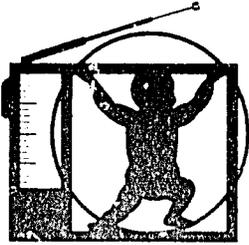


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Communication for Child Survival
HEALTHCOM

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

SUMMARY REPORT

Technical Advisory Group Meeting

February 9, 1988

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Technical Advisory Group Meeting
HEALTHCOM Project
February 9, 1988
Academy for Educational Development
Washington, D.C.

SUMMARY REPORT

I. ISSUE 1: POLICY CHANGE AND COMMUNICATION PLANNING

Statement of Issue

What are the most important changes likely to occur in the major child survival technologies (particularly ORT and EPI) in the near future that will have significant policy implications for health communication? How can large-scale health communication programs best adjust to shifts in biomedical policy? Should programs, for example, back off from specific instructional objectives in favor of more generic approaches--e.g., from how to mix a specific ORS solution to why to give more fluids?

Discussion

Dr. William Smith opened the discussion by noting that we still have much to learn about child survival practices and appropriate technologies. Promotional strategies often have to be adjusted in the field, as new information becomes available. Adjustments are not easy to bring about among health workers or caretakers, and frequent or major policy changes can have serious negative results. Dr. Smith asked members of the TAG to consider what biomedical advances might affect the project in the near future, and what the proper mechanisms would be for informing the project of these changes in a timely way.

A second concern relates to the specific child survival policies of the countries in which HEALTHCOM works. Different countries operate under different constraints, and their child survival policies vary and often evolve over time. At present, policy issues are particularly challenging for HEALTHCOM in countries whose ORT programs continue to promote sugar-salt solutions in the face of growing evidence internationally that this is ill-advised. The primary client must always be the country government. Should HEALTHCOM play a role in helping governments reposition their policies?

Mr. Robert Hogan of WHO stressed that policy decisions are not always arrived at rationally. He stated that assisting the reformulation of national policies should be a HEALTHCOM priority. A discussion of policies regarding different child survival technologies followed. Mr. Hogan said that ORT policy, as such, has changed very little, but that changes are likely with the completion of studies of super-ORS, which promises to address the problems of volume and duration of diarrhea which current solutions do not. Future recommendations are likely to emphasize the promotion and mixture of

super-ORS solutions, as well as interventions for preventing diarrhea. Policy regarding control of ARI is still in the very early stages. Last fall WHO established an ARI unit within its CDD unit. Mr. Hogan cautioned against premature communication efforts in this area.

Policies regarding EPI are the most straightforward at present. However, there are likely to be changes as the hepatitis B vaccine becomes readily available, perhaps in five to ten years. Thailand, Indonesia, and the PRC are conducting large-scale field trials. Within five to ten years it is also hoped that reusable syringes will be completely replaced by a prefilled, single-dose system. Several conferences have been scheduled on policy for tetanus toxoid. No studies have been conducted since WWII and reformulation of policy is urgent. Dr. Smith noted that the rising incidence of AIDS has implications for blood and injection issues and that the importance of immunizations must continue to be emphasized in this new context.

Policy regarding malaria is perhaps the most unstable at present. Increasing prevalence of chloroquine resistance makes it difficult to formulate effective messages.

Recent nutrition studies have implications for CDD policy. Caby Verzosa pointed out that the Dietary Management of Diarrhea project has discovered in Peru and Nigeria that the negative effects of withholding food during diarrhea are not as important as the overall inadequacy of childhood diets. Their strategy has shifted to promoting better weaning foods in general, with a focus on initiating changes during illness. Dr. Robert Black pointed out that where diet is already marginal, any difference in feeding can have a profound effect; however, the typical fall-off in growth during illness is due to complex factors.

Ms. Verzosa also discussed the importance of growth monitoring as a child survival technology which links all the other technologies. In some countries, growth monitoring is the focus for mothers' regular visits to the health center. Dr. Northrup pointed out that policy decisions for growth monitoring are still largely made by biomedical personnel, but that it is fundamentally a behavioral technology. Behavioral scientists and communication planners thus have an important role to play in this area. Dr. Smith cautioned that growth monitoring/counseling can be a punishing event for mothers because it points out where they are failing. These programs therefore have to be carefully managed.

Ms. Anne Tinker noted that one area which will receive new emphasis soon within A.I.D. is that of maternal health. A "safe motherhood initiative" will concentrate on maternal morbidity and mortality, prenatal services, and nutrition.

