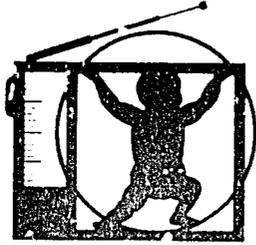


PA-A1311 6/31

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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**

**Third Annual  
Technical Advisory Group Meeting**

**February 23, 1989**

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**Technical Advisory Group Meeting**

**HEALTHCOM Project**

**February 23, 1989**

**Academy for Educational Development**

**Washington, D.C.**

**SUMMARY REPORT**

The third annual Technical Advisory Group Meeting of the HEALTHCOM Project focused to a large extent on the results of two important project events. The first of these was an independent midterm evaluation of the HEALTHCOM Project, conducted from September through November of 1988, through the Office of International Health, DHHS, by a team of four professionals with backgrounds in health, social science, and management sciences. The team's draft report (issued February 1989) provided the basis for further project review during a two-day Health Communication Task Force meeting by selected members of the TAG, and five outside health and communication experts. The 17-member Task Force addressed a series of issues raised by the evaluators. These issues were grouped under the topics of methodology development, sustainability and institutionalization, and research and evaluation.

The evaluation report, together with reports by the Task Force, served to guide the TAG agenda. Evaluation team leader, Dr. Abraham Horwitz, gave the group a summary of his team's findings, and individual task force members presented the core or responses which had emerged in the previous two days of discussion. This TAG was then charged with making specific recommendations for new directions and activities to be pursued during the remainder of HEALTHCOM I.

**MORNING**

Ms. Anne Tinker, Chief, Health Services Division (S&T/H), moderated the morning sessions of the TAG meeting.

**I. INTRODUCTORY REMARKS**

**Dr. Nyle Brady  
Sr. Assistant Administrator  
Bureau for Science & Technology**

Dr. Nyle Brady opened the TAG meeting with thanks and congratulations to those at HEALTHCOM and A.I.D., in particular, and others who have helped increase the broad acceptance and use of communication in support of development efforts. The importance of communication and social marketing goes beyond the child survival arena, into areas such as agriculture, AIDS, and nutrition. It is time now to think of making these approaches part of the development culture. Sustainability of efforts should be a major focus. ICORT III demonstrated the power of involving national leaders and those

within government bureaucracies in laying a foundation of awareness within their ministries. Many challenges remain. We should continue to investigate the factors which influence positive health behaviors, which actively involve community networks, and which effectively support service delivery, so that knowledge will eventually permeate society.

## II. SUSTAINABILITY AND INSTITUTIONALIZATION

### Statement of Issue

How can HEALTHCOM strengthen the commitment of host governments to permanent health communication programs? What type of "government-entry strategies" and conditions precedent should the project develop so that the process of institutionalization can begin with project start-up? How can the project most effectively strengthen its training of principal counterpart staff, and diffuse knowledge and skills in health communication within a country? Should HEALTHCOM more actively seek to influence the curricula of health and other training institutions, or focus its immediate efforts on upgrading the health communication capacity of the existing health system and personnel? How can HEALTHCOM elicit more active participation in health communication programs from the private commercial sector? How should the project try to strengthen its collaboration with NGOs and PVOs, both internationally and locally?

### Introduction

Dr. Gerald Hursh-César  
Intercultural Communication, Inc.

Dr. Hursh-César, a member of the evaluation team, defined sustainability as the persistence of behavior change within a target group after the project has withdrawn from a country. Sustainability is difficult to recognize in the short term, because changes in health behavior need to be measured over successive generations. In a project's early years, criteria will focus on the practices of individual mothers; criteria will eventually shift to indicators of reduced disease prevalence. The evaluation team suggested that the process of sustainability could be strengthened by increased efforts in face-to-face communication. Health worker training, and monitoring of that system's effectiveness, can provide a framework for sustaining change.

If sustainability refers to caretakers' practices, institutionalization refers to the practices of organizations. Successful institutionalization will be based upon the simultaneous capability to deliver services, and to create demand. Dr. Hursh-César described four areas in which progress can be measured: within the public sector; the private sector; education systems (within universities, among pharmacists, in secondary and primary schools); and at the village level. The evaluation also proposed that the methodology itself could be refined so that it could be more quickly adopted in a given environment.

## Task Force Report

Mr. Mark Rasmuson  
HEALTHCOM Project

Mark Rasmuson summarized the Task Force's recommendations regarding ways to strengthen institutionalization. Formal training opportunities for project counterparts should be a priority. So far funds have not been available for long-term training in health communication (e.g. masters degrees); this should be considered in the future. Although overseas training is often followed by reassignment to other positions, such programs will eventually help build a pool of skilled personnel.

Examples of suggested training models included programs arranged by the CCCD Project (with assistance from UNC and Tulane) and the CDC Global EIS Program. One important consideration is participants' expectations of degrees or credentials of some kind. The Task Force supported the idea of an annual conference (such as that arranged by CDC for the Global EIS Program) which gives participants a chance to present research findings, share experiences, and receive technical support and recognition from colleagues. The group also discussed training courses and internship programs with collaborating private sector institutions in the U.S., such as those offered by the SOMARC Project and USTTI. An important first step in the area of training will be to develop a comprehensive curriculum in health communication which can then be adapted to both long-term and short-term training programs. The HEALTHCOM methodology manual provides a good basis for a curriculum, and last summer's Faculty Workshop resulted in curriculum development activities at five U.S. public health schools. The final development of a curriculum should probably be a HEALTHCOM II activity. However, HEALTHCOM already is planning various new counterpart training activities, including collaboration with CCCD and Tulane in conducting a health education short course in Zaire for francophone Africa participants later this year.

