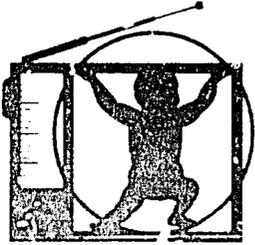


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Communication for Child Survival

HEALTHCOM

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

SUMMARY REPORT

Technical Advisory Group Meeting

January 28-29, 1987

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**TECHNICAL ADVISORY GROUP MEETING
HEALTHCOM PROJECT
January 28-29, 1987
Academy for Educational Development, Washington, D.C.**

S U M M A R Y R E P O R T

I. DISCUSSION ISSUE: SUPPLY AND DEMAND

Statement of Issue

How can HEALTHCOM ensure that communication activities do not outdistance other program elements? To what extent should HEALTHCOM be turning attention to strengthening supply-side components? What is the proper balance in a particular HEALTHCOM country between supply and demand elements of the health communication strategy?

Introduction

Dr. Robert Northrup pointed out that the force of public demand for specific health services can have both a positive and negative effect upon an overall health system. A communication program clearly emphasizes the demand side of the equation. However, what is being "supplied" is not always clear-cut. It might be a simple product or a variety of services based upon an extensive infrastructure. This complicates the task of achieving "balance."

In the best situations, an increase in public demand can put stresses on the supply side--local institutions or government infrastructure--and stimulate increased services. On the other hand, if newly stimulated demands cannot be satisfied, this can discourage consumers and cause long-term damage. Some campaigns can be carried out without making any demands upon the infrastructure (e.g. promotion of SSS). On the other hand, the very existence of a communications program can put time and management stresses on a particular agency.

Dr. Northrup opened the discussion of this topic with a number of questions: How do we measure the relative balance between supply and demand in a given situation? How is this balance linked to the particular product being delivered? How is it linked to other factors? What is the role of HEALTHCOM in terms of evaluating and monitoring this area? How far should the program really go beyond media work--e.g. to product distribution or training?

What is the Present Balance?

There followed considerable discussion about whether supply has sufficiently outdistanced demand globally to make the question of "balance" moot. Mr. Robert Hogan cited WHO data showing an increase (from 1984-1985) in access to ORS in developing countries from 33-50 percent, but an increase in ORS use from 12-15 percent. This would indicate our emphasis should be on the creation of greater public awareness and demand, and Mr. Hogan encouraged HEALTHCOM to move aggressively forward with demand creation programs. The use of the term "access" was discussed. The availability of a certain number of ORS packets is not necessarily a good measure of access. The existence of a health center does not ensure provision of services. Dr. Northrup suggested that 10 percent mortality at health centers does not indicate adequate service.

What is the Product?

A second subject of debate was whether mothers were being led to demand an appropriate product for diarrheal diseases. Mr. Hogan suggested it may be time to emphasize specificity rather than sensitivity. In other words, mothers should not be told they need to use a new product (ORS) in every instance of a child's diarrhea, because it is unnecessary and furthermore they know this. Our message for diarrhea control should be: 1. keep feeding; 2. give fluids; and 3. know when to seek further treatment (perhaps at a health center). Dr. Bart questioned whether it is possible to identify a specific target group which is a priori at greater risk for dehydration and death. Participants discussed the signs mothers use to distinguish between simple and serious diarrhea, and whether messages could take advantage of this natural differentiation. Dr. Smith said HEALTHCOM has studied mothers' cues for severity. In many cases doctors say these cues are at too late a stage in the illness for effective intervention (especially if the child is some distance from a health center).

Are Campaigns Dangerous or Beneficial?

A number of participants were wary of public health campaigns as demand-creating devices. A campaign is highly visible and therefore highly risky. Failure can have a long-term effect. Moreover, campaigns are sometimes alternatives to important investments in the infrastructure of a health system (e.g. in training). Participants agreed that campaigns can be tremendous forces for stimulating public and political awareness. This awareness can sometimes be the necessary first step for longer range mobilizations. To be effective, campaigns should be planned in pulses, and should evolve into sustainable health service programs targeted at high-risk groups without access to services.