Dr. Robert Northrup suggested that strong policy recommendations are often made without sufficient research into what's really going on in the home. WHO's past opposition to flavoring and coloring of ORS, for example, was not based on sufficient data. Policies about cereal-based ORS and other ORT issues should be made in view of many considerations, including consumer acceptance, other than those which are purely biomedical. Dr. Northrup also said HEALTHCOM's primary challenge is not so much adjusting to agreed upon policies, but in settling conflicts among different policy-making bodies. Where data does not support existing policy, should HEALTHCOM choose its own position? How should HEALTHCOM deal with policy discrepancies? Dr. Northrup suggested that a forum at which policies could be discussed would be advisable.

Ms. Mary Debus emphasized the need for more consumer oriented research. In particular, marketers would like to know the natural thresholds of different child survival behaviors among different target audiences.

Is policy consensus regarding certain technologies either possible or desirable? Mr. Hogan stressed that WHO tries to keep the public informed of changes and makes recommendations, but does not make policy per se. He added that many international organizations do not want to operate on consensus. Dr. Cliff Block questioned whether consensus is desirable in an environment where research is lacking. Dr. Hornik suggested that consensus may not always be possible regarding appropriate communication strategies, but that consensus regarding technical information is always important. HEALTHCOM is not a technical project, and must rely upon others for formulation of policy in many areas.

Summary Conclusions

1. Child survival is an area of evolving technologies. Policy consensus regarding these technologies is vital to the design of communication strategies. A regular technical forum of representatives from the major international donors is strongly recommended.

2. HEALTHCOM should play a role in helping countries reformulate their technical policies, bringing appropriate information from other country experiences to the attention of policy-makers and highlighting the consumer and communication aspects of current and new health policies.

3. There needs to be greater use of available data at the country level, and more research to help shape policy, such as studies of accuracy in mixing sugar-salt solutions and of appropriate home-available fluids already in use. HEALTHCOM should encourage such studies, and in countries where no other project (such as PRITECH or CCCD) is carrying out such studies, HEALTHCOM should implement them with appropriate technical guidance.

4. Further research is necessary regarding certain technologies, such as ARI control. In the interim, communication interventions should be approached with caution.

II. ISSUE 2: RESEARCH AND DEVELOPMENT--

Statement of Issue

Are HEALTHCOM's current R-and-D efforts on target? Where should HEALTHCOM focus its research efforts in the future? What are the key policy issues emerging around communication for child survival programs which HEALTHCOM should help address?

Discussion

Dr. Robert Hornik outlined the different types of research which the Annenberg School is conducting for HEALTHCOM: research to help form communication strategies; evaluation of specific country interventions; evaluation of the utility of public health communication across sites. Annenberg's comparisons across sites provide perspective on questions regarding the effectiveness of different channels, the acceptability of treatments, alternatives for immunization strategies, and the cognitive and social cues which lead mothers to move from one treatment to another. HEALTHCOM adapts its methodology to individual countries and government priorities and policies. The project also tries to assist governments in changing their policies.

Dr. Dennis Foote, from HEALTHCOM's subcontractor, Applied Communication Technology, described the resurveys ACT completed in Honduras and The Gambia during the past year. The results are mixed. In Honduras, ORS utilization rates continue to climb, while in The Gambia, interventions ceased after the MMHP Project ended and ORT use has dropped significantly. (Details are provided in the TAG meeting working papers.) Dr. Foote attributed the differences in these outcomes to several factors. The most important of these is the level and duration of sustained program effort achieved in these countries. Honduras has now received sustained support from A.I.D. for eight years and its HEU has been transformed from a small, inactive unit into a multidisciplinary team routinely carrying out multi-channel research-based communication programs. In The Gambia, MMHP's technical assistance lasted only three years, and the Government of The Gambia was unable to sustain even a modest maintenance program in the years following. Another factor is the difference in technologies. The Gambia relies upon a complicated water-sugar-salt solution for home treatment, while the Honduras program uses a locally produced ORS packet. Dr. Foote pointed out that high health worker turnover is a major obstacle to long-term maintenance. This turnover often leads to discrepancies between health worker messages and national policies.

Dr. Judith Graeff described HEALTHCOM's health practice studies as small-scale behavioral studies complementing and helping to shape large-scale interventions. Dr. Graeff and Dr. John Elder discussed the project's current health practice studies in Mexico (investigating the quantity of ORS solution given by mothers to sick children); in Ecuador and Nigeria (health worker interaction with mothers in clinics); Nigeria (the effect of different clinic teaching aids on mothers' behavior); Honduras (current caretaker practices in treating ARI); and Zaire (factors influencing caretakers' prevention/treatment choices).