The project can also, in the short term, assure greater involvement among counterpart organizations by engaging in more collaborative planning during project start-ups. In Zaire, for example, HEALTHCOM recently held an implementation workshop that included participants from national, regional, and zonal levels. This contributed to a genuine sense of commitment in the project's objectives. HEALTHCOM can also more actively involve international groups such as WHO, PAHO, and UNICEF in in-country planning activities. At the same time, the Task Force agreed with the evaluation team's recommendation that more explicit statements might be made to host countries about conditions precedent to the project's successful institutionalization, and that termination of assistance be an option if such conditions aren't met. A level of financial and personnel commitment (possibly a formal research counterpart) might be proposed. HEALTHCOM should also develop with a host country a plan for phasing out technical assistance over the long term.

Greater collaboration can be sought with the private sector, including private commercial groups, PVOs, and NGOs. Specifically, the Task Force recommended A.I.D. consider establishing a small grants program which would allow HEALTHCOM to engage PVOs having particular strengths or networks within a community, to carry out some aspect of project implementation.

While training is crucial, the Task Force also affirmed the need for collaborators to gain personal experience that the methodology works. Demonstrations of success help assure the methodology's acceptance by and institutionalization within an organization.

## Discussion

Dr. Emile McAnany (University of Texas at Austin) stressed the importance of identifying who should be trained and in what skills. Further specification is needed, both of target audiences and objectives. Dr. Clifford Block (S&T/ED) said that once skills have been specified, various simple written "job aids" should be developed, which may remain part of a system after those individuals involved in initial training may have left.

Dr. Horwitz emphasized that financial sustainability must also be explicitly planned, because external assistance cannot go on forever. Although government officials may change, his experience has been that they take commitments seriously to promote health and nutrition. In addition, HEALTHCOM needs to have high level USAID mission support to provide a channel for policy dialogue and institutional reviews.

TAG representatives from WHO and UNICEF described what their organizations are doing to institutionalize the health education and communication aspects of their programs. Mr. Luis Rivera explained that UNICEF conducts an initial situation analysis at the country level, which covers financial allocations to communications, government policies in this regard, the location and staff of health education units, mass media, and social organization networks (grass roots, private sector, PVO, and political). The goal of the analysis is to build upon existing country capacities, and to utilize these fully. Often a good cadre of trained individuals is available in-country. However, problems often arise because communication professionals are not planning specialists, and vice versa. In the past UNICEF tried to promote communication, education, and information strategies among program managers by sharing policy documents. However, they have now shifted to an active training process for those at the decision-making level. Since instituting the program, in-country investment in these areas has jumped from 10 to 25 percent. Mr. Rivera offered to share the training package with the Academy and resident advisors or other key people. He also emphasized that UNICEF is pursuing greater collaboration at the country level with all organizational players. A recent meeting with 17 agencies, including AED, confirmed the common elements of communication methodologies, and stressed the need to pool resources. Mr. Rivera added that AED's own experiences and contributions have become an important part of the institutionalization process.

Ms. Cathy Wolfheim mentioned that WHO also stresses the utility of building a communication policy into a country's program, so that a commitment can more easily survive changes in decision-making personnel. In addition, WHO believes that, to become a real partner in the process, it is essential for the organization to remain active in-country over the long term.

One of the overriding themes of HEALTHCOM's evaluation report was the need to view institutionalization as a long-term process, requiring 15 to 20 years. Robert Clay (S&T/H) said this new view gives us a better understanding of the difficulty of the process, and also suggests the wisdom of a phased approach. Some countries may require an initial promotion phase which demonstrates the effectiveness of the methodology before they will commit to other aspects of institutionalization. Mr. Clay also remarked that HEALTHCOM can tap into the resources of local PVOs and NGOs in areas such as community participation, and draw upon their skills and expertise in this area.

Ms. Anne Tinker (S&T/H) asked the TAG to comment on the relationship between an intensive, long-term program approach and shorter-term technical assistance, in view of the sustainability issue. Ms. Wolfheim stressed that continuing relationships make

work progress, but can also result in dependence on outside assistance. One approach is to concentrate efforts in a few important sites; another is to make sure countries are not pushed faster than they are able to go. TAG participants affirmed the value of an in-country resident advisor, while suggesting short-term assistance can provide initial impetus for an institution's interest. HEALTHCOM and AED have pursued several ways of sharing the methodology, including regional workshops, the methodology manual, and assistance with the WHO communication manual. Broader in-country diffusion is necessary, although the costs of doing this might be high.

Eugene Chiavaroli (S&T) asked how the Bureau, which is charged with both conducting research and transferring technology, can develop better ways of diffusing a methodology. Dr. John Austin (S&T/H) suggested that one approach is to set an example at home. Before putting pressure on ministers, we should be making sure projects within A.I.D. are communicating, and that a technology such as HEALTHCOM's is shared with those working on malaria, water and sanitation, and other problems which have serious public education implications. A.I.D.'s Office of Health would benefit from holding a coordinating meeting on health communication; similarly, donors and collaborating agencies might convene such groups in-country to explore opportunities for cooperation. With this foundation the next step would be for governments to hold their own communication policy meetings, perhaps with donors as observers, to strengthen in-country networks. This is essential for governments to feel they own and manage the process. Mr. Rivera said UNICEF would be interested in providing financial assistance to both types of fora.

At the same time, we shouldn't expect to solve the world's problems within the next ten years. According to Robert Clay (S&T/H), HEALTHCOM's successes so far have depended on an approach which emphasizes discrete activities that can be accomplished within a given time frame. When governments do understand the power of communication, they sometimes adopt unreasonable expectations about how much can be attempted. Maintaining the project's quality and focus should always be a priority. Resident advisors are already burdened with a tremendous scope of work.

Several participants discussed the meaning of the word "streamlining," in view of this concern about quality. Dr. Robert Hornik (Annenberg School of Communications) cautioned that we may do the project a disservice by telling governments the methodology can be accomplished with "less." Commitments to health education and communication are traditionally very low, and governments need rather to increase their investments--in terms of both finances and personnel. We need to continually emphasize the importance of combining preventive and curative approaches. Dr. William Smith (AED) pointed out that HEALTHCOM has so far been conscious of the need to establish levels of quality. Are focus groups doing more than providing better anecdotes, for example? Are we producing quality data? In the future this emphasis may shift. Participants confirmed the value of maintaining a research and development component in the project, to investigate the further refinement, or possible streamlining of the methodology.

