompanying evaluation program was set in motion to

collect and analyze data on the process and results of the project. The evaluation was begun by the Institute for Communication Research at Stanford University, and completed by the Food Research Institute at Stanford and its subcontractor, Applied Communication Technology (ACT). Both the implementation and the evaluation of the project were funded by the Office of Education and the Office of Health in the Bureau of Science and Technology of USAID. The USAID mission in The Gambia and the Ministry of Health contributed additional resources for many project-related activities.

The Mass Media for Infant Health Project (as it was called in The Gambia) used three different media to teach mothers about infant diarrhea and to motivate them to change how they treated diarrhea:

- interpersonal communication through the existing network of health providers,
- radio broadcasts, and
- print materials.

The project was most interested in persuading mothers to use a home-mixed oral rehydration solution (consisting of water, sugar and salt) in treating their infants' diarrhea. Oral rehydration solution (ORS) reduces the child's risk of death from dehydration by replacing the water and electrolytes lost by the body during diarrhea. The project also wanted mothers to continue breastfeeding infants with diarrhea who had not yet been weaned, feed nutritious foods to their children with diarrhea, and prepare their foods in a sanitary manner.

To meet these objectives, the project staff (consisting of personnel of the DMHS and AED) taught mothers and health workers how to treat dehydration in small children who had diarrhea. The homemade mix of water, sugar and salt was the constant theme promoted by each of the three teaching channels. To this theme, other aspects of oral rehydration therapy were added, including the proper feeding and the

continuation of breast feeding during diarrhea, when to take a child with diarrhea to the clinic, and how to prevent diarrhea in the first place.¹

The Department of Medical and Health Services (DMHS), and the Health Education Unit. The project was negotiated by officials of USAID and the DMHS, within which sat the Health Education Unit. Although the staff members within the Ministry of Health who had direct responsibility for implementing the project were within the HEU, the project staff also had to involve other units of the Ministry in the project, especially the leadership of the DMHS.

The professional staff of the DMHS consisted of a director and assistant directors who were responsible for each of the department's five units: Epidemiology and Statistics, Maternal and Child Health, Primary Health Care Training, Nutrition, and Health Education (HEU). Four of the unit heads had direct line authority over activities throughout the country, which were implemented through offices on the regional and village levels. These were "vertical" units. The HEU, in contrast, was a "horizontal" unit that serve the other four units with education and materials-production expertise.

The professional staff of the HEU included the Health Education Officer, the Assistant Health Education Officer, two Health Educators, and a graphic artist, all based in Banjul, the capitol of The Gambia. Prior to the MMHP project, the major work of the HEU was assisting schools in developing curricula in health education. During the project, the unit developed a reputation for its ability to produce radio-broadcast messages.

During the time between the MMHP project's inception in 1982 and 1987 the directors of both the DMHS and the HEU left, assistant directors were promoted to the vacancies, and members of their staffs became assistant directors.

¹This section on the background of the MMHP project is based directly on Spain and Snyder, "The Mass Media and Health Practices Evaluation in The Gambia: A Report on the Process Evaluation", August 1985.

The other government offices that played a critical role in the project were the Rural and Adult Education division of Radio Gambia in the Ministry of Information and Tourism, and the Book Production and Material Resources Unit in the Ministry of Education.

The project evaluation. The evaluation done by Stanford University and ACT tracked the process of the project's implementation and effects as well as the project's results after two years. (The third year of the project was focused on institutionalizing the methodology). The evaluators concluded that the project succeeded in introducing the oral rehydration solution to mothers, and that during its second year, more than half the episodes of diarrhea in children were being treated with the water-sugar-salt solution.

The evaluation methodology included a variety of studies, the most comprehensive of which was a collection of survey data from repeated visits to about 1,000 mothers in 20 communities. Another study was the process evaluation, the purpose of which was to "examine the major activities and events in the life of the project, looking for lessons and insights that are useful for planners of similar activities."²

The final phase of the evaluation (1987) was a follow-up survey conducted by ACT of mothers and health workers to determine how well they were maintaining the practices taught to them during the project. During the follow-up survey, we investigated to what extent health workers on the village level still knew about ORT and were helping mothers use it. We also interviewed DMHS staff members to find out how well the methodology had been institutionalized.

²Spain, Peter and Leslie Snyder, The Mass Media and Health Practices Evaluation in The Gambia: A Report of the Process Evaluation. Applied Communication Technology, Menlo Park, California, August 1985, p. 3.

THE INSTITUTIONALIZATION STUDY

The purpose of this study is to evaluate the extent to which the methodology introduced in the Mass Media for Health Practices (MMHP) project was institutionalized in The Gambia, and to draw conclusions from this case study for use in other projects in developing countries.

The MMHP project was designed primarily as a research and development effort: a test of the effectiveness of the methodology, which, if successful, would be replicated in other developing countries. It was not until the last months of the two-year project period that USAID decided to extend it for at least a year in order to help the Ministry integrate the methodology fully into its own operations.

To establish the importance of the study, we discuss the importance of the methodology and of the process of its institutionalization.

The methodology. The MMHP project was designed to test the assumption that programs directed toward changing how mothers care for the health of their children will have a better chance for success if they are based on:

- research on how to communicate the information to mothers, and
- the integration of interpersonal and mass media.

The methodology based on these assumptions evolved during the course of the MMHP program. The first description of the methodology appeared in the Project Paper prepared by USAID's Bureau of Science and Technology in 1978, in which it was said to include:

- message selection and design,
- product testing,
- message pretesting,
- overall instructional program design,
- management of media production and distribution, and
- monitoring and modification of program components.

This initial description called for "the orchestration of these six elements into a comprehensive, simplified methodology".

During the project, as research and development activities proceeded, the definition of the methodology was somewhat modified. In 1985, at the conclusion of the MMHP project, Spain and Snyder described a slightly different set of components constituting an "innovative methodology drawn heavily from social marketing to promote health behavior change"³:

- village-level research on practices, cultural concepts and vocabulary for planning and message development;
- behavioral analysis for defining desired behaviors and planning paths for arriving at them;
- use of a highly integrated multi-channel communication strategy that used each channel to its best advantage and to reinforce the messages carried in the other channels.

