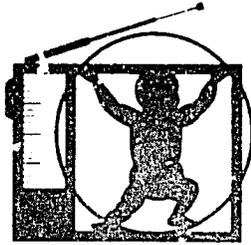


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Communication for Child Survival
HEALTHCOM

Office of Health and Office of Education • Bureau for Science & Technology • Agency for International Development

SUMMARY REPORT

HEALTHCOM Regional Workshop – Asia

**Puncak, West Java, Indonesia
May 29 – June 2, 1989**

HEALTHCOM ASIA REGIONAL CONFERENCE

EXECUTIVE SUMMARY

HEALTHCOM held an Asia Regional Conference in Puncak, Indonesia from May 30 through June 2, 1989. This meeting brought together five HEALTHCOM Resident Advisors and six host country counterparts from the current projects in Papua New Guinea, the Philippines, and Indonesia (Jakarta, Central Java, West Java) as well as two Washington-based Country Program Managers and the A.I.D. Chief Technical Officer. The goal of the meeting was to frankly share experiences and critically analyze the HEALTHCOM methodology and approach. The agenda topics included country status reports, methodology development, research and evaluation, sustainability and institutionalization, and training.

There was unanimous agreement that the HEALTHCOM methodology was simple, complete, and practical and needed no major alterations except for a simplification of the terminology used to describe it and a streamlining of formative research approaches to provide quicker results for decision makers--including more emphasis on monitoring systems. The participants felt HEALTHCOM should strive to develop host country research and evaluation capabilities by working with and through local groups. The participants wondered if the results of country experiences and research had wider applicability: are there universal messages for some interventions that transcend national boundaries? to what extent can communications materials be utilized in a new geographic area following basic revisions?

HEALTHCOM's focus on behavior change of parents should be expanded to include decision makers and MOH staff. The participants outlined that staff development needs of a range of personnel. To counter the feeling that "communications are expensive", health communicators need to present cost-effectiveness data and create an awareness that communications programs for complicated health interventions (e.g., CDD) would be more expensive than programs with simpler messages (e.g., Vitamin A capsules). Special communications campaigns should fit into overall national plans, develop materials that will continue to be used, have pre-set objectives, and focus on increasing awareness; long-term behavior change would primarily occur through an integrated communications program.

The counterparts strongly felt that HEALTHCOM Advisors should be allowed to assist with a range of MOH programs--not just child survival efforts. Their communications expertise was needed in many health programs, and the methodology would have an increased chance of institutionalization. On the question of moving from small-scale to large-scale, there was general agreement on an

approach of "Think Big--Start Small--Go Big." In other words, initially develop a large-scale, long-term health communications plan; identify a nationally representative "test" area and develop and demonstrate the communications program; and then refine the program and replicate on a large scale using the most cost-effective media.

DAY ONE: COUNTRY REPORTS: WHAT WE'RE DOING AND HOW

The first day of the conference was spent on country reports by the Resident Advisors and their counterparts which reviewed the communications activities they were conducting and the issues and problems they had faced. Detailed notes on most of the presentations are given in the appendix. The programs discussed were:

1. The work of the Center for Community Health Education (PPKM) in Jakarta to promote health communications, support provincial efforts, and encourage the development of national communications guidelines for CDD programs. Dr. I.M. Mantra, Director of PPKM, Gertruide Tampubolon, senior staff member, and Dr. John Davies, HEALTHCOM R.A.
2. The West Java CDD Intensification Program was described by Mr. Lukman, program administrator; Drs. Omay Sitisnaputra, head of the PKM West Java office, and Terry Louis, HEALTHCOM R.A. The West Java program had been working since 1985 to promote ORT use through a phased intensification program that has grown from one regency (kabupaten) to five.
3. The Central Java ROVITA program was reviewed by Drs. Victor Sartono, Head of the PKM Central Java office, and Tom Reis, HEALTHCOM R.A. This is a Mission-funded program managed by Helen Keller International that is promoting the administration of megadoses of Vitamin A capsules to children under five for two months a year through the Posyandu system. The program also has begun promoting ORT as well.
4. The program in Papua New Guinea is promoting ORT and helping to train Aid Post Orderlies in ORT and counseling techniques. Tau Lakani, District Health Supervisor, and Andy Piller, HEALTHCOM R.A., reviewed this program and presented and discussed a video tape that they had produced for the training of A.P.O.s in how to counsel mothers on ORT.
5. Activities in the Philippines were described by HEALTHCOM staff members Ernie Hernandez and Nora de Guzman. The Philippines program has just concluded a successful mass media campaign for measles immunization in the Metro Manila area. Plans are now underway for a national immunization media effort. The program has also begun media work on ORT including the development of a highly

creative animated spot featuring the dread monsters "Dehydration" and "Diarrhea".