### Summary Conclusions

1. The TAG supported the evaluation team's recommendation that sustainability and institutionalization be viewed as long-term processes, possibly requiring a phased approach. Activities to promote these processes can be increased. Options include training (both short- and long-term), an

annual conference, more collaborative planning, and more explicit negotiation of conditions precedent to project start-up. Some of these activities (e.g. long-term training) may be appropriate for HEALTHCOM II.

2. Efforts to engage the private sector, PVOs, and NGOs, should increase. HEALTHCOM II might include a small grants program for PVOs.
3. Demonstrations of the methodology's success play a major role in gaining government commitment. To an extent, project success has hinged on its ability to focus on discrete objectives during a specific time-frame.
4. HEALTHCOM should continue to maintain a research and development component. In the future, this might be directed at investigating whether and how the methodology might be streamlined.
5. An Office of Health-sponsored meeting on health communication, involving major participants at the central and country level, would be a useful way to promote collaboration, networking, and ownership of the project.

### III. FUTURE DIRECTIONS OF THE METHODOLOGY

#### Statement of Issue

Should/can the HEALTHCOM Project strive towards a standardized, streamlined package of formative research that can be applied across all sites? What can reasonably be simplified in the methodology while still maintaining appropriate quality and impact standards? Can/should HEALTHCOM use other methodological concepts? What interpersonal channels should receive greater priority? How can the project best engage community participation in program planning and implementation? What skills are key to the methodology? What does HEALTHCOM hope to leave behind when it leaves a country?

#### Introduction

**Dr. Emile McAnany**  
**University of Texas at Austin**

Increased interest in the applicability of communication to development issues is both gratifying and also problematic. As expectations grow regarding what communication can achieve, so also do misconceptions about the process. After an initial phase of enthusiasm about communication during the 1960s, development professionals began justly to criticize the process for creating expectations it could not fulfill. Skepticism in the 1970s has given way to another phase of enthusiasm; we should once again be cautious of making promises which cannot be kept.

One of the great achievements of those at A.I.D. in the 1970s, and also projects like the Stanford Heart Disease Prevention program, was a new emphasis on the importance of achieving verifiable outcomes. The success of programs such as Stanford's, however, left the impression that only the mass media can provide sufficient reach among target populations to effect behavior change. The HEALTHCOM methodology is not simply a mass media methodology; but the association has been made. We should be vigilant in seeking effective alternatives to mass media, or in

combining mass media with appropriate technologies such as face-to-face communication, especially with health workers.

Increased agreement that behavior change is the ultimate goal of health communication gives us further reason for both congratulations and caution. While there is now general acceptance that communication programs must focus on the audience, on empirically or data based decisions, and on coordination of efforts, it is easier to discuss these goals than to carry them out--and it is significantly less easy to teach others in developing countries how to carry them out. Can the methodology be reasonably transferred? HEALTHCOM's approach is really common sense; it overlaps significantly with the methodologies of other agencies. To an extent such a methodology can be "demystified," and its vocabulary can be simplified. But we underestimate the cultural challenge of taking a pragmatic, data-based, empirical way of planning, and assuming it can be carried out by people with little motivation or training--whether here or in developing countries. The methodology requires a new way of thinking by people on a large scale. The success UNICEF and WHO have had in training their own agency people is encouraging. This process may begin to diffuse down to ministries and others.

### Task Force Report

Dr. William Smith  
HEALTHCOM Project

The goal of streamlining the methodology can be looked at in two ways--with the object of streamlining what's being done, and with the object of streamlining how we discuss it. With regard to the first, the methodology has three characteristics: 1) It puts great weight on research, asking that people work empirically rather than only intuitively; 2) It is a multi-channel methodology (emphasizing broadcast, print, and interpersonal communication). This makes it more challenging than many approaches which are driven by a single channel; 3) It is multidisciplinary. The methodology talks about different professions working together. The Task Force spent most of its time discussing whether or how the fundamental empirical base of the methodology could be streamlined. They proposed several options. For example, HEALTHCOM might look at reducing or standardizing the number of research techniques used. However, another approach is to focus on the research decisions which need to be made. HEALTHCOM can help program managers focus on the five or ten key questions which need to be answered in regard to a given technology. We now have experience with different "product categories" and our knowledge can illuminate the decision-making process.

Various suggestions were made regarding how to streamline the language of the methodology. Vocabulary can be simplified, jargon and unnecessary labels removed. The health practices component of the methodology can be integrated, rather than isolated. It is time to make fewer references to disciplinary differences. We should focus on developing a single coherent curriculum. This task will itself force us to determine what decisions are key to the methodology. HEALTHCOM might hold a workshop entitled "What Really Matters." Perhaps ten people who have been engaged in practicing the methodology should try to reach consensus on priority areas for institutionalization efforts.

The Task Force proposed that attention to streamlining requires simultaneous attention to the goal of professionalization. HEALTHCOM must assure that it is doing a good job so that standardization of methods will be valuable. There was concern that the attempt to streamline might end by trivializing the methodology. This can also happen through an oversimplification of language. There is no advantage in making something appear simple when it is not. We should determine the minimal quality standards for

specific elements. But we should also be practical. It may be that far fewer elements than are suggested in the manual will really be sustainable.

### Discussion

Mr. Rivera suggested that it would be appropriate to conduct audience research on the users of the methodology--in-country decision-makers and technical people. Users' expectations may center on behavior change, or on institutional mobilization, or on policy development, or on financial or other areas. Whether appropriate or not, these expectations should affect HEALTHCOM's approach to streamlining the methodology. A KAP of users would help determine what types of decisions and results users value, and what is available in the methodology to help them. While the methodology should require some minimum quality standards, it will inevitably be subjected to natural variations in the field. Different levels of constraints will determine what stages might be skipped. The project should assess how the model can be "planted" in different environments.