The overall effect of the evolution of the methodology's characteristics was to synthesize a series of particular tasks into the broader guidelines of (1) research-based development of messages, often in accordance with "social marketing" principles, and (2) integration of interpersonal and mass media channels.

³Spain, P., *et al.*, *op.cit.*, p. 6.

Institutionalization activities. By the end of the second year of the MMHP project the methodology had been conceptually solidified and successfully implemented. When the project was extended for a third year, the staff set objectives for helping the Ministry, particularly the HEU, adopt the methodology:

- to provide some formal training (e.g., workshops);
- to coordinate with Radio Gambia and the Book Production Unit;
- to integrate project activities into the ongoing concerns of the DMHS, and
- to conduct a mini-campaign incorporating all steps in the process.

The mini-campaign was used to guide the HEU staff members through all the tasks they would need to master in order to plan and implement projects that used the methodology. They would need to know how to:

- conduct research on mothers' knowledge and practices relevant to the practices targeted in the campaign;
- set specific objectives;
- write an implementation plan for a campaign;
- develop a campaign using the three media channels;
- run the campaign;
- monitor and evaluate the campaign.⁴

⁴Interviews held by ACT with DMHS staff in 1987.

EVALUATING THE INSTITUTIONALIZATION OF THE METHODOLOGY⁵

The guiding questions. In 1984, as the MMHP project in The Gambia was drawing to a close, USAID posed a number of questions about institutionalizing the methodology:

- How long does institutionalization require?
- Where is the best institutional location for expertise in the methodology?
- What institutional procedures and plans evidence adoption of the methodology?
- How do personnel and budgetary allocations evidence adoption of the methodology?
- What were key elements in the process of institutionalization?

⁵ In 1984-85 the term "institutionalization" was used to describe The Gambian government's adoption of the methodology for use in its own projects, independent of USAID technical assistance. Since then USAID has used the term "sustainability" in describing USAID's role in designing and implementing projects that have a long-term impact. For example, An Evaluation of the Factors of Sustainability in the Gambia Mass Media and Health Practices Project describes the prerequisites and components of an agreement between USAID and The Gambia that would enhance The Gambia's capacity to continue to produce benefits from the project after it ends.

While the focus of that report is on the terms and conditions that need to be in place in order to promote the project's sustainability, our focus in this study is on the knowledge, skills, attitudes needed by the people who take over the project, and the institutional structures that are amenable to the adoption of the methodology. Sustainability is related to the benefits of a project; institutionalization is related to the methodologies which lead to those benefits. Sustainability deals with the political interaction between the government receiving aid; institutionalization with the transfer of knowledge, skills and attitudes within the institution.

We doubt that anyone would disagree with our conclusion that the MMHP methodology was not institutionalized in The Gambia. It was not adopted by the DMHS for use either in the continuation of diarrheal disease control or in other health projects. We have asked the question, "why not?", and turned for answers to those who, during the three years after the termination of the MMHP project, were close to the project and its results. We believe that the shortcomings of the institutionalization process in this case have provided insight into some of the necessary prerequisites and components of that process.

Framework for analysis. We have selected as an analytical framework the Knowledge-Attitude-Practice (KAP) scheme often used in examining individual changes in behavior. Though this scheme is generally used in quantitative studies (including the evaluation study of the MMHP project in The Gambia), we have adapted it here for use in organizing qualitative data. We have asked three general questions about the data:

- What knowledge and skills did The Gambians acquire that would help them adopt the methodology for use in other projects?
- What was their attitude toward the methodology and their capacity to adopt it?
- How did they restructure their activities in order to adopt the methodology?

Hierarchical levels of the institution. We have used this framework to look at each of three levels of the "institution" involved in the project: (1) the Ministry of Health, Labor and Social Welfare (MHLSW), (2) the Department of Medical and Health (DMHS) within the Ministry, and (3) the Health Education Unit (HEU) within the Department.

We have examined the changes that took place on each level, and asked whether the HEU was the best unit to house the project, or whether the project would have been more effectively placed elsewhere.

The project actually extended to a fourth and fifth level: (4) clinics situated throughout the country, and (5) the network of village-level health workers (Village Health Workers (VHWs) and Traditional Birth Attendants (TBAs)) who helped mothers use ORT. Although we have focused on events in the central offices of the Ministry, we have also considered what happened on the regional and village levels.

Sources of information. Most of our information comes from two series of interviews and three written reports. The interviews were conducted with the directors of the DMHS, unit heads, HEU professionals, health workers on the regional level, the Radio Gambia staff person involved in the MMHP project, and representatives of donor agencies in The Gambia who were familiar with the project. We conducted the first series of interviews in mid-1985, one year after the project had terminated, and the second series two years later, in mid-1987, at the time of the follow-up survey. Both series of interviews were based on open-ended questions, probing for what those being interviewed knew about the methodology, what they thought about it, and how they had used it after the MMHP project had been completed.

We drew additional information from the three reports, one prepared by the Stanford University and ACT evaluation staff, one by an USAID/Washington official, and one by a consultant to the World Bank.

"The Mass Media and Health Practices Evaluation in The Gambia: A Report of the Process Evaluation", written by Drs. Peter Spain and Leslie Snyder in August 1985, describes how the project was implemented. It discusses what was done to institutionalize the project methodology, and assesses the results of those efforts.

"Strengthening Family Planning and Nutrition Communications Programs in The Gambia", was written in 1986 by Daniel Lissance and Ellen Piwoz to advise the World Bank as to whether it should fund social marketing programs in family

planning and nutrition. The World Bank wanted to assess whether the Nutrition Unit in the DMHS was using social marketing techniques.

"The Gambia Mass Media and Health Practices Project", a memo written in 1986 by Dr. David Eckerson of the Africa Bureau in USAID, assesses the extent to which the DMHS had taken over for its own use the methodology introduced by the MMHP project. Information from Dr. Eckerson's memo was incorporated in 1987 into a report published by USAID entitled An Evaluation of the Factors of Sustainability in the Gambia Mass Media and Health Practices Project, (USAID Evaluation Special Study No. 51).