Mr. Rasmuson mentioned that improved health worker instruction was identified as a priority at the last year's TAG meeting and that the project had responded in planning several behavioral studies in this area. Several TAG members confirmed that massive training efforts are necessary, not only among health workers but among other groups including the private sector. Dr. Hornik described the difficulties of training to train volunteers and mentioned that large-scale volunteer training efforts are often inefficient. Dr. Smith pointed out that the energy level involved in providing training to peripheral groups (for example in the schools) is very high. One group which would benefit from more emphasis, particularly in certain countries, is pharmacists. However, training is not itself enough. Structural issues within the distribution system--such as supervision and incentives for health staff--also need to be addressed.

Participants recommended various priority issues for continuing research. Dr. Northrup suggested further studies of mothers' responses to diarrhea and ARI; the quality of interaction between mothers and health workers; efficient and effective methods of growth monitoring and the role of that technology in relation to diarrhea; increased training of doctors and pharmacists in communication skills; and research on effective strategies. Ms. Petra Reyes said more work should be focused on reaching poor, traditional populations and others who are at highest risk and often have least access to the mass media.

Mr. Hogan encouraged more formal evaluation of campaigns as a communication strategy. He noted the danger of a program becoming a series of short campaigns which cannot be sustained over time. Dr. Bart stressed the importance of mobilizing communities and observed that campaigns are often the first steps in this process. Data on the efficacy of campaigns have not been uniformly assessed. Until that time, a particular method of intensification should not be condemned. Robert Clay pointed out

that REACH is presently conducting studies in this area. He cautioned against any "blueprint" approach to public health communication--technical and social realities must always be incorporated into the planning task.

From the social marketing viewpoint, a number of areas for research deserve focus. Ms. Debus recommended cooperation with the private sector in pursuing some research tasks, including studies of early adopters, high vs low involvement behavior change, and tracking of key indicators.

Dr. Block summarized the morning session, noting the impact of the HEALTHCOM methodology and the broad diffusion of its findings to date. Research questions relating to biomedical technologies should be distinguished from research relating to questions of availability and acceptability.

Summary Conclusions

1. Members of the TAG generally endorsed HEALTHCOM's R-and-D agenda and urged the project to continue existing levels of funding and implementation of these activities.

2. Among the topics suggested by the TAG for special priority are: evaluation of campaigns and alternative communication strategies; research on consumer responses to illness and to new health technologies and practices; more effective methods for training and motivating health providers; and mechanisms for maintaining new practices among large populations over time.

III. ISSUE 3: PROGRAM PRIORITIES--

Statement of Issue

Should HEALTHCOM focus its resources in a smaller number of emphasis countries rather than continuing expansion? Is the project committing its resources to the right mix of interventions.

Discussion

Dr. Robert Black of Johns Hopkins University opened the afternoon session's discussion by asking the TAG to address the questions of whether HEALTHCOM is becoming overextended. He noted the scope of challenges involved in tailoring interventions to specific countries, in providing appropriate expertise, and in coordinating efforts with other A.I.D. projects, donors, and contributors and relying upon those other resources for some aspects of interventions. He suggested that two years may not be enough for an effective intervention or for institutionalization of the HEALTHCOM methodology in a country. The current criteria for defining a country as an "emphasis" site are: population size; need in terms of child morbidity and mortality; priority for A.I.D.; USAID mission support; and perceived opportunity for conducting a successful intervention with some positive measurable outcomes. What level of resources should be provided to these countries and what results are expected in return? How is a project sustained over time?

Mr. Rasmuson and Dr. Smith responded to a question about the small sizes of MMHP's original countries. At that time, the project sought sites with viable and

accessible health and communication systems where pilot interventions could be carried out with relatively modest resources and with reasonable expectations of success. Selection considerations at the time also included interest on the part of individual USAID missions, which was not especially high at that time, particularly in the Africa region. Today the project is working in and giving priority to a number of large countries, including Indonesia, the Philippines, and Nigeria. In these countries, HEALTHCOM is now generally starting work in one or a few states or regions, and then applying the experience and lessons learned in later regional and national expansions. Experience to date in such large countries demonstrates that program implementation is primarily a state or province affair, and that the project's impact at the national level will be primarily in terms of sharing methodology with national counterparts rather than seeing national communication impacts.

Discussion followed on the nonmonetary resources essential for a country program, and the role of the resident advisor. Participants agreed that a long-term in-country presence--e.g., five-ten years--is vital if a program is to be more than a research and development effort. Participants also agreed that while the project should not give up its emphasis on demonstrating communication impacts in countries, as results will encourage continuation of the methodology, HEALTHCOM should also place more attention on structured skills training for country counterparts.