During the country presentations, the conference facilitators noted significant issues as they arose out of the discussions. These issues were as follows:

1. Health education/communication manpower development
2. Managing the budget flow for communications
3. The acceptability of external evaluation
4. Role of the Resident Advisor: big five child survival interventions plus other interventions?
5. Changing CDD treatment policies
6. Enhancing inter-sectoral cooperation
7. Maintaining quality of training-of-trainers to the bottom level of a pyramidal training structure
8. Methods and means of pre-testing
9. How do health educators and physicians work together?
10. Institutionalizing successful techniques
11. Sustaining programs after funding ends
12. Documenting costs of field activities
13. Choosing low cost and cost-effective approaches
14. Monitoring
15. Using volunteers and other community workers
16. Moving from small-scale to large-scale
17. Involving the retail sector
18. Do communicators follow national or provincial guidelines and policies?
19. Communications for diarrhea prevention instead of treatment
20. Reinforcing positive health worker behavior
21. Sustainability of high impact programs
22. Reducing stresses on health services by high impact programs
23. Developing close cooperation between communicators and health program staff
24. Gaining the acceptance of the medical community of health communications, social marketing, etc. (public and private sector)

These issues were reviewed and categorized according to the general topics already listed on the agenda and became the basis for the discussions on those topics.

DAY TWO: REFINING AND IMPLEMENTING THE METHODOLOGY: HOW WE'RE WORKING AND HOW WE CAN IMPROVE

The morning was spent on a discussion of the methodology: its essential elements; major implementation challenges; and needed skills.

RESEARCH, DEVELOPMENT, AND EVALUATION

The discussion focused on several questions:

1. What research is essential to effective communication programs?
2. How should research be done to make it more manageable and relevant?
3. What action steps should be taken?

The discussion of these issues followed several main themes:

1. What research is needed?
2. What types of research have we used?
3. Formative vs. summative research
4. How well do we conduct communications research?
5. The roles in research of international T.A., MOH, subcontracted agencies, a research agenda

RESEARCH NEEDED

The research needed depends on the intervention, product, country's needs, and existing information. Counterparts noted that a capacity for research might not exist at the local level and that it would probably be necessary to get help from the central level. The discussion identified many types of information needed for a communication program. These were:

- I. Audience Identification and Characterization Information
 - A. Socio-economic and demographic data (e.g., literacy rates)
 - B. KAP information
 1. don't necessarily need large-scale surveys
 2. in-depth interviews, focus groups, and perhaps behavioral data may be required
 3. desk research: find out what exists first
- II. Communication Channels: What media is available to reach the target audience?
- III. Disease Specific Information: gaining an understanding of the disease
 - A. Epidemiological data
 - B. Present practices in its treatment
 - C. Environmental factors

- D. Types of data needed include qualitative, KAP, and perhaps specific data related to the intervention such as weaning foods, etc.

IV. Related Behaviors and Interventions

V. Research on Influential People

- A. Community leaders and others who may affect parents' decisions
- B. Information on who makes decisions on health care practices at the family and treatment level

VI. The Four Ps of Marketing

- A. What is available, where, at what price?
- B. Need to use a marketing framework

VII. Training Process Evaluation

VIII. Research on Health Policies

RESIDENT ADVISORS AND RESEARCH

It was noted that the type of research/evaluation undertaken in a country often relates to the expertise of the Resident Advisor. This reflects a natural tendency to undertake the type of research (e.g., marketing, anthropological) one is familiar with. R.A.s should become more familiar with a range of research.

The Resident Advisors noted that it would be helpful for them to get more support during their initial 3-6 months in the country both for planning and logistical matters. It would be helpful to have the initial Letter of Agreement state interventions to be addressed and some of the objectives to be accomplished during the technical assistance.