Summary Conclusions

1. Supply of and demand for health services should always be viewed together, rather than as separate goals. The "product" is a CDD program--not just ORS packets, but proper case management at home and in the health facility. HEALTHCOM should begin to find ways in which communication can help support the entire system, and the services of health care workers as well as home users.

2. HEALTHCOM should move carefully in defining the CDD "product," giving increasing attention to feeding, fluids, and referral messages and away from home-mixed sugar-salt solutions. The project should continue in-country research to better specify appropriate messages.

3. HEALTHCOM should work within an overall program plan (for CDD or EPI) incorporating communication and demand-creation within a larger child survival program.

4. HEALTHCOM should continue to respond positively to individual countries' requests for assistance, even when the requests are primarily for public health campaigns. A campaign can provide a necessary entry point, and HEALTHCOM can then be in a position to promote appropriate attention to other needed aspects of a sustained delivery system.

II. DISCUSSION ISSUE: BEHAVIOR CHANGE

Statement of Issue

What is needed for a new health practice to be adopted and maintained? What are the behavioral, marketing, and communication research perspectives on this question? What should HEALTHCOM's research and development priorities be for developing behavior change and maintenance strategies?

Behavior Analysis Perspective

Dr. Paul Touchette explained that a behavior analyst prefers to begin on a small scale, working with a group of five to ten families. He or she gathers detailed information about this small group, examining those practices which might be changed and the "behavioral ecology," or context, in which they occur. The initial concern is not representativeness, but behavioral detail and specificity. This helps identify what motivates people, and in turn discover how to shift these motivations and plan ways to maintain change. Dr. Touchette said the HEALTHCOM project is a golden opportunity to work with other disciplines, and emphasized the need to integrate behavior analysis more formally into the methodology.

Social Marketing Perspective

Mr. William Novelli described the flexibility of marketing and its applicability to public health issues. Marketing is an eclectic discipline based on the principles of psychology, sociology, anthropology, and economics. Its basic elements include:

- information that can be disseminated through mass media,
- information that can be shared through face-to-face communication,
- technological changes (including product development),
- economic measures (such as pricing strategies),
- sanctions.

HEALTHCOM can support all of these in developing country public health strategies, except the last. Mr. Novelli also outlined a number of traditional ways of changing a marketing approach: 1. get out of the business; 2. integrate vertically, forward or backward (e.g. actually produce ORS salts or other related product); 3. expand geographically; 4. expand the range of offerings (e.g. include immunizations, growth-monitoring, nutrition, in a single program); 5. consolidate the product line (e.g. reduce the number of themes in a program); 6. improve operational efficiency.

Communication Research Perspective

Dr. Dennis Foote described ACT's continuing analysis of the MMHP data from Honduras and The Gambia. It focuses on three specific areas: 1. characteristics of ORT and EPI users; 2. accuracy of ORT performance among mothers who participated in the intervention; 3. maintenance requirements among ORT users. Dr. Judy McDivitt summarized some of ACT's findings. In first-time trials they have noted a steep rise in knowledge and practice in the first year, with some continued new adoption in the second year. In Honduras, they noted a pattern of skipping relative to severity of case and intensity of campaign. This would indicate a need for a series of interventions, or pulses. In The Gambia, 47 percent of those who used ORT in the first year also used it three more times in the second year; 32 percent used it four more times. In Honduras, 36 percent of those who used ORT in the first year also used it for the majority of cases in the second year.

Discussion

Most of the discussion focused on behavior analysis--the difficulties of incorporating it into public health strategies, the question of whether that was in fact desirable, and the extent of behaviors HEALTHCOM can be expected to influence. Dr. Anthony Meyer, S&T/Ed, explained that AID has given HEALTHCOM generous support for behavior studies in order to develop a new brand of social marketing that derives from repeated experiences of asking behavior questions, and to apply that to specific child survival technologies. Dr. Smith pointed out much health research still focuses on attitudes and knowledge, rather than practice. Formal behavior analysis has not yet established its credentials in the developing world. Many countries are highly skeptical of its language.