Dr. Smith noted that the methodology also varies according to the background and emphasis of individual resident advisors and consultants. Perhaps this isn't bad, but points up the value of an overall disciplinary balance. Dr. Smith also cautioned that as the power of communication is realized in a country, HEALTHCOM is sometimes asked to assist in its inappropriate use--such as an election campaign--and this has to be avoided.

HEALTHCOM staff were asked to comment on the roles of other parts of the government and of nongovernment groups in the methodology. In Ecuador, HEALTHCOM worked with the Ministry of Education and successfully mobilized school children to go door to door, inviting mothers to have their children immunized. Dr. Smith said this approach can be particularly useful to launch a program, but is not sustainable over long periods. Establishing a curriculum at the primary and secondary level can stimulate direct interaction among teachers, students, and parents. This channel, however, is most appropriate when 5 to 10 years can be invested for these program activities. Similarly, community volunteers require long-term support. Community activities in The Gambia were extremely successful in the short run, but the government did not support the Red Flag village volunteers after HEALTHCOM ended. The best strategy is to identify ongoing community networks which can be tapped into but will persist after HEALTHCOM leaves. The Task Force recommended increased involvement of community leadership structures as a path towards sustainability.

Dr. Horwitz suggested that these issues are peripheral to the main question: can the methodology be simplified and standardized in some manner so that it can be applied internationally? Mr. Rasmuson responded that the Task Force took this question very seriously. (Further discussion under Issue III.) The group felt hindered by a lack of guidance in the evaluation report regarding what was in the minds of the team, and also by a sense that a dissection by this group of the different stages and techniques of the methodology would be premature. The minimum essentials of the methodology are not self revealing. However they may become clear through research. The Task Force believed that an important contribution to streamlining would be to approach the process through the perspective of what key management decisions are required in a communication program. This framework, varying from one child survival technology to another, might be proposed initially through a country-by-country analysis to survey what research techniques have been used in what contexts, and so forth. Robert Clay mentioned that HEALTHCOM has already conducted a number of "experiments" regarding the methodology. Programs in certain countries have received less funding,

and in some instances one advisor has been active in two or more countries. Generally our experiences in streamlining through reduced effort and reduced resources have shown reduced success.

Elizabeth Herman (The Johns Hopkins University) remarked the group was clearly uncomfortable with defining streamlining as "simplification." It might be useful rather to investigate the range of obstacles to efficient use of the methodology. In particular, the creative and interpretive aspects of the methodology, the processes involving use of data to make decisions, or to design messages, are extremely challenging. The steps of the methodology are not individually as difficult as is the process of going from one step to the next. This underlying characteristic of the methodology--that it rests upon a way of thinking, rather than just a series of techniques--makes it particularly resistant to a "recipe" approach. Dr. Horwitz agreed that, in efforts to improve nutrition surveillance systems around the world, for example, data management is improving, data analysis is improving, but decisions based on data are hardly moving. There followed a discussion on the value of computer models as an aid to data-based decision-making. Anne Tinker summed up the session with the observation that communication is indeed as much an art as it is a science.

### Summary Conclusions

1. An effort to streamline the methodology's techniques will benefit from a country-by-country analysis of what aspects have been used for what purposes and with what success. This exercise will help overcome the tension between theory and practice.
2. HEALTHCOM must distinguish between what can be standardized in terms of techniques, and what is required in terms of decisions. More attention should be given to the very difficult creative and interpretive steps of the methodology.
3. HEALTHCOM should look at the possibility of deriving a model and data set that can be used to demonstrate aspects of decision-making with regard to different child survival technologies in developing countries.

### AFTERNOON

Mr. Robert Clay, Deputy Chief, Health Services Division (S&T/H), served as moderator of the afternoon sessions of the TAG meeting.

## IV. EVALUATION—PROCESS AND OUTCOME

### Statement of Issue

HEALTHCOM's midterm evaluation report recommends that the project shift from an evaluation strategy focused on outcomes to one focused on process. What would be the nature and implication of such a shift? Are other outcome measures more appropriate than those used now? For example, would case fatality rates be meaningful measures of project success? What level of evaluation capability should HEALTHCOM strive to

institutionalize in its country sites? How can this process best be accomplished? The evaluation report suggests a number of "low cost and easily teachable methods of data collection." Which of these should HEALTHCOM consider for implementation in the short and long term? How can HEALTHCOM best improve the systematic monitoring of communication interventions? What indicators and methods should be highest priorities?

### Task Force Report

Elizabeth Herman  
The Johns Hopkins University

Dr. Herman commented that although the TAG Meeting's agenda lists evaluation and research as separate topics for discussion, both areas involve the collection, processing, analysis, and interpretation of data. The Task Force found that, given the iterative nature of the HEALTHCOM methodology, there is a great deal of overlap between monitoring, evaluation, and research. Dr. Herman chose to discuss two specific recommendations offered by the evaluation team: 1) that the focus of HEALTHCOM's evaluation strategy shift from outcome indicators to process indicators, and from summative purposes to formative purposes; and 2) that the HEALTHCOM evaluation methodology should be better institutionalized.

The Task Force discussed the first recommendation at great length. They interpreted the basic issue as a question of whether it is appropriate or not to continue spending money to prove the methodology works. Would it be better to focus resources on improving and institutionalizing the methodology? An argument can be made that summative evaluation should focus on institutionalization as an objective, and should not focus on the achievement of behavior change. The Task Force was in agreement that the use of outcome indicators is integral to the HEALTHCOM methodology. (Outcome indicators measured by HEALTHCOM at this time pertain to behavior change rather than mortality or case fatality rates.) Data collected to measure behavior change feeds into various loops of the methodology, so the distinction between formative and summative evaluation is vague. The purpose of using outcome variables is not necessarily to prove that the methodology works, but that the specific approach or messages apply to target audiences at a specific point in time. A country needs to know if its program is working. However, this assessment will also help improve the methodology.

Many questions about the methodology remain to be answered. If HEALTHCOM is to determine the minimal inputs necessary to achieve the desired results (for the purpose of "streamlining"), it is necessary to assess the outcome achieved using different levels of inputs. HEALTHCOM is still learning about applications of the methodology to technologies other than CDD and EPI.