The information in each of these reports is based largely on interviews with the same Gambian health officials and USAID staff members, except that Spain and Snyder also used data from first-hand observations made during the course of the project.

Data collection methods. While the results of the project evaluation were based primarily on quantitative data, our report is derived from the data gathered through open-ended interviews. The interviews provide well-grounded, in-depth information about the institutionalization process, and there is consistency among their findings.

RESULTS

KNOWLEDGE OF THE METHODOLOGY.

In our experience, an institution needs the following kinds of knowledge and skills in order to institutionalize the health communication methodology:

A conceptual understanding of the methodology, the premises on which it is based, its purposes, uses and limitations;

The managerial ability to operationalize the methodology -- to put it into a plan for action that coordinates the activities of several bureaucratic units;

Technical skills, including skill in social marketing techniques, training and supervision of health workers in the field, producing print and broadcast materials, and in collecting and analyzing health-related data.

The DMHS senior staff's conceptual understanding of the methodology seems to have grown during the course of the MMHP project. Interviews in 1985, 1986 and 1987 with senior staff in the department reveal an increasing depth of understanding of the methodology's purpose and its characteristics.

In 1985 Spain and Snyder reported that the directors of the DMHS "were able to describe the important features of the MMHP approach....One regional medical officer said he had learned from the MMHP experience that: (1) the educational methodology emphasized "delivering the goods" -- not just disseminating information, but educating; (2) using resources appropriately; (3) building in evaluation; and (4) targeting a broad audience, including doctors, nurses, and community health nurses to mothers."⁶

⁶Ibid., p. 55.

Eckerson observed in 1986 that in the DMHS, "the same senior policy makers remain who were around at the beginning of the MMHP. These policy makers have espoused the MMHP methodology, and seek to resurrect it in a more Gambian, more sustainable fashion."⁷

Our interviews in 1987 with DMHS directors revealed that these senior people could discuss in depth the methodology and its use in the Gambian context. They were aware of the importance of research for message development, the need for training and supervising health workers who have line responsibility in using the methodology, and of the value of continuous, systematic collection and maintenance of health data.

In the years after the project ended, HEU staff members were also able to describe the methodology and discuss it in a manner that evidenced conceptual understanding. Spain and Snyder reported in 1985 that HEU staff members "understand the methodology and concepts behind it."⁸ Subsequent to the ending of the MMHP project, the new Director of HEU had received four months of training in London in the concept and methods of "distance learning" -- providing education through broadcast channels. He demonstrated the sophistication of his conceptual knowledge about the MMHP methodology during our interview as he discussed the similarities in concept and strategy between distance learning and the MMHP methodology.⁹

The institution did not acquire the managerial skills it needed to implement the methodology. There were two reasons for this. First, the project was not situated, as it should have been, on the directorate level in the DMHS; its implementation

⁷Eckerson, David, AID/AFR/TR/HPN, "Trip Report, The Gambia." U.S. Agency for International Development, Washington, D.C., October 1986, p. 11.

⁸Spain, P., *op.cit.*, p. 55.

⁹One of the evaluators (Manoff, 1986) did not find universal understanding of the methodology; it is not clear from that report, however, on what level or in what offices misunderstanding was perceived: "...there is considerable disagreement and confusion about what social marketing embodies among the different persons interested or disinterested in its application. Some people that were interviewed resisted the social marketing approach because they felt it meant the use of radio only".

became the responsibility of the staff of the HEU. Hindsight tells us that HEU staff members did not have the authority to manage the integrated efforts of several units. Staff members on the DMHS directorate level staff, who had that authority, were not trained to manage the integrated effort.

Since the integration of mass media and interpersonal channels is critical to the methodology, such integration must be managed on a level that has line authority to both channels. The HEU had no line authority; it provided service to other units in the department. The staff was not intended to have managerial expertise, and the project did not train them in management skills.

While its staff became skilled in designing messages for the mass media (broadcast and print), they could not work directly with the interpersonal channels. These channels consisted of health providers, who were trained by the Primary Health Care-Training Unit and reported to the Maternal Child Health Unit.

The second reason that the HEU staff was not adequately trained to manage the planning and implementation of the methodology was due partly to the independence in authority and resources that the AED project staff had from the Ministry. Although the project offices were physically attached to those of the HEU, the decision to bring HEU staff into the fold of decision-making and authority was not made until the project was in its second year. Then USAID agreed with the Ministry to "establish within the HEU an institutionalized capacity to carry on the MMHP project's educational methodology after the departure of the implementation staff."¹⁰

The strategy used to create within the HEU an institutional capacity to implement the methodology was a "mini-campaign." "The mini-campaign tried to incorporate all the aspects of the project's campaign strategies, compressed into a shorter time frame and with more modest goals reflective of the level of effort possible within the

¹⁰Ibid., p. 53.

HEU after the withdrawal of the foreign resources."¹¹ The intent of the mini-campaign was to allow the HEU staff to take responsibility for planning and conducting a health-education campaign which employed the methodology, while the project staff was still available for guidance. However, Spain and Snyder reported, the HEU was unable to provide a full complement for this exercise in management:

Central to institutionalization was the question of counterparts [HEU staff who would work alongside project staff in planning and implementing the project]. The implementation staff lobbied for a full time counterpart. Such an arrangement had already been formally agreed to in the project agreement, but the interruptions of training and the pull of many duties on the one or two people in residence had made the counterpart relationship a sometimes thing. To staff the mini-campaign, the Health Education Unit compromised with the implementation team: the mini-campaign was acknowledged to be a priority activity within the Unit. Both Gambian Health Inspectors [only two were on active duty in the Unit at the time] would spend major parts of their time on the mini-campaign though neither would be full time. The more senior Gambian, the director of HEU, involved himself in the planning phases of the mini-campaign, while the junior Gambian recently back from [training in] Nigeria, would work more on the operational side of the mini-campaign -- the research and pre-testing, the development of messages, the training of rural health staff, and the formative and summative evaluations.¹²

Nonetheless, our interviews with DMHS staff in 1987 indicate that no one on either the HEU staff or the DMHS directorate staff was taught to manage resources needed to use the methodology. Some DMHS people thought that the methodology required a high level of resources not available within The Gambia. They "discounted it as too costly for The Gambia because of its 'continuous requirements of external assistance and advisors.' Social marketing is not practical

¹¹*Ibid.*, p. 53.