The Country Implementation Plans should focus on a longer term than just HEALTHCOM's first two-year involvement. The communication plan should take a longer term view of the country's needs and then take into account HEALTHCOM's initial participation.

STANDARD RESEARCH PACKAGE: THE HOLY GRAIL?

All participants felt a need for a "package" of research activities/methods that could and should be applied. A question

that was raised is whether such a package could be developed that is applicable in different parts of the country crossing over linguistic and cultural boundaries. KAPs are generally the same for each group.

The technical messages of health education may be used from area to area, but they cannot just be translated. Communicators must adjust their creative approach to match the target audience. When one presents a message, one may have to do it in different ways. We need to conduct small scale/quick research to determine how research methods could be made more suitable for the local level.

HEALTHCOM R&D

There needs to be more inter-country sharing of results. HEALTHCOM should explore the transferability of program materials between countries. Are there enough similarities in KAP and message basics that can be transferred without special adaptation? Are there universal messages to be delivered for each intervention? The presentation of those messages may vary from country to country. The key symbols used for a communication program may vary with the culture. HEALTHCOM should look at the strategy behind communication campaigns (e.g., common diarrhea message of getting child to drink fluids) and see if R.A.s in different countries find similarities. Overall, it is important for HEALTHCOM to examine the research that has been conducted so far for common points of interest and applicability across countries.

USE OF RESEARCH METHODS

Each program was discussed in terms of the types of research that has been undertaken to date. A summary of this research and an indication of the degree to which it was used is contained in the following chart.

COUNTRY	ANTHROP.	MARKET	BEHAVIORAL
W. JAVA	*	*	*
C. JAVA	*	**	*
JAKARTA	*	*	*
PHILIPPINES	*	****	* (ARI)
P.N.G.	existing	*	*

Among the problems cited in trying to do research was finding good organizations with which to work. Another priority was helping the MOH to understand each research component and supporting the MOH and the implementing agency. In some cases local resources like universities can be tapped for research

expertise. Pre-testing activities may also be used to get additional information from the target audience.

Since anthropology focusses on how people get and transmit knowledge, local anthropologists can be helpful in gathering information about mothers. There is no real need to develop a global ethnography that looks at the overall culture.

One of the problems with research is the analysis of data. It has taken a long time to get additional analysis from the large-scale KAPs. Simple frequency tabulations are available much faster and can be used by planners to look for trends/points of importance before the detailed analysis is done by experts. Some small-scale studies such as that conducted by Survey Research Indonesia with 120 mothers has proven to be very useful.

Focusing on BEHAVIOR allows for the use of different approaches/tools (e.g., anthropologists, marketing companies, etc.). They can perform different types of research. HEALTHCOM-Asia has involved a number of approaches. The West Java program has been able to utilize a number of indigenous resources for some research from university faculty to private sector advertising and research firms. PPKM-Jakarta has used market research but had difficulty analyzing all the data.

With a plethora of previous research and current researchers in country, the HEALTHCOM staff in Papua New Guinea have been able to gather important information informally through contact with anthropologists. The Philippines has used an anthropologist for some initial work on ARI but has largely depended upon market research by local firms. Unlike anthropology and behavioral psychology, marketing is not an academic discipline but an eclectic approach that takes from a variety of fields.

MAKING RESEARCH MORE MANAGEABLE AND RELEVANT

One of the challenges facing health educators is conducting research that is manageable by MOH personnel and relevant to the issues at hand. Some of the points brought up in this discussion were:

1. The host country generally needs HEALTHCOM's help in developing and managing research and in developing the long-term research and research management capability of local staff. Research decisions are often made at the national level; therefore it is important to work with those decision makers (e.g., National Research Board, MOH Research Division).

2. There is a need to coordinate research with local research authorities.

3. Outside technical assistance consultants supplied by HEALTHCOM have to recognize that they come under the Resident Advisor and his counterparts. The consultants need to work through them to identify what is needed and how to proceed.

4. There may be a danger in doing too much pre-program research. It may convey the impression to policy makers that too much time is being used for research. We must limit research to what we need for media and message development.