An alternative question might be whether the project should be considering models for behavior change which are less data dependent. However, Dr. Herman asserted this is a peculiar suggestion in view of the empirical nature of the methodology. Yet another question might be whether we can use the cumulative experience of 10 years in 17 countries to determine the most critical pieces of information to be collected, the minimal requirements for frequency of data collection, the rigorousness of sampling techniques, and so forth. This returns to the issue of streamlining.

The evaluation team's recommendations regarding institutionalization of the evaluation process involve two issues: the level of expertise in evaluation that HEALTHCOM should seek to institutionalize; and the processes and mechanisms that can

be used to facilitate the institutionalization of evaluation capacity. It was the Task Force's understanding that the level of sophistication in data collection, analysis, and interpretation that characterizes the work by Applied Communication Technology and Annenberg was not intended to be institutionalized. The distinction should be made between evaluation conducted to answer questions proposed by A.I.D. about the methodology, and evaluating the specific interventions carried out in a given country. Institutionalization of the latter clearly is an important goal. HEALTHCOM can perhaps do a better job of leaving data behind and of using country nationals in the collection and analysis of data. Training to develop their skills and expertise should be more routine. The project should develop a more systematic approach to institutionalizing this aspect of the methodology.

### Discussion

Dr. Horwitz remarked that the evaluation team did not think the HEALTHCOM methodology could be expected to show reductions in mortality, although governments may want the project to do so. A.I.D.'s nutrition communication program in Indonesia offers an example of the problem. They were able to show large reductions in mild and moderate malnutrition, but little effect on severe malnutrition. Behavior change cannot be expected to alter such serious problems. He suggested that case fatality rates may relate more closely to the impact of the methodology. Dr. Horwitz also commented on the variations in certain measurements of behavior change, for example some of the knowledge, attitude, and practice (KAP) measurements relating to Litrosol use in Honduras, and speculated on whether impact can ever be adequately demonstrated. Monitoring, on the other hand, should be carried out according to terms laid out by a planning process--in relation to clearly stated objectives and clearly identified activities.

Dr. Robert Hornik agreed that although the project's goal is ultimately to save lives, HEALTHCOM cannot collect a large enough sample, or sufficiently separate causal effects, to measure changes in mortality meaningfully. The project has not attempted this for some time. It is also difficult to measure and attribute causal effect to changes in behavior. However, in certain cases, for certain technologies (for example PREMI's vaccination interventions), reasonable associations can be made. While recognizing the difficulty of these issues, the Task Force confirmed that measures of behavior change can illuminate in what ways a given program has and has not been effective. Mr. Bradshaw Langmaid (S&T) said a team needs to be constantly aware that its primary goal is sustainable behavior change, and many audiences are unfortunately still unconvinced of the links between communication and this goal. We must continue to try to show causal relationships.

Dr. Marjorie Pollack said that the general view of the Task Force was not in favor of comparative case fatality rates as a means of measuring impact. (Case fatality is a ratio of the number of deaths due to a disease, to the total number of cases of that disease. It can be measured with regard to the general population, to a community, or to a health care institution.) If, for example, measures are being taken of a hospital population, seasonal variations and changes in treatment patterns may produce a rise in case fatality rates, when mortality is actually decreasing, and vice versa. Other indicators may prove valuable, however. One of these might be a measure of the degree of dehydration presenting at a hospital or clinic, since one of the project's goals is to reduce dehydration associated with diarrheal episodes.

HEALTHCOM has learned a great deal from its longitudinal CDD study in Honduras. Dr. Dennis Foote (ACT) said that the many point measurements have been

useful for estimating general trends, but difficult for estimating precise levels. The more use we make of single large estimates of what is going on in a given country, as opposed to continuous monitoring, the less likely we are to know what is really happening. The study has shown the importance of confidence intervals. Dr. Foote also explained that the 80 percent usage rate which their study reported for Litrosol was a cumulative, ever-used measure. Case treatment rates have varied from 25 to 45 percent. However, the important policy implication is that a lot is happening, and rates do in fact seem to be rising. Regions, for example, which were not exposed to the HEALTHCOM intervention but were exposed to the later, less intensive national (or "institutionalized") intervention achieved almost the same rates as the pilot areas. There is still a great deal to learn about level of effort required to achieve impact and sustainability.

Several TAG members commented on the special challenges of measuring ORT use. Progress has been made in standardizing the definition of usage, and data do show that incidence of use is rising. However, difficult questions remain about how much of this is effective use, and what the definition of effective use really is. Studies about the volume of ORS administered by mothers have been disappointing. In addition, many mothers are producing high sodium concentrations, even with packets. Effort should be put into coming up with better clinical norms for appropriate use, so that mothers are being asked to follow reasonable guidelines, and so we can determine what incidence of use is really necessary to affect mortality rates.

HEALTHCOM's behavior observations have been particularly valuable in studying some of these questions. Dr. Block suggested that, in a project's formative stages, much effort is put into examining how mothers think and how they choose behaviors. Perhaps more of this needs to happen during monitoring stages. Dr. Herman said that anthropological studies have shed much light on how mothers think about fluid replacement. She expressed interest in collaborating with HEALTHCOM on some of the work she has been doing with WHO.

### Summary Conclusions

1. The TAG found problematic the evaluation team's recommendation that outcome indicators be replaced by process indicators. The TAG affirmed that measures of behavior change are valuable to country programs. However, the distinction between formative research and summative evaluation is somewhat arbitrary in the HEALTHCOM methodology; often what is evaluative of one stage of the project is formative for the next. The TAG recommended that HEALTHCOM move away from this distinction and focus increasingly on a continuous monitoring orientation and activities that serve both formative and summative purposes.
2. The TAG agreed with the evaluation team's recommendation that it is not HEALTHCOM's job to measure changes in mortality. However, such changes are the ultimate goal of a HEALTHCOM Project, and governments should be encouraged to collect such data.
3. Behavior studies, focus groups, and other studies of how mothers think and choose behaviors should be carried out beyond the formative stages of the project, in order to test hypotheses in depth.