¹²*Ibid.*, p. 54.

because...projects terminate 'when the faucet is turned off.'¹³ These kinds of statements reveal that DMHS staff members had not been taught to implement the methodology with the resources available to them, and they associated the methodology with a high price tag.

The technical skills that are needed to implement the methodology are:

- social marketing techniques,
- print materials production,
- radio program production,
- field-worker training and supervision, and
- data collection and analysis.

It appears that by the end of the project, The Gambians were practiced in social marketing techniques, graphic art and radio-program production, but did not know how to train or supervise fieldworkers, or how to collect and analyze health data:

Social marketing techniques. According to Spain and Snyder, the HEU staff learned from the mini-campaign "how much can be learned from research...the necessary discipline required to simplify the message, and...that they need to resist the temptation to try too much in one campaign."¹⁴ In other words, the two HEU staff members who participated in the mini-campaign learned how to use social marketing techniques in a campaign. (A third HEU Inspector had spent the first year of the project serving as a counterpart and becoming skilled in social marketing techniques. After a year though, she left the country for training, and when she returned she was assigned to the Nutrition Unit.)

¹³Lissance, Daniel and Ellen Piwoz, "Strengthening Family Planning and Nutrition Communications Programs in The Gambia." Manoff International Consultants, Washington, D.C., May 15, 1986.

¹⁴Ibid., p. 54.

Radio program production. The Rural Broadcasting and Adult Education unit of Radio Gambia (in the Ministry of Information and Tourism) was responsible for producing the radio programs that contained messages developed by the MMHP staff. During the project, the AED staff wrote the material for radio programs about oral rehydration therapy, and did not emphasize the development of the writing skills of Radio Gambia staff members. The radio staff were trained during two workshops (one on radio production in June 1982, and one on news reading in February 1984) and through occasional direct work with a consultant brought in to write radio programs. In spite of this training focus, the AED staff was not satisfied with the progress in developing programming at Radio Gambia, and did not think the workshops had made much difference in the staff's skills.¹⁵ In short, the institution acquired some new skills in radio program production as a result of the project, but these may not have been adequate to maintain implementation of the methodology.¹⁶

Production of print materials. The Book Production and Material Resources Unit in the Ministry of Education supplied the institutional capability for graphic art. The Unit appears to have had a sufficient level of skills to meet the project's needs from the beginning; it was "the most reliable unit", and, as a result of the project's donation of additional equipment, was probably able to serve its purpose in the institution's implementation of the methodology.¹⁷

Training and supervision. The Gambia had a health care and training system, extending from the DMHS headquarters down through the regional to the village levels. Health care in clinics and villages was provided through Maternal Child Health clinic system, and training was provided through the

¹⁵ACT interviews with MMHP project staff in 1985.

¹⁶ACT interviews with DMHS staff in 1987.

¹⁷Spain, P., *et al.*, *op.cit.*, p. 38.

Primary Health Care Training Unit. The HEU did not participate in the ongoing training of this extended system of health workers.

During the MMHP project, the project staff offered a series of training courses to clinic-based health providers in using ORT to treat dehydration. The clinic-based staff was instructed to relay this training to village-based health providers.

The health workers had learned from the project staff the importance of integrating interpersonal channels with mass media channels in communicating health messages to mothers. Spain and Snyder reported that:

By the time project radio broadcasts began on May 1, 1982, the rural health staff had been trained or invited to training. They were made to realize from the start that the campaign was an integrated effort, that they were a vital part of it, and they were able to identify and draw prestige and legitimacy from the radio messages....

This was not simply good public relations; it was the heart and soul of the project's substance. Utilizing the health workers so well and especially instilling so much enthusiasm within them was at least as important as the radio production or any other aspect of the project.¹⁸

But once the project ended, it was up to the Primary Health Care Training Unit to continue in-service training of health providers. The HEU staff did not participate in this training; thus one of the important links in the integration of the interpersonal channels and the mass media channels was effectively severed. Again, had the project staff worked with DMHS staff on a level higher than both the HEU and the training units, the integration of channels would have been more likely to be institutionalized.

¹⁸*Ibid.*, pp. 31-33.

Data collection and analysis. Except for providing a seminar during the mini-campaign on formative evaluation, the project does not appear to have focused any training activities for DMHS staff members on skills of health-data collection and analysis. Again, because the project did not directly involve the heads of the five vertical units, it appears not to have had any direct impact on the Epidemiology and Statistics Unit, which would logically hold the institutional capacity for data collection and analysis skills.

Summary. To summarize what we know about the institutionalization of knowledge about the MMHP methodology, we have found that:

Professionals in the directorate of the DMHS and the HEU acquired a conceptual understanding of the methodology;

Training in how to manage the integration of mass media and interpersonal channels was not given to DMHS directorate staff, who were best situated for this responsibility. No one appears to have been trained in how to implement the methodology in accordance with available resources.

Some of the technical skills required for implementing the methodology were acquired:

- Social marketing techniques by two HEU staff members (and one who was transferred out of the Unit);
- Some improved skills in radio programming by the Rural Broadcasting and Adult Education section of Radio Gambia;
- Possible refinement of existing skills in graphic art by the Book Production Unit in the Ministry of Education.

The project did not develop a systematic means of continuing to involve the health providers in clinics and villages in the integrated delivery of messages.

Data collection and analysis skills central to the methodology were not linked to the Epidemiology and Statistics Unit's ongoing operations.

In sum, the DMHS was left with staff members trained in social marketing skills, but not in the managerial skills required to implement the methodology on a level of effort to match their own resources.

ATTITUDES TOWARD THE METHODOLOGY:

We can make a distinction between the Gambians' attitudes toward the MMHP project and their attitudes toward the methodology. While the attitudes of DMHS and HEU staff toward the methodology as it was embodied in the MMHP project were generally favorable, their attitudes toward the methodology as an operation to be adopted and used by The Gambian government were generally skeptical. There were some exceptions to these generalized attitudes, which we will discuss.