Some participants expressed interest in applying behavior analysis to problems within the health delivery system, for example to those relating to the health workers, to discover natural reinforcements and incentives for improved use of ORS. Others emphasized that there is a limit to what HEALTHCOM can be expected to do to change the infrastructure of a country.

Summary Conclusions

1. Not everyone involved in child survival programs needs to become a professional behavior analyst, but communication must focus on behavior change as a final goal. Measurements of knowledge, attitude, and self-reported behavior must be distinguished from those of actual behavior.

2. Many development programs have successfully promoted first trials of new behavior, but the real challenge remains that of maintaining these new practices over time.

3. HEALTHCOM should expand its support of health care provider training, while being realistic about the extent to which it alone can be responsible for the overall delivery system.

III. DISCUSSION ISSUE: INSTITUTIONALIZATION

Statement of Issue

How should institutionalization be defined for HEALTHCOM? How should the goal of institutionalization be operationalized? What can HEALTHCOM realistically accomplish under the existing project model in terms of institutionalization of the methodology?

Discussion

Ms. Caby Verzosa opened the discussion by pointing out that institutionalization is often one of the primary concerns of a developing country. In the Philippines, for example, the new minister of health was most interested in knowing how HEALTHCOM could build the ministry's communication division.

Institutionalization can be viewed on many levels--from specific skills training for counterpart professionals, to effective transfer of a methodology within a counterpart institution, to national adoption of new attitudes and practices. Dr. Meyer said skills training is only one essential step. Institutionalization carries with it implications for budget and planning and for a myriad procedures within a bureaucracy. Margot Zimmerman (PATH/PIACT) pointed out that identification of a collaborating institution in order to share knowledge is really the essence of the development process. However, sometimes it takes months or years to determine which institution is the appropriate one. Ms. Sylvie Cohen (WHO) emphasized the importance of generating resources, and the need to maintain cooperation among various groups such as educators, advertisers, health workers, etc. Ultimately, institutionalization will only be achieved if it is backed by political will. Mr. Tony Hewett (UNICEF) said it is a mistake to think only in technical terms of interventions, behavior, marketing, etc., when success is largely dependent on societies and governments.

Mr. Rasmuson suggested it is unreasonable to expect resident advisors to achieve even moderate success along these lines in only two to three years, when we also ask them to support a variety of child survival programs, help refine the HEALTHCOM methodology, and collaborate with other programs and agencies. He asked for AID's guidance in determining a balance of these goals from country to country.

Dr. Robert Hornik (Annenberg) said HEALTHCOM's primary goal should always be a measurable health status improvement, with the underlying notion and goal that the administrative conditions leading to this success will be worked back into the system. Intelligent dialogue can be based upon actual results when they are obtained.

Summary Conclusions

1. Pursuing the goal of institutionalization requires that a long-term advisor approach his or her job from a special perspective. He or she must invest time cooperating with many public agencies and private organizations, and enlist support at a national level. However, there are limits to what a single advisor or program can be expected to achieve.

2. The first goal of a resident advisor should be to apply HEALTHCOM's methodology to a working program in order to demonstrate real success. Tangible results supply the base upon which institutionalization can be furthered.

3. USAID missions should assist HEALTHCOM in determining realistic goals of institutionalization in given countries.

IV. SUMMARY RECOMMENDATIONS

The TAG meeting reaffirmed the basic principles underlying HEALTHCOM's approach to demand creation for child survival: the importance of communication planning, of data collection, of blending marketing and behavior analysis. It highlighted the need to address a "moving bottom line" of changing target audiences, new messages, and new technologies. Particular goals for future emphasis are:

- To broaden the "behavior environment" studied to the health system itself, rather than just the mothers served by it. To increase our understanding of the health worker and the incentive system.
- To include health care providers as a significant new audience and expand the support of country programs to reach them.
- To establish clear guidelines in program design and evaluation, to focus on behavior change rather than just changes in knowledge and attitude, as the fundamental goal of communication activities.
- To ensure that as much attention is given to behavior maintenance and sustained change as to first trials of new child survival behaviors.
- To avoid any short-term communication intervention which has no explicit plan for linkage to sustained service delivery.
- To include case studies of institutionalization and cost analysis as key success elements in HEALTHCOM programming.