4. If clinical norms can be improved, communication objectives will be more reasonable and more effective. To the extent appropriate, HEALTHCOM should collaborate with WHO and with governments in this area.
5. Some confusion remains about the degree to which HEALTHCOM evaluation activities are carried out to satisfy questions posed by A.I.D. and the degree to which they can be devoted to questions by in-country audiences. However, HEALTHCOM should focus more on leaving data behind and on using country nationals in the collection and analysis of data. Training to develop their skills and expertise should be more routine. The project should develop a more systematic approach to institutionalizing this aspect of the methodology.

## V. RESEARCH AND DEVELOPMENT PRIORITIES

### Statement of Issue

What can HEALTHCOM do better to use and integrate research methods from marketing, ethnography, behavior analysis, and other disciplines? What are the minimum essential elements of an effective formative research program? What important contributions has behavior analysis made to the methodology? What lessons have been learned and need to be applied to make face-to-face networks truly effective? How can HEALTHCOM use community participation in program planning and implementation? The midterm evaluation report suggests a number of possible areas for future research and development efforts. To which of these should HEALTHCOM assign highest priority?

### Task Force Report

Dr. Marjorie Pollack  
Consultant

Dr. Dennis Foote  
ACT

Dr. Marjorie Pollack said the Task Force looked at a series of research and development questions posed by the evaluation team report. Some of these pertained to the issue of streamlining. For instance, is the model too research-driven, and can it be simplified, or rather refined? Other questions pertained to the issue of institutionalization. Should there be a research counterpart in country under the ministry, for example? Still others pertained to longer-term research directions. The evaluation report emphasizes the need to look beyond the short-term, to a process which will continue over 10 or 20 years. The Task Force therefore discussed some possible directions for HEALTHCOM II. The participants agreed with the evaluation report recommendation that HEALTHCOM should investigate the possibilities of applying the methodology to new audiences--suppliers, ministries, health care providers, and so forth.

The Task Force confirmed the value of a variety of ongoing research efforts, including behavior studies (which can become more integrated in the methodology), focus groups, KAPs, and so forth. However, the members agreed with the evaluation report recommendation that the project should study whether the level of complexity of the research being conducted is essential to achieve minimum levels of quality.

Dr. Foote outlined a number of specific questions which should be subjected to straightforward empirical study: Is it possible to reduce various inputs (technical assistance, research efforts, etc.) and if so, what are the trade-offs? Can specific skills be transferred effectively to ministry counterparts? Is it possible, and what is required, to institutionalize this methodology? It will be fruitful to synthesize much of the rich, divergent situation analysis being conducted by Annenberg. In addition, A.I.D. has produced a wealth of information regarding the transferring of technology, which can be drawn upon in these studies.

The evaluation report, and the Task Force, gave serious attention to the role of face-to-face interaction and community participation. Dr. Foote provided some historical perspective on this issue. Mass communication was first embraced enthusiastically 25 years ago because it spoke to many problems that seemed insurmountable. Interpersonal networks in governments or communities were lacking; the resources required for development were great; the logistics appeared impossible to support; quality control was lacking; and there was no equity of access. Sustaining any effort based on community participation and mobilization, moreover, has always been extremely difficult. Mass media provided new kinds of solutions, and different limitations. Now, the question is how to combine the strengths of different communication channels. As interest swings back to face-to-face channels, however, the project should keep in mind what problems were encountered years ago, and the limitations that were discovered in interpersonal and community-based channels.

Dr. Foote reviewed recommendations suggested earlier in the TAG (and reported under Issue I) for improving face-to-face and community-based activities.

### Discussion

Mark Rasmuson summarized some of the work HEALTHCOM has carried out with health providers, and with the "supply side" of child survival. Activities have ranged from design of treatment protocol posters for physicians in Honduras and The Gambia, to a physician study with Ciba-Geigy and several volumes of child survival references in Ecuador, to an improved training methodology for community health volunteers in Indonesia. Lessons learned in Indonesia about basic instructional principles have been incorporated into training programs for health workers in Nigeria and Honduras. The project can do a great deal more, however. At the same time, we have to recognize the constraints ministries commonly put on who can conduct training and how. Governments do not see HEALTHCOM as a training project. Mr. Rasmuson said at best our focus needs to be narrow--we must find opportunities to influence health education without threatening how a system is set up; we can help refine training methodologies; we can plug into existing supervision systems and build in monitoring components. Priority goals will include better monitoring of training, and more follow-up training. We must also consider the heavy management implications of training programs. We have to recognize how much is required of an advisor and counterpart, and provide appropriate resources for face-to-face efforts.

Dr. Block pointed out that we easily confuse the obvious fact that face-to-face communication is a powerful influence on behavior, with our relative ability to design effective interventions using this medium. We know that peer pressure and social mobilization really dictate behavior to a great extent. But this doesn't mean we have learned how to influence that process effectively. On the other hand, we do know that mass media does affect social norms, and that, as a result of sustained mass media effects, face-to-face channels are also mobilized.

Mr. Rivera said UNICEF is very familiar with the challenges of using community mobilization strategies to influence behavior change. The resources required to sustain face-to-face networks are often grossly underestimated. This would be a good subject for research. Sometimes quite radical changes in behavior are required. Many community groups are extremely conservative. They are used to a top down method of instruction, rather than a participatory approach. Often they have racial or ethnic prejudices, or have problems communicating with certain groups. Disincentives for behavior change are often very strong. Research is needed to find out what is necessary to motivate different groups, and then to sustain that motivation.

A discussion followed on the role of incentive structures in face-to-face delivery systems. Effective incentives range from simple praise, to financial rewards, to the sense of responsibility, social recognition, and authority. TAG members agreed that when motivated, health care workers and community volunteers can be a powerful channel. Examples were described of several successful programs, including a condom distribution effort in Pakistan and a CCCD training system in Rwanda which relied on frequent supervisory visits and a standardized checklist. However, reward systems are most often anathema to public health bureaucracies. Supervisory systems generally deliver punishments rather than rewards. Unless HEALTHCOM can influence reinforcement systems, the project can do little effective training. Ministries almost uniformly resist any tampering with reward systems, even on an experimental basis.