The DMHS personnel embraced the MMHP project from the beginning, especially as it fit nicely into the Department's broad health objective. Although we know little about any fluctuations in their attitude toward the project, we can assume that they remained positive, since the project reported continual success and the Department consequently gained prestige and recognition from both within the government and beyond it, including public health planners and researchers worldwide.

After the project, the DMHS directors maintained a positive attitude toward the MMHP methodology, but expressed some doubt about whether it could be adopted in The Gambia. The new assistant director, who had replaced his successor after 1985, when the project terminated, appears, more than anyone else, to have had a conceptual grasp of the project that allowed him to believe that the methodology could be adapted for use within the constraints of The Gambia. When we interviewed him in 1987, he discussed the importance of testing messages, and he

suggested that the various units of the Department could share resources in the field in order to implement the methodology for their own purposes. He wanted to see the methodology used in other projects, such as malaria eradication and nutrition, but he felt that his department lacked the knowledge needed to incorporate the methodology into projects; he wanted further training in this area.

The new DMHS director, when interviewed in 1987, expressed a positive attitude toward the methodology as he had experienced it within the MMHP project.

The Health Education Unit. An advisor to the HEU during the course of the project, an expatriate funded by the British Overseas Development Agency, had opposed the project and its methodology from the onset. From an institutional standpoint, he should have played the key role in the project, acting as a counterpart to the AED project staff and acquiring the managerial skills needed to plan and implement the methodology. But he seems to have exercised enough influence to discourage better cooperation from the HEU unit.

So it appears that, while the DMHS directors favored the methodology during and after the project, the HEU's attitude was colored negatively by its director. In 1986 the consultants to the World Bank noted this discrepancy. Reporting the attitude of the DMHS, they remarked that as a result of its experience with the MMHP project, "the Directorate ... feels strongly that the forthcoming communications programs ... should be developed and conducted according to social marketing principles."¹⁹ In contrast, in noting the attitude of the HEU, the evaluators stated that "discussions of the social marketing process with HEU staff reveal that...there is a rather deep-seated skepticism, cynicism and resistance bordering on hostility to the use of social marketing...."²⁰ The HEU director is not specifically named as the bearer of this attitude, but in-depth discussions with other HEU staff members revealed positive attitudes toward the project.

¹⁹Lissance, D., et al., op.cit., p. 20.

²⁰Ibid., p. 23.

The other HEU professional staff member, the Gambian who eventually succeeded the expatriate as Health Education Officer, favored the methodology as he knew it in the MIMHP project. His attitude had been reinforced by what he had learned subsequent to his participation in the MMHP project during a training course in London on distance learning. But he was skeptical about the ability of the Gambian bureaucracy to adopt the methodology for use in its own projects. When we asked him in 1987 to define the strengths of the methodology, he answered in terms of the MMHP project's strengths: its autonomy in use of resources, planning and timing. He felt that his own unit was frustrated by a lack of control over transport, that his staff members were too busy and lacked the authority to properly plan and carry out the steps of the methodology in their projects.²¹

Of those remaining in the HEU unit, the health educator who had been most closely involved with the operations of the mini-campaign echoed the sentiments of his superior. He felt that they were constrained in using the methodology by not enough time or transport, and by a lack of support on the regional level and of incentives and support for field workers. He believed that, with the absence of the former expatriate health officer, morale could improve, but overall, he did not know enough about how to implement the methodology to feel confident that his unit could adopt it without the resources provided through the MMHP project. He too believed that while the methodology had worked well within the project, it could not survive outside of it: "While the project had funds, autonomy and flexibility, everything we do now has to go through channels."²²

Discussing the current activities of the HEU, an environmental-sanitation campaign and an AIDS awareness campaign, he noted that they had not been able to follow the methodology "strictly." Because they had no time to pre-test messages, they used "common sense" in designing them, assuming that they were "straightforward" and that people would understand them. The attitude toward the methodology of this

²¹ACT interviews with DMHS staff in 1987.

²²ACT interviews with DMHS staff in 1987.

staff person, who was the best trained and knew most about the methodology, was positive regarding the success it had brought to the MMHP project, but negative regarding its appropriateness for a country with such a low level of available resources as The Gambia.²³

The HEU had one other inspector on its staff in 1987 who was absent for training and on leave during most of the project. According to his colleagues when interviewed in 1987, he was "keen" on the methodology.²⁴

DMHS-unit heads and regional staff. Spain and Snyder found in 1985 that "other enthusiasts of the educational methodology included...most unit heads....[who] hoped the HEU would be attempting more grassroots education in the future." One regional medical officer praised the MMHP project for "educating" and not just "disseminating information", for "appropriate use of resources", for built-in evaluation and for the involvement of everyone from doctors to mothers.²⁵

The heads of the units expressed interest in employing the methodology in their own projects, and the Nutrition Unit went so far as to request an extension of the MMHP project for the purpose of nutrition education. (The project was turned down by the USAID mission).

Radio Gambia and the Book Production Unit. We have less direct information about the attitudes of staff members at Radio Gambia or in the Book Production and Materials Development Unit toward the methodology. They worked responsively and cooperatively with the MMHP project staff, evidencing a favorable attitude, and at Radio Gambia, they continued to have a good working relationship with the HEU staff.

²³ACT interviews with DMHS staff in 1987.

²⁴ACT interviews with DMHS staff in 1987.

²⁵Spain, P., *et al.*, *op.cit.*, p. 53.

Health providers on the village level. Although those who worked in the MMHP project on the village level (Village Health Workers and Traditional Birth Attendants) may not have been asked to understand the purpose and characteristics of the methodology, and although they may not have had opinions and feelings about the model as a concept, they developed attitudes toward the work they were asked to do in implementing the methodology. Our reports indicate that they were enthusiastic about their work as long as it was supported by the MMHP project, but demoralized when those project resources were pulled away.²⁶

Spain and Snyder described in 1985 a process in which major attention was focused on training and supporting the field health providers, who made up a critical channel of communication: the interpersonal communication channel. The health providers were brought together for several days of intensive training by the project staff, who helped them understand that the messages which they were communicating were being reinforced by print media and radio broadcasts. The evaluators concluded that the field health providers felt as if they were part of a team effort, and that their enthusiastic attitude toward their work contributed in no small part to the project's success.²⁷

But by 1987, when the MMHP project resources were gone, the morale among health providers in the field was low. They were no longer receiving any training or supervision in health education. (We do not know what kind of support they were getting from other DMHS units for other kinds of activities). The lack of support provided them with no incentives for working: transport was not readily available, their salaries were low, and they had poor working conditions.²⁸

Apparently the MMHP project had overcome these grievances to create positive responses to the demands it put on health providers. After the project had

²⁶ACT interviews with DMHS staff in 1987.