5. Sometimes we do too much formative research. We need to do more pre-launch small-scale interventions to see how well our communication program works before launching a full-scale effort. It may be more prudent to first try out our communication efforts in one village, or in an area served by one radio station, or in one district. In any case, a small amount of pre-program research is necessary, and it should be simple, practical, and workable. We should think more about using the pattern of:

INITIAL
RESEARCH

MOCK-UP
TRIALS

FLIES
OR
FAILS

6. HEALTHCOM needs to depend more on local analysis since the turnaround time from U.S. companies is much too long.

**DAY THREE: SUSTAINABILITY, INSTITUTIONALIZATION, AND TRAINING:
WHAT WILL WE LEAVE BEHIND?**

Sustainability refers to behavior change being maintained over time. Institutionalization refers to HEALTHCOM's ability to build an organizational capacity within our counterpart agency for communication program planning and implementation.

Sustaining behavior change should be a concern even at the initial pilot project phase. Ministry of Health officials should have an appreciation for the fact that behavior change entails a long-term intervention program. Thus, if the HEALTHCOM in-country presence is only for two to three years, there should be a long-term, five-year communication program perspective. The HEALTHCOM workplan should be within the context of what will be required, communication program-wise to maintain behavioral changes initiated under the HEALTHCOM project.

Because the aim of HEALTHCOM is to institute sustainable behavior change in its target audiences, it puts a premium on programs that are designed to avoid pitfalls of high impact programs, such as national immunization programs, which are not sustainable in the long run. Thus, the Philippine measles

immunization campaign uses, exclusively, fixed health center facilities in its Metro Manila and nationwide urban campaign. Funding continuity is an important aspect of sustainability. As a HEALTHCOM program activity moves from pilot phase to large-scale replication, the government and other donor support must be encouraged so that activities do not come to a halt after global funding support through the HEALTHCOM program has ceased.

Institutionalization of a capacity for communication program management is a priority. Training of Ministry of Health counterparts is the mechanism through which institutionalization can be achieved. Training can be formal, such as seminars and lectures, or it can be informal, such as through an active, on-the-job training of counterpart staff. Both types of training are valuable. As more HEALTHCOM country programs mature HEALTHCOM must find ways to share the project experience cross-culturally. Thus, one concrete suggestion made by the Asia workshop participants is the possibility of holding an international conference on "Communication for Child Survival" where case studies from country projects across HEALTHCOM sites can be shared.

Following is a table presenting an analysis of training needs. (See Attachment.) It describes who needs to be trained in what skills and using which training methodologies.

DAY FOUR: AED ISSUES ON PROGRAM MANAGEMENT

The last session of the conference involved only Academy personnel and focused on the issues identified by field staff. The issues that were discussed were:

1. AED's ability to predict A.I.D.'s decisions

Some field staff felt that AED could do a better job of anticipating the chances of A.I.D. approval for actions such as equipment procurement and subcontract hire. Given AED's extensive history in working in this area, some staff felt that AED should be more willing to take a risk and authorize actions by field staff (such as purchases) even before A.I.D. provides their approval. This would prevent some harmful delays launching field work. In many cases, AED already knows that A.I.D. contracts will eventually approve a request, but it may take months to get that approval because of a heavy workload at A.I.D. contracts office.

2. AED efficiency

Sometimes getting approval from AED adds another degree of difficulty to implementing field activities. This defeats one of the purposes of a buy-in from the Mission perspective. They hope that a buy-in will lead to a faster decision and facilitate the

flow of project funds. In reality, the Missions may see their funds transferred to Washington where they are subject to another layer of bureaucracy that slows field activities. This is especially apparent in local subcontracts. The Philippines has experienced major delays in completing important subcontracts because the paperwork has been delayed in AED.

3. Site Selection

In the process of considering buy-ins, HEALTHCOM needs to carefully examine the country situation so that it has a realistic picture of the potential of that site. If a Resident Advisor is put into a bad situation to begin with, there may be little s/he can do to make that program a success.

HEALTHCOM should also establish realistic expectations for each country program. The situations, resources, and constraints of each situation are different and it is unrealistic to have the same level of expectations for each program. During the site analysis and initial planning, HEALTHCOM should strive to set realistic goals for each program and not assume that the methodology will be implemented to the same degree of success and extent in all sites.