HEALTHCOM TECHNICAL ADVISORY GROUP MEETING

AGENDA
January 28, 1987

Chairpersons: -Dr. Kenneth Bart (AM), Ms. Anne Tinker (PM)

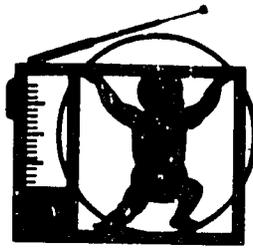
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|------------|---|---|
| 9:00 a.m. | Welcome and Introductions | Mr. Stephen Moseley |
| 9:10 a.m. | Opening Remarks | Dr. Kenneth Bart |
| 9:20 a.m. | Review of HEALTHCOM's First Year | Mr. Mark Rasmuson |
| 9:45 a.m. | Major Technical Issues in Health Communications | Dr. William Smith |
| 10:30 a.m. | BREAK | |
| 10:45 a.m. | AID's Contract Objectives for HEALTHCOM | Dr. Anthony Meyer |
| 11:00 a.m. | Issue 1: Supply and Demand | Dr. Robert Northrup |
| | How can HEALTHCOM ensure that communication activities do not outdistance other program elements? To what extent should HEALTHCOM be turning attention to strengthening supply-side components? What is the proper balance in a particular HEALTHCOM country between supply and demand elements of the health communication strategy? | |
| 12:00 p.m. | LUNCH AT AED | |
| 1:30 p.m. | Issue 2: Behavior Change | Dr. Paul Touchette
Mr. William Novelli
Dr. Dennis Foote |
| | What is needed for a new health practice to be adopted and maintained? What are the behavioral, marketing, and communication research perspectives on this question? What should HEALTHCOM's research and development priorities be for developing behavior change and maintenance strategies? | |
| 3:00 p.m. | BREAK | |
| 3:15 p.m. | Issue 3: Institutionalization | Ms. Caby Verzosa |
| | How should institutionalization be defined for HEALTHCOM? How should the goal of institutionalization be operationalized? What can HEALTHCOM realistically accomplish under the existing project model in terms of institutionalization of the methodology? | |
| 4:30 p.m. | Summary Comments | Mr. Robert Clay |
| 5:00 p.m. | Conclusion of Meeting | |

AGENDA

January 29, 1987

Meeting of Subcontractors and Behavioral Task Force

- 9:00 a.m.** **Small Group Working Meetings**
- o Behavioral Task Force
 - o Evaluation Subcontractors
- 12:00 p.m.** **LUNCH**
- 1:30 p.m.** **Subcontractors Administrative Meeting**
- 3:00 p.m.** **Presentation of Issues and Plans from Morning Meetings**



KEY ISSUES FACING HEALTHCOM

1987

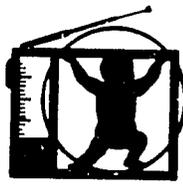
FOR DISCUSSION AT TAG:

1. Supply vs. Demand Creation
2. Role of Behavior Analysis
3. Institutionalization

OTHER KEY ISSUES:

1. Role of "Campaigns"
2. Combining Child Survival Themes
3. Quality Standards for Formative Research
4. Sugar/Salt vs. ORS vs. ORT Promotion
5. Targeting Health Care Providers as well as Consumers
6. Regional Program Support
7. Exclusive Short-Term Assistance

The following three papers provide a background statement for each of the first three issues selected for discussion at the TAG Meeting.