²⁷Spain, P., *et al.*, *op.cit.*, pp. 30-36.

²⁸Applied Communication Technology interviews with DMHS staff in 1987.

terminated, the Health Education Officer reported that field workers were no longer recognized in their role as health educators, they did not feel they were being listened to, and they missed the direct and regular contact with the staff at headquarters.²⁹ While this observation does not tell us anything directly about the field health providers' attitudes toward the methodology, it shows that their attitudes toward their work were strongly affected by the good management during the project of their efforts and coordination of those with the use of mass media.

Summary. To summarize what we know about the attitudes of those in the institution toward the methodology:

With the significant exception of the head of the HEU during the project, the professional health staff associated with the project had a favorable attitude toward the methodology as they experienced it in the project.

Once the MMHP project resources were pulled away, the staff of the HEU unit viewed the methodology as dependent upon the abundant resources that had been provided by the project. Their attitude toward the methodology as something they could implement within the structure and resources of their own government agency was skeptical. One of their senior staff in the DMHS retained a more positive attitude toward the methodology, and viewed it as something his agency could adopt if central and regional staff could learn to manage its components.

Other unit heads within the DMHS, regional health staff and village level health workers were enthusiastic about the methodology as viewed from their own vantage points during and immediately after the project. We do not know how unit heads and regional staff felt about the methodology two years later, but we know that village-level health workers had lost their eagerness to be involved in the methodology because they received no further training or support for their functions.

²⁹Applied Communication Technology interviews, 1987.

PUTTING THE METHODOLOGY INTO PRACTICE

In looking at practices within the DMHS related to using the methodology, we first look at the organizational behaviors that might be expected to change: staffing patterns, budget allocations, planning and operations. Then we examine the activities carried out subsequent to the institutionalization phase of the project to see how these might have been influenced by use of the methodology.

Organization and staffing patterns: As we discussed earlier, effective implementation of the methodology would require that a staff member with authority over the training and operations of both mass media channels (in this case the HEU, which produced broadcast messages and the Book Production Unit, which produced print materials) and interpersonal channels (the Maternal Child Health Unit, which directed health providers in the clinics and the villages, and the Primary Health Care Training Unit, which trained them). Ideally, the staff members responsible for managing the implementation of the methodology would also have a direct say in the activities of Radio Gambia and the Epidemiology and Statistics Unit, both of which needed to help implement the methodology.

But as we have seen, the MMHP project was situated in the HEU, where it could hardly penetrate rest of the DMHS, and had a limited range of authority. While staff members in the Directorate of the DMHS offered conceptual support for the methodology, they were not expected to commit either financial, material or human resources to its implementation.

In 1986 a new position, Diarrheal Disease Coordinator, was created and within the Department of Epidemiology and Statistics. The person hired to fill this position reported directly to the Medical Officer of Health (on the Directorate level). Although he had no line authority, his program was to be approved by the Directorate, and all unit heads were to cooperate in it. The Diarrheal Disease Coordinator had not been directly involved in the MMHP project, but his job description required that he "work with the HEU, Radio Gambia and others

interested and skilled in mass communication to ensure the continuation of a radio and poster programme...."³⁰

With this important exception, there appear to have been no material changes in the number of staff members or the nature of their responsibilities related to use of the methodology in either the DMHS or the HEU. During the MMHP project, counterparts to AED staff members had been assigned from the HEU and occasionally "borrowed" from other units. The first counterpart was a Health Inspector who, after one year, absented the office for training abroad and was then reassigned to the Nutrition Unit. After she left, counterparts were provided on an occasional basis. Even during the mini-campaign, for which the DMHS had committed a counterpart, the responsibilities were shared by the Health Officer (during the planning phase) and one of the Health Educators (during the operations phase).

When the project terminated, these two former counterparts remained in their positions in the HEU unit, together with one other Health Educator and a graphic artist. (The third Health Educator had been assigned to another unit, and a second-graphic artist slot was vacant). The unit had been strengthened in that its chief had studied distance learning in London, and the two Health Educators had attended the Public Health Education Center at the University of Ibadan in Nigeria, but there is no evidence that what they learned there was relevant to the methodology or had an impact on their operations. (Indeed, the institutionalization of the methodology may have suffered more from the absence of these inspectors during their training programs than it profited from what they learned abroad).

In the directorate of the DMHS, the number of positions and responsibilities of each do not seem to have been affected by the project. At least some of these senior-staff members favored the methodology from the time of the inception of the project. But their own job descriptions were never altered to include more direct responsibility for

³⁰Quoted from the "National Diarrhoeal Diseases Control Programme Job Description: Programme Coordinator" issued July 1986 by the Medical Officer of Health in The Gambia.

planning and implementing projects that used the methodology. Nor did they incorporate expertise in the methodology into positions with line responsibility.

One of the assistant directors of the DMHS, in discussions with us in 1987, recognized that it was not sufficient to limit expertise in the methodology to the HEU. The HEU had no direct line authority and was not expected to implement its own projects, but to serve the "education" needs of the other units. In spite of this recognition, however, no action was taken to reorganize responsibilities so that staff members with line authority would also know how to use the methodology.

This same assistant director saw the need for expertise in the methodology on the regional level -- between the central office and the village level health workers. But again, no action was taken to merge expertise into the operations on the regional level.

There is no report of changes in staffing patterns in either Radio Gambia or in the Book Production Unit. The inter-ministerial relationship of these two units with the HEU in implementing their projects settled into direct communication, avoiding formal channels, between the two units outside of the health Ministry and the staff of the HEU.