Dr. Northrup noted that given the project's commitment to institutionalization, we must avoid intervening in technologies in which we don't have sufficient information or expertise. Dr. Smith emphasized that HEALTHCOM is in some ways a "shadow" of its biomedical partner, such as CCCD or PRITECH, and that we don't move into countries or technologies without cooperation.

To what extent should levels of morbidity and mortality determine HEALTHCOM's priorities? Dr. Smith said he hoped to see more epidemiological criteria brought to bear. However, the pertinent question is not just where are most children dying, but where can the project in fact save the most lives. This discussion led to the topic of AIDS, and its potential for wiping out all of the gains made in the areas of EPI and CDD. It is understandable that missions would wish to make this challenge a priority, and that they would be frustrated by the necessity of dividing money and attention between child survival and AIDS, among others. However, TAG members agreed that AIDSCOM, rather than HEALTHCOM, has expertise in this area and should be relied upon for technical assistance. Each public health theme requires a systematic approach.

Summary Conclusions

1. The TAG endorsed HEALTHCOM's selecting emphasis countries for an increased level of effort and urged HEALTHCOM and A.I.D. to identify contractual means through which the project can commit additional resources to these countries.
2. The TAG agreed that two-year programs were unlikely to lead to sustainable health communication programs and that extensions of program activity beyond two years should take place in the emphasis countries.
3. National versus regional implementation is not an "either-or" choice for HEALTHCOM. Projects implemented regionally have the potential for more universal application. The appropriate level of emphasis at a particular site should be governed by many factors, including both theoretical and practical considerations and a country's ability to commit various resources.

4. The TAG endorsed the current mix of interventions the project is supporting. HEALTHCOM's agenda does not include AIDS education in any significant way at this time. However, the project must remain sensitive to the interrelation between child survival and AIDS issues, and cooperate with missions to the extent possible.

IV. ISSUE 4: EVALUATION OF PROJECT SUCCESS--

Statement of Issue

What criteria should be used in HEALTHCOM's overall midterm evaluation later this year? In countries where priorities or constraints make quantifiable changes in health practices an unlikely outcome, what is an appropriate evaluation approach and level of effort for assessing accomplishment of other program objectives?

Discussion

Dr. Robert Northrup pointed out the problematic nature of evaluating a project which provides technical assistance but cannot control many of the factors determining the success of its interventions. In theory, evaluation might measure the following: impact of the project on morbidity and mortality; changes in behavior; appropriateness of individual aspects of the methodology (were media products successful? was research adequate? institutionalization achieved?); central project management (was the quality of administration and staff high? did the project meet country requirements? were findings disseminated?) HEALTHCOM should only be held accountable in certain areas. Dr. Northrup asked the participants to consider what criteria are most relevant to an evaluation of the HEALTHCOM project.

Mr. Clay said A.I.D. is presently developing the scope of work for the midterm evaluation. He emphasized the difference between evaluation of the HEALTHCOM project, and evaluation as a part of the HEALTHCOM methodology. "Success" as reflected in the summative evaluation of an intervention is not necessarily an appropriate measure of the project itself.

Members of the TAG agreed with Dr. Northrup about the difficulty of measuring and attributing impact of a communication intervention in a complex country environment. Morbidity and mortality changes are particularly difficult, and expensive, to document. There was consensus that HEALTHCOM's country programs should be judged primarily on the basis of knowledge and behavior changes achieved, and the degree of methodology transfer, or institutionalization.

Mr. Rasmuson noted that even these two primary objectives--to bring about a change in health practices and to institutionalize the HEALTHCOM methodology--may come in conflict with each other when time and resources are limited. In a two-three year intervention, particularly in a large complex country, it may be impossible to show significant progress towards both of these goals. He noted that the health education units in Ministries of Health with whom the project is working are largely very weak institutions in terms of trained manpower and other resources. Mr. Rasmuson suggested that HEALTHCOM should make a realistic assessment of opportunities and constraints on achievement of its various objectives in each country, and then prioritize these objectives. Evaluation of project success should then be on the basis of these stated priorities.

Dr. Foote noted that a midterm evaluation should play a diagnostic and constructive role. For example, it should point to ways of paring down costs or show ways in which the country interventions may have been pared too lean. He said evaluators should not lose sight of the fact that HEALTHCOM should be driven by market research. An evaluation should focus on questions of methodology. He questioned whether operational funds and time available to the resident advisor are realistic in view of project goals.

Summary Conclusions

1. HEALTHCOM does not have control over many elements influencing