4. Resident Advisor Orientation

This needs to be expanded and standardized. One R.A. spent only half a day at AED before his departure. HEALTHCOM should be as clear as possible about its expectations for the Advisor's first 12-14 months in-country. While the objective should be stated, there should also be enough flexibility in those objectives to allow the Advisor to develop the program according to the local situation.

5. Letter of Agreement

All agreed that HEALTHCOM needs strong Letters of Agreement before proceeding with work in the field. The country situation should be thoroughly assessed and the letter should set down the Who, What, Where, and When of the situation including counterpart staff and support.

6. Beginning in a New Country

It is extremely important for the new Resident Advisor to hold talks with the Mission to understand exactly what they want from HEALTHCOM. It would be very helpful if the Mission would also take responsibility for introducing the new R.A. to all of the key players.

At least one R.A. believed that the Country Program Managers should supply more assistance in the first 3-6 months helping the

Resident Advisor to get established and to develop the program.

When coming into a new country, HEALTHCOM staff should give a presentation to key people at the Mission and the government on HEALTHCOM's organization and objectives. A video presentation would be particularly useful. It could highlight HEALTHCOM's emphasis on improving child health and survival and promoting behavior change through a special focus on reaching mothers.

It is important to document any agreements made with host country officials. If a Letter of Agreement has not been concluded after a visit, the HEALTHCOM staff should at least send a memo back to all discussants giving the details of what HEALTHCOM perceived was agreed upon. This would allow an opportunity for any misunderstandings to be cleared up before a program is agreed upon and a Resident Advisor is posted.

7. Publications

The group reviewed the need to have Mission, host country, AED, and S&T approval before an article is published. All articles should be cleared locally and sent back to the Country Program Managers for clearance in D.C. also.

8. Consultant Contracts

In drawing up contracts, it would be helpful if some time was allowed for additional work by the consultant back in the U.S. In many cases there is a need for the consultant to do some additional work required by the job either before departure or after his return. If the contract is written with this flexibility in mind, it will not be necessary to draft a second contract to cover a few days of activities.

TRAINING NEEDS

PERSONS	ESSENTIAL SKILLS	METHOD
Decision makers	General Knowledge & appreciation of communications	Conferences, field exposure to international work, systematic presentation of results, audiovisual presentations.
Program managers	Same as above, motivational methods, supervising methods, familiarity with method	More involvement in field, more OJT, management workshop, case studies, comparison studies.
Health Educators	Communication skills, communication management process, training skills, planning and budget skills.	OJT, Local short-term training, video, workshops, internships for marketing, site visits, skill transfer.
Health workers	Care Personal training skills, counseling skills, planning, specific skills for monitoring and pretesting.	Workshops, video, site visits, rewards, supervision, mass media, newsletters, include in basic training program.
Researchers	Small-scale techniques, working with units, presentation skills.	OJT, Cooperative efforts.

DISCUSSION SCHEDULE
HEALTHCOM/ASIA REGIONAL CONFERENCE
May 29 - June 22, 1989
Puncak, Indonesia

MONDAY, MAY 29: TRAVEL AND INTRODUCTIONS

01:30 Departure from Borobudur Hotel
03:30 Arrival and Registration at Bukit Raya Hotel in
Puncak
05:30 Dinner
07:30 Introductory Meeting and Get-together

TUESDAY, MAY 30: COUNTRY REPORTS: WHAT WE'RE DOING AND HOW

08:00 INDONESIA: JAKARTA REPORT: Pak John, Pak Mantra, and
Pak Gertruide
09:15 INDONESIA: WEST JAVA: Pak Omay, Pak Terry, and
Pak Lukman
10:30 BREAK
10:45 INDONESIA: CENTRAL JAVA: Pak Victor and Pak Tom
12:00 LUNCH
01:00 PAPUA NEW GUINEA: Pak Pau and Pak Andy
02:15 BEHAVIORAL STUDIES: INDONESIA AND PNG: Pak John E.
03:00 BREAK
03:15 THE PHILIPPINES: Pak Manuel, Pak Ernie, Ibu Nora

WEDNESDAY, MAY 31 REFINING AND IMPLEMENTING THE METHODOLOGY:
HOW WE'RE WORKING AND HOW WE CAN IMPROVE

08:00 METHODOLOGY DEVELOPMENT:
Essential Elements and Their Refinement
Major Implementation Challenges
Additional Methodological Concepts
Needed Skills
Interpersonal Channels
Interventions
Community Participation

12:00 LUNCH

01:00 RESEARCH AND DEVELOPMENT
Integrating Methods
Essential Elements
Improving Interpersonal Techniques
Future S & D Focus

EVALUATION

Summative-Formative Relationship
Appropriate Outcome Measures
Developing Evaluation Capacity
Affordable Data Collection Methods
Communications Monitoring

THURSDAY, JUNE 1: SUSTAINABILITY, INSTITUTIONALIZATION, AND TRAINING: WHAT WILL WE LEAVE BEHIND?