Budget allocations. The Gambian government was in a shrinking phase during and after the project, and there was not much opportunity to increase budget allocations anywhere. And, given the overwhelming responsibilities of all government officials, including those in the DMHS, there was little room for flexibility in budgeting. Nevertheless, except for an allocation to cover the cost of a Diarrheal Disease Coordinator, there are no indications of any significant budget reallocations in regard to the methodology. The vehicle which had been left to the HEU by the MMHP project staff was put into the pool for general department use.

The HEU, whose mandate it was to serve the "vertical" units, never gained direct budgetary control over its own projects. Its annual budget of roughly \$5,000 was to be spent on educational efforts in response to requests from the other units. Except

for some minor adaptations of pieces of the methodology, the HEU spent money after the MMHP project much as it had done so before the project: on developing health education curricula for school children and responding to the requests of other units in the Department.³¹

The question has been raised in USAID's study of the sustainability of the MMHP project in The Gambia whether the country had the financial resources required to implement the methodology on any level of effort.³² A major tenet of the methodology is that by integrating mass media channels with interpersonal ones, messages about recommended health practices can be delivered efficiently. Thus, insofar as the DMHS aimed to persuade mothers to use ORT, it did so more effectively at a lower cost by using the methodology than it would have by other means. If this is so, the issue is not whether the MMHP methodology is affordable, but whether any other effort to change health practices is more cost-effective than the MMHP methodology.

Planning and operations. In our discussions in 1987, members of the HEU staff claimed that though they could not afford to use the methodology, they used "parts" of the methodology in educational campaigns. We will look more closely at these "parts" in our subsequent description of the HEU's activities after the MMHP project.

In 1986 the World Bank consultants concluded that the HEU was not employing the social marketing techniques that are at the core of the methodology:

"HEU's orientation is on 'education' and 'provision of information' rather than 'communications' and 'innovation'. The Unit's interest in the materials is at the expense of the process that produces them. There is no attempt made to

³¹ACT interviews with DMHS staff in 1985.

³²Lieberson, J., D. Miller, D.Eckerson and H. Keller, An Evaluation of the Factors of Sustainability in The Gambia Mass Media and Health Practices Project, A.I.D. Evaluation Special Study No. 51. U.S. Agency for International Development, Washington, D.C., December 1987, pp. 8-12.

investigate the needs or problems of the intended target audience as the basis for message strategy development, nor does there appear to be any recognition of the need to segment audiences into clearly defined target groups. Pretesting of materials is reportedly conducted, but there are no written records or reports available for examination. No formal evaluation research is done on the effectiveness of the materials produced and disseminated. Basic principles of message design and dissemination -- simplicity, single-mindedness, clarity, repetition -- are generally disregarded.

"In sum, there is no evidence that any of the materials address issues of concern to their intended audiences or that they indeed accomplish the strategic objectives of the DMHS."³³

In assessing the planning procedures and operations of the DMHS, the consultants commented that:

"operations can best be described as ad hoc. While a sketchy and loosely formulated annual plan was prepared, there is no evidence that this plan is followed by the [Health Education] Unit, nor is there any indication that it is used by the Directorate as a management control tool.... Work is done as time, staff and resources permit."³⁴

There appear to be no notable changes in how the institution carried on its business as a result of exposure to the methodology.

Activities. Was there a noteworthy change in the kind of activities taken on by the HEU staff after the project? The one that comes closest to reflecting the methodology was an AIDS campaign done in 1987. The government wanted something to be done toward preventing the spread of AIDS, and had formed a

³³Lissance, D. *et al.*, *op.cit.*, p. 20.

³⁴*Ibid.*, p. 21.

committee to execute an AIDS education campaign. Assuming that nobody knew anything about AIDS, it was decided to forego a developmental investigation. A series of radio broadcasts was created to reach a general audience, based on information provided by the World Health Organization (WHO). The initial radio programs were broadcasts of taped lectures on AIDS given to groups such as the Women's [Council], and speeches (in all languages spoken in The Gambia) by the Director of the DMHS.

The radio broadcasts advised people to obtain the leaflet published by the DMHS. The leaflet, written in English, was pre-tested among people in the Department and their friends to see if it could be understood. The leaflet was available in May 1987, but as of August, no health workers had yet been trained in educating people about AIDS. Thus, the basic tenets of the methodology -- research-based message design, testing among the target audience, and integration of the interpersonal and mass media -- were not fully taken into consideration.

In response to an urgent need for help in garbage collection and clean-up, the HEU did a hurried campaign on environmental sanitation in mid-1987. Radio messages were developed without pre-testing because "there was no time for pre-testing" and the HEU thought that the messages they were putting across were "straightforward" and easily understood.³⁵

Other activities being undertaken in 1987 included in-service training of TBAs in ORT, development of radio broadcasts on family planning, and reprinting of some of the print materials on ORT. The new Diarrheal Disease Coordinator reported that he was involved in the in-service training of TBAs in the North Bank Region, and in revising messages and posters on ORT. Not having been involved in the MMHP project, anything he knew about the methodology would have been learned indirectly.

³⁵ACT interviews with DMHS staff in 1987.

The Rural Broadcasting and Adult Education unit of Radio Gambia continued to have a good direct working relationship with the HEU. Radio Gambia had a collection of messages to broadcast about ORT, and based on the priorities of the Diarrheal Disease program, selected messages to use from broadcast to broadcast. Subsequent to the MMHP project, all development-related programming had been reduced to one hour, thus further limiting the actual air time focused on health messages. Radio Gambia was reportedly using the information on its audience collected during the project, but was no longer pre-testing messages.

The Book Production and Materials Development unit was reportedly pre-testing materials.

Summary. In the final count, the methodology introduced by the MMHP project does not appear to have affected the staffing, budget, planning and implementation procedures or the activities of the DMHS and the HEU in a significant way. The staff members involved appear to have been unable to adopt the methodology to fit into their structure and resources. While some staff members were aware of how the methodology could have been employed, they did not use it because their perceived inadequacy of time, money, staff and logistical support.

SUMMARY AND CONCLUSIONS

Summary. The communication methodology introduced in The Gambia by the MMHP project is based on two major tenets: first, messages must be developed on the basis of research to insure that mothers can comprehend and act upon the messages. Second, the integration of interpersonal and mass media channels reinforces the messages that mothers hear.