The possibility of using behavior change principles within the ministry itself is a possible subject for research. Dr. Marjorie Koblinski (John Snow Inc.) cited a training effort in Bangladesh which illustrated the difficulty of bringing about change without engaging the highest level people. Ms. Caby Verzosa (HEALTHCOM) remarked that in some countries ministry objectives are so unreasonable that they actually become strong disincentives for health workers who are assured of failure. Can HEALTHCOM participate in research to help revise policy at the ministry level? Mr. Rivera pointed out that ministries have a very difficult time formulating behavior objectives. They often have "laundry lists" which are very long but miss key areas. HEALTHCOM might conduct research to help people select appropriate behavioral objectives. Do certain behavioral techniques work better with different channels? Are there techniques which can be used which do not require specialists?

The TAG discussed several other areas of possible research. Among these was the status of ARI communication programs in relation to clinical policy norms, or lack of such norms. HEALTHCOM is facing an interesting situation in Honduras, where the government has asked them to proceed with an ARI education program on the basis of some pilot research regarding knowledge and practices. Some TAG members expressed concern that a communication program is being asked to proceed ahead of technical policy. This situation also demonstrates the inequity of resources for child survival around the world--many countries still have no assistance in areas such as CDD and EPI. In this instance HEALTHCOM needs to respond to the government's request, but also needs to encourage a new formulation of the clinical norms, preferably through the ministry's consultation with PAHO.

### Summary Conclusions

1. HEALTHCOM should investigate the possibilities of applying the methodology to new audiences--suppliers, ministries, health care providers, and so forth.

2. HEALTHCOM should study whether the level of complexity of the research being conducted is essential to achieve minimum levels of quality.
3. While investigating ways to incorporate face-to-face interaction and community mobilization efforts more effectively into the project, HEALTHCOM should keep in mind the well understood limitations of these processes.
4. HEALTHCOM might focus future research efforts on several areas: interpersonal strategies; training for health care providers; supervision/incentive systems; and alternate program strategies.
5. To the extent appropriate, HEALTHCOM should collaborate with ministries and WHO in helping formulate up-to-date clinical norms.

## VI. SUMMARY COMMENTS

**Dr. Clifford Block**  
Office of Education  
A.I.D.

Discussion during the third Technical Advisory Group Meeting focused primarily on questions relating to sustainability of behaviors, institutionalization of communication activities, and of the HEALTHCOM methodology. Sustainability is an issue vital to all development projects. The TAG opened with a summary by Dr. Nyle Brady of this topic and its emphasis at ICORT III. Mr. Rasmuson then provided an overview reflecting the tremendous diversity of the HEALTHCOM Project. Dr. Horwitz presented highlights of the midterm evaluation, stressing the team's recommendation that A.I.D. support efforts in communication for child survival for at least the coming decade or the valuable contributions made by this methodology will disappear. The challenge now is to look at what sustainability requires, both in terms of self-sustaining behavior within institutions, and at the family level. The last ten years have brought about dramatic changes within A.I.D., WHO, and UNICEF, and also within ministries, but advances have been fragile. Support for communication at the policy level is vital. Allocation of resources to communication should be a fundamental part of public health planning.

The TAG talked primarily about how HEALTHCOM and its successor can enhance the sustainability of effective communication within developing countries. Categories of effort are interrelated, including training, extension of involvement from the center to the village provider level, and institutionalization of a specific set of skills. Those stages of the methodology which are most key should now be subjected to analysis so that they can be clearly structured and transferred to those having different levels of training.

A number of recommendations were suggested for HEALTHCOM's consideration:

- To diffuse project materials broadly in the developing world.
- To retrain health education staff and health staff more broadly with regard to communication and behavior change planning. Include staff at all levels, particularly decision-makers and policy-makers.

- To begin training in academic institutions and medical/public health communities; to develop a model communication curriculum. This process will help refine key elements of methodology. To educate donor communities in country and engage in policy dialogue. To involve ministries in making commitments needed to make the methodology work.
- To demand, to the extent possible, that ministries agree to conditions precedent to institutionalization of the methodology.
- To explore the possibility of providing small grants to involve and possibly train PVOs as agents to carry out certain aspects of project implementation.
- To provide for the development of job aids and potential new technologies, such as microcomputer simulations, to encourage data-based decision-making.
- To broaden and institutionalize use of the methodology among A.I.D. contractors in areas of health, education, and agriculture where behavior change is the key to success. To hold advisory group meetings at the country level. HEALTHCOM has enormous skills now and needs to think about how to expand their use to the extent possible while maintaining the integrity of project priorities.
- To bring together people who have worked with the methodology to assess what might be streamlined. To attempt this within the framework of those key decisions which must be made within a communication program, and their implications for information gathering.
- To conduct research to assess the feasibility of streamlining aspects of the methodology. To test the workability of a streamlined or structured methodology with actual audiences and to assess its impact on behavior. To test the possibility of reducing certain inputs, without compromising the efficacy of the project.
- To monitor behavioral outcomes carefully. These are the grounds for determining in each country how effective the project is and how it can improve. To focus on monitoring techniques as a feedback mechanism for improving messages and refining strategies.
- To conduct studies to define better what constitutes effective treatment for certain conditions. To assist in establishing better clinical norms for certain technologies. To conduct studies on what mothers are doing, and how they think about health.
- To study the incentive systems of health care providers and other intermediaries in the health care system. There is still a great deal to learn about how to sustain behavior.
- To focus new research on topics such as outreach to school systems, on-the-job training, and various broader implications of health behavior change on the way people think, and on the development process.