Issue 1

SUPPLY AND DEMAND

The primary function of health communication is to increase the educated demand for health services and products. By educated we mean simply that the right people ask for and use appropriate health services in a safe and effective way. It is not enough to have thousands of new ORS users if those individuals don't know when to use ORS, how to administer it properly, what else to do for their child's diarrhea, and when to seek outside help.

But demand, even educated demand, for health services can be counterproductive if the supply of those services is inadequate. Indeed, precocious health promotion programs which create demand for services as yet unavailable, can do great damage to long-term program implementation, by destroying consumer confidence and frustrating health providers.

While recognizing this fundamental truth, it is also necessary to recognize that many service delivery programs, which have the capability to work effectively, lack political and moral support. Popular demand for health services is often the most effective means to encourage political support. While not exactly a chicken-egg problem, health communication is often faced with the dilemma:

- o If I wait until service delivery is fully adequate we may not have programs of any kind for years, and
- o If I proceed aggressively to create demand now, we may frustrate both consumers and providers.

This simple dilemma is compounded by three additional factors:

- o The service delivery system is often very confident of its ability to delivery services; decision makers often reject premise one above.
- o While it may be possible to generate a short, rapid increase in service delivery, sustainability of those changes is more difficult to produce.
- o A window of opportunity may exist now which should not be missed. It is possible to use health communication to stimulate better service and raise the overall system's consciousness and effectiveness in service delivery.

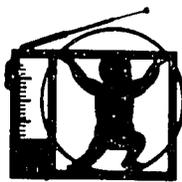
Finally we do have more than two alternatives -- more than all or nothing. There are a number of opportunities to increase demand responsibly, even in the absence of excellent service delivery. For example:

- o Focus on messages which require little or no outside service delivery - feeding, preventive hygiene, etc.
- o Focus on areas where services can be delivered; either geographical areas or service areas. Use a "laminating approach" to program development -- promote whatever can be done at any given moment in an additive fashion.
- o Use the opportunity and visibility of communication to drive service delivery into more creative solutions -- BRAC in Bangladesh, Honduras's radio Dr. Salustiano, Egypt's TV and pharmacy programs.

HEALTHCOM has already made significant contributions to both supply and demand sides of child survival programs. In addition to promotional activities, the Project has assisted the establishment of ORS delivery systems, the behavioral refinement of training methodologies, and the actual technical training of large numbers of health personnel in a number of countries. In several other countries HEALTHCOM is currently working to improve the supervision and staff motivation systems. In planning future country programs:

1. What is the proper balance between supply and demand components? What is the most appropriate timing for a public communication component vis-a-vis other program elements?
2. Should communication be used to stimulate a lagging child survival program?
3. What else should HEALTHCOM be doing to strengthen the supply* of child survival services?

* Supply is defined here to mean not only the supply of commodities (such as ORS) but the broad spectrum of activities including product distribution, health personnel training, and monitoring and supervision which together comprise an effective health service delivery system.



Issue 2

BEHAVIOR CHANGE

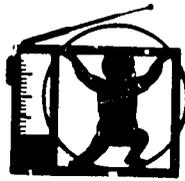
Behavior analysis represents a major disciplinary contribution to the HEALTHCOM methodology. Along with social marketing it contributes a fundamental new way of looking at health communication. Continued experimentation with behavior analysis has demonstrated its potential to improve our understanding of what people are actually doing and increase our repertoire of how to best change behavior to ensure sustainability. Moreover, behavior analysis has been shown to be compatible with social marketing -- often labeling the same principle or condition differently, but arriving at complementary action conclusions.

It was behavior analysis which stimulated the insights leading to the lottery in The Gambia, the Breastfeeding Radio Course in Honduras, the immunization study and health worker incentive system in Ecuador, and the skill-based ORT training modules in several HEALTHCOM countries.

But behavior modification continues to be perceived as an esoteric and often threatening discipline. It remains appreciated by only a few core members of the HEALTHCOM team.