08:00 **SUSTAINING AND INSTITUTIONALIZING THE METHODOLOGY**
Definitions
Essential Elements
Models To Follow
Measurements of Success
Strengthening Government Commitment
Methods of Collaboration

12:00 LUNCH

01:00 **TRAINING AND CURRICULUM DEVELOPMENT**
HEALTHCOM successes to date
Fundamental Skills
Key Elements of a Curriculum/Training Program
Target Audience and Methods
Strategies to Institutionalize Training
Next Steps

06:30 Bilateral Issues: HEALTHCOM and Host Country
06:30 Closing Dinner

FRIDAY, JUNE 2: AED/HEALTHCOM ADMINISTRATION AND MANAGEMENT

08:30 AED Staff Meeting: Mutual Support Systems for Field
and Home Office Staff (will continue to late
afternoon until all major issues are discussed)

09:00 Checkout and Departure of Host Country Counterparts
to Jakarta and Bandung

PARTICIPANT LIST

Ny. Geertruida Hutahaean Tampubolon
Pusat Penyuluhan Kesehatan
Masyarakat - Dep. Kes. R.I.
Jl. Pasar Minggu No. 17
Jakarta 12780
Indonesia
Tel.: 7992524

Robert Clay
Deputy Chief
Room 714, SA-18
Agency for International Development
Washington, D.C. 20523
Tel.: (703) 875-4761

Terry Louis
Consultant USAID
Dinas Kesehatan
Jl. Ternate No.2
P.O. Box 433
Bandung, Indonesia
Tel.: 43506 - 50960

Thomas K. Reis
HKI-ROVITA
Tromol Pos 546/SM
Semarang 50002
Jawa Tengah
Indonesia

Dr. John Davies, P.H.
Social Marketing
Pusat Penyuluhan Kesehatan
Masyarakat, Jl. Pasar Minggu 17
Jakarta Indonesia 12780
Tel.: 7992524

Dr. I. B. Mantra
Pusat Penyuluhan Kesehatan
Masyarakat, Jl. Pasar Minggu 17
Jakarta Indonesia 12780

Lukman Hamid
Jl. Prof. Eyckman
45 Bandung
Indonesia
Tel.: 81075

Drs. V. Sartono, SKM
Departemen Kesehatan Republik Indonesia
Wiiayah Propinsi Jawa Tengah
Jl. Imani Bonjol 209 Telp. 20470
Semarang
Indonesia

Tau Lakani
Department of Central Province
Division of Health
Free Mail Services
Konesobu
Papua New Guinea
Tel.: 214281

Omay M. Sutisna Putra
Dinas Kesehatan Prop. D.T. 1 Jabar
Jl. Ternate No. 2 Bandung
Indonesia
Tel.: 50960 - 435026

John Elder, PhD.
Associate Professor and
Head, Division of Health Promotion
School of Public Health
San Diego State University
San Diego, CA 92182
Tel.: (619) 594-2997

Nora de Guzman
HEALTHCOM
c/o PIHES
Department of Health
San Lazaro Compound
Rizal Avenue, Manila
Philippines
Tel.: 711-6245

Andrew Piller
Health Communications
P.O. Box 7137
Boroko
Papua New Guinea
Tel.: 217033 ext. 22

Cecilia C. Verzosa
Senior Program Officer
HEALTHCOM
Academy for Educational Development
Suite 400
1255 23rd Street, N.W.
Washington, D.C. 20037
Tel.: (202) 862-1283

Dr. Willard Shaw
Senior Program Officer
HEALTHCOM
Academy for Educational Development
Suite 400
1255 23rd Street, N.W.
Washington, D.C. 20037
Tel.: (202) 862-1276