The MMHP project built on these two tenets as it guided the development of the methodology, and succeeded in demonstrating the efficacy of the methodology in changing the behavior of rural Gambian mothers in their treatment of diarrhea in infants. During the third year of the project, the staff endeavored to transfer the knowledge and skills need to use the methodology to the Department of Medical and Health Services, and in particular, to the Health Education Unit of that department.

This transfer, or institutionalization, of the methodology was a critical goal. Without it, the Gambians could not maintain the practices needed to influence mothers' behavior in treating infant diarrhea, nor could they use the methodology in other health-education projects. We have analyzed the extent to which the MMHP methodology was institutionalized in the DMHS: the extent to which staff members in the Department acquired the knowledge, skills and attitudes required to adopt the methodology. We have found that in 1987, three years after the project terminated, the DMHS was left with an incomplete knowledge of the methodology, a mixed attitude toward it, and virtually no change in the way it developed and implemented health education projects.

In regard to knowledge, senior staff members in the department had a sound conceptual understanding of the methodology -- its purpose and characteristics. But neither they nor their subordinates had practice in managing the implementation of

the methodology or adapting its basic tenets and techniques to a particular project. Within the HEU there were staff members with skills and experience in social marketing techniques, but none who could "go head to head with expatriate communications experts...to talk about the Gambian success and what to do next."³⁶ Staff members in the Book Production Unit had learned to pre-test print materials, and at Radio Gambia, they knew how to pre-test programs.

The most common attitude toward the methodology among those who had worked with the MMHP project was that, while they were positive about its demonstrated success and would be happy to see it employed again in other health projects, they were skeptical about its usefulness to The Gambia without the accompanying abundant resources provided by foreign governments. Most felt they were not prepared to design a project based on the tenets of the methodology and implement it with the limited resources of their own government.

In practice, the DMHS and the HEU did not change the way they designed and carried out projects with public health education components. Developmental investigations were foregone, pre-testing of messages was done haphazardly, if at all, and there is no evidence of formative evaluation. The link between the interpersonal communication channel (health providers in clinics and villages) and mass media channels (radio and print) was not maintained. Neither the organization and staffing pattern, budget, planning processes nor the activities of the DMHS appear to have been permanently affected by the project.

Conclusions. The communication methodology introduced by the MMHP project in The Gambia was not fully institutionalized. Based on what we learned from the attempt to institutionalize the methodology in this case, we conclude that the following measures will help government agencies adopt the methodology for use in their own programs:

³⁶Eckerson, op.cit., p. 11.

- Those who are responsible for implementing the methodology must thoroughly understand the basic tenets upon which it is based so that in the face of scarce resources they can decide wisely what is most important to do.
- The locus of project management must be within the institution it serves from the earliest phase of the project. Although the MMHP project was nominally attached to the HEU, the activities of the first two years of the project were managed outside of it, without involving DMHS staff on a daily basis, and circumventing the normal bureaucratic channels for getting things done. The goal of institutionalizing the project occurred as an afterthought, and not enough time or resources were committed to that process.
- Staff members with line authority over the units which operate both mass media and interpersonal channels must be trained to manage the implementation of the methodology. They must know how to transform the methodology from an abstract into concrete terms, using the limited resources available to them. No one in The Gambia was taught to manage the integrated use of several media channels. The counterparts assigned to the project had no line authority or managerial responsibility; their function was limited to the development of messages to be delivered through broadcast and print media.
- Those who will have managerial responsibilities once the technical assistance team has left must be involved in the project with the team on a daily basis in order to become familiar with planning and implementation issues. Due to a shortage of counterparts in The Gambia, and circumstances which prevented any one counterpart from participating in the entire project, this did not happen.
- Even though the project budget may depend heavily on foreign donor funds, it needs to be prepared and monitored in conjunction with the funds available from the government agency, so that the government is prepared to reduce the scope of its endeavors in subsequent projects or to seek other foreign-

donor assistance as needed. The MMHP project appears to have relied almost completely on foreign funds, and the limitations of The Gambian budget for health education was disregarded.

The local staff must be taught to train and supervise field staff, as well as to perform other technical skills. Although the Gambians were taught social marketing and media production techniques, they were not taught to train and supervise the health workers. Thus, no procedures were established for maintaining this important channel.

It is not our intention to lay blame at the feet of anyone for the shortcomings in the process of institutionalizing the MMHP project in The Gambia. In this case, the decision to institutionalize the methodology came too late, and the time allotted for doing it was too little. But we think that the case of The Gambia provides important lessons about procedures to use in helping other governments adopt the methodology for their continued support of ORT use and of other health projects.

Our final conclusion is that the methodology needs to be separated from the high costs associated with it as a research and development effort. What the Gambians observed in the MMHP project would hardly resemble a low-cost manifestation of the methodology that they might plan and execute in their own programs. We recommend that USAID and its contractors assist ministries of health to acquire the knowledge and skills they need to use the methodology within the limitations of their own financial, material and staff resources. This should boost the likelihood that the benefits of ORT use and related child-survival health-practices will be maintained.

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Persons interviewed by ACT:

1987:

Dr. Hatib N'Jie, Director of Medical Services
Dr. M. Cham, Assistant Director of Medical Services
Dr. Matthew Baldeh, Diarrheal Disease Program Coordinator
Mr. Sekhou Dibba, Director of the Health Education Unit
Mr. Sekhou Ceesay, Health Educator
Mr. Adama Jeng, Health Educator
Mr. Musa Marenah, Training Officer (Primary Health Care Training Unit)
Sister Bertha M'Boge, Senior Public Health Nurse
Mr. Yaya Sanyang, WHO Country Representative

1985:

Dr. Fred Oldfield, Director of Medical Services
Mr. Paul Robson, Director of the Health Education Unit
Mr. Saihou Dibba, Assistant Director of the Health Education Unit
Mr. Saihou Ceesay, Health Educator
Dr. K.O Jaiteh, Director of the Epidemiology Unit
Mr. Musa Marenah, Training Officer (PHCTU)
Mr. Paul Chinnock, Nutrition Advisor
Dr. Akim, WHO Country Representative