The principal issues we would like to discuss today include:

1. How can we promote a better understanding of behavior analysis and its contribution to improved health communication?
2. How can we best integrate behavior analysis with social marketing to produce a genuine hybrid rather than the present approach of "creative redundancy"?
3. What aspects of behavior analysis have proven most useful to health communication and which have proven less useful?
4. How can we best organize to provide more effective and comprehensive behavior analysis assistance?



Issue 3

INSTITUTIONALIZATION

The HEALTHCOM contract defines institutionalization as "the ability of a host country institution or set of institutions to apply the project methodology in an ongoing way, as part of the normal routine of how it (or they) conduct public health education."

HEALTHCOM believes that critical elements for institutionalization of the public health communication methodology include the following:

- o commitment to public health communication program by leadership of Ministry of Health and relevant private sector institutions
- o creation of permanent communication department/position and budget within counterpart institutions
- o commitment to formative research and evaluation
- o fundamental orientation toward the consumer
- o regular, comprehensive communication planning
- o ongoing, substantial use of mass media
- o budgetary commitment.

Operationalizing these elements, however, poses a whole set of difficult challenges. As the project expands to new countries and implementation plans are developed, important operational issues include the following:

- o How can HEALTHCOM effectively obtain input at each project stage from leaders in the Ministry of Health as to what steps should be taken toward the introduction and establishment of the methodology within host country institutions?
- o How can private sector institutions, both voluntary and commercial, be optimally included in this process?
- o How can HEALTHCOM effectively work at both the national and the provincial levels?
- o How can HEALTHCOM apply its methodology (i.e. marketing, anthropology, behavior analysis) to affect the process of change within host country institutions?

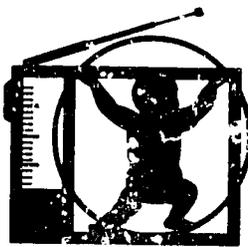
- o What types of additional resources may be sought to assist the process of institutionalization?

Moreover, all of these issues must be addressed within the constraints of the existing project model. The HEALTHCOM model now calls for the assignment of a Resident Advisor to a country for a 2-3 year period. During that time the Resident Advisor has responsibilities both to carry out communication activities in support of specific objectives of the national child survival program and to carry out in-service training and other activities which will further the goal of institutionalization of the methodology. Given the two-year time frame,

- o What is the appropriate balance of effort on the part of HEALTHCOM?
- o Does the two-year time frame place inordinate constraints on the Resident Advisor in playing both the implementation and institutionalization roles?
- o Should HEALTHCOM provide for medium or long-term training in health communications for host-country counterparts?
- o What is an appropriate technical assistance phase-out strategy for a HEALTHCOM project? What types of long-term follow-up activities can most usefully support HEALTHCOM institutionalization in a given country?

From among all of these issues, we would like to seek your advice today on the following three, which we consider special priorities:

1. What is the appropriate balance HEALTHCOM should seek between supporting particular child survival program objectives and supporting institutionalization of the methodology?
2. What types of additional resources may be sought to assist the process of institutionalization? How can HEALTHCOM best coordinate its efforts at institutionalization with other AID projects which support national child survival programs?
3. How can HEALTHCOM use the techniques of anthropology and behavior analysis to learn more about and affect the process of change within host country institutions.



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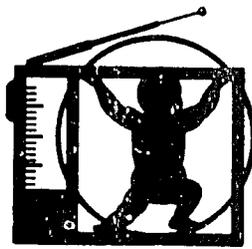
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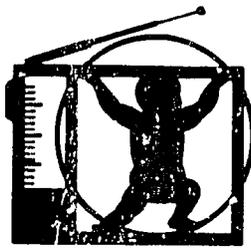
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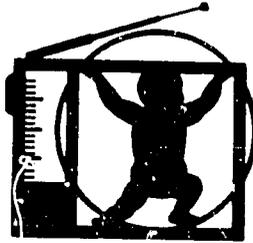
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