HEALTHCOM PROJECT  
TECHNICAL ADVISORY GROUP MEETING  
February 23, 1989

First Floor Conference Room  
Academy for Educational Development  
1255 23rd Street, N.W.  
Washington, D.C. 20037

AGENDA

**Morning**

- MODERATOR:** Ms. Anne Tinker
- 9:00 Opening Remarks Dr. Nyle Brady
- 9:15 Project Overview Mr. Mark Rasmuson
- 9:30 Summary of HEALTHCOM Mid-Term Evaluation Dr. Abraham Horwitz
- 10:00 Task Force Report: Sustainability and Institutionalization Dr. Gerald Hursh-Cesar
- Discussion**
- 11:15 Task Force Report: Future Directions of the Methodology Dr. Emile McAnany
- Discussion**
- 12:30 Luncheon Embassy Suites Hotel (next door to the Academy)

**Afternoon**

- MODERATOR:** Mr. Robert Clay
- 2:00 Task Force Report: Evaluation-- Process and Outcome Dr. Elizabeth Herman
- Discussion**
- 3:00 Task Force Report: Research and Development Priorities Dr. Marjorie Pollack
- Discussion**
- 4:00 Summary of Discussion and Recommendations Dr. Clifford Block
- 4:30 Conclusion of Meeting

HEALTHCOM PROJECT  
HEALTH COMMUNICATION TASK FORCE  
FEBRUARY 21 - 22, 1989

Main Conference Room  
Academy for Educational Development  
1255 23rd Street, N.W.  
Washington, D.C. 20037

AGENDA

**Objective:**

To review issues raised by HEALTHCOM's mid-term evaluation and recommend actions to TAG group for implementation under HEALTHCOM I.

**FEBRUARY 21, 1989**

9:00	Welcome and Introductions	Mr. Mark Rasmuson
9:15	Overview of Evaluation	Mr. Robert Clay
10:00	Small Group Discussion: Methodology Development	
	<ul style="list-style-type: none"><li>• Formative Research</li><li>• Behavior Studies</li><li>• Face-to-Face Channels/Community Participation</li></ul>	Dr. William Smith Dr. Clifford Block Mr. Mark Rasmuson
12:00	Lunch	
1:30	Reports from Small Groups	Dr. William Smith
3:00	Discussion: Sustainability and Institutionalization	Mr. Robert Clay
5:00	End of Day 1	

**FEBRUARY 22, 1989**

9:00	Discussion: Research and Evaluation	Dr. Clifford Block
	<ul style="list-style-type: none"><li>• Outcome Evaluation</li><li>• Monitoring/Process Evaluation</li><li>• Operations Research</li></ul>	
12:00	Lunch	
1:00	Summary Session: Review of Recommendations to TAG	Dr. Gerald Hursh-Cesa Dr. Elizabeth Herman Dr. Marjorie Pollack Dr. Emile McAnany
3:00	End of Day 2	

**ISSUES FROM MID-TERM EVALUATION  
FOR DISCUSSION**

**Formative Research**

1. What can HEALTHCOM do to better utilize and integrate research methods from marketing, ethnography, behavior analysis, and other disciplines?
2. Should the project strive towards a standardized, streamlined package and sequence of formative research that can be applied across all sites?
3. What are the minimum essential elements of an effective formative research program? What is the appropriate balance of quantitative and qualitative methods?

**Behavioral Studies**

1. What are the most important lessons we have learned from the project's health practice studies?
2. What are the most important contributions behavior analysis has made to the HEALTHCOM methodology?
3. How can the essential elements of behavior analysis be simplified for integration into the routine practice of health communication?
4. Are there any changes in topics or methodology that should be made in those studies still to be completed during HEALTHCOM I?

**Face-to-face Channels/Community Participation**

1. HEALTHCOM has already begun training efforts in several countries to improve the health education skills of public health personnel. What other interpersonal channels among the following should be priorities for increased effort during the remainder of HEALTHCOM I?
  - Private physicians and pharmacists
  - Traditional midwives and medical practitioners
  - School teachers
  - School children
  - Religious leaders
  - Women's groups
2. What lessons have been learned and need to be applied to make face-to-face networks truly effective (e.g., training, retraining, supervision, evaluation, etc.)?
3. Given the nature of HEALTHCOM's mandate and activities, how can the project best engage community participation in program planning and implementation? What guidance exists from recent experiences of other projects?

## Evaluation

1. Should HEALTHCOM shift, as the Mid-term Evaluation Report recommends, from an evaluation strategy focused on outcomes to one focused on process?
2. Should case fatality--the rate of mortality for children treated within specified health interventions--become the major criteria against which project success is measured?
3. What level of evaluation capability should HEALTHCOM strive to institutionalize in its country sites? How can this process best be accomplished?
4. The Mid-term Evaluation Report (on page 28) suggests a number of "low-cost and easily teachable methods of data collection." Which of these should HEALTHCOM consider for implementation in the short-term and in the long-term?
5. How can HEALTHCOM best proceed in studying cost-effectiveness of health communication interventions?
6. How can HEALTHCOM best improve the systematic monitoring of communication interventions? What indicators and methods should be highest priorities?
7. The Mid-term Evaluation Report (pages 19-21) suggests a number of possible areas for future research and development efforts. To which of these should HEALTHCOM assign highest priority?

## Sustainability and Institutionalization

1. How can HEALTHCOM strengthen the commitment of host governments to permanent health communication programs? What type of "government-entry strategies" should the project develop to begin institutionalization at the very beginning of project start-up?
2. Should HEALTHCOM have more explicit and stronger "conditions precedent" concerning institutionalization (especially regarding counterpart staff and budget) and be prepared to withdraw from countries that do not comply?
3. How can the project most effectively strengthen its training of principal counterpart staff in health communication?
4. How can the project most effectively diffuse knowledge and skills in health communication within a country? Should HEALTHCOM more actively seek to influence the curricula of health and other training institutions, or focus its immediate efforts on upgrading the health communication capacity of the existing health system and personnel?
5. How can HEALTHCOM elicit more active participation in health communication programs from the private commercial sector, beyond the provision of paid services such as research and advertising?
6. How, in specific operational terms, should the project try to strengthen its collaboration with NGOs and PVOs, both international and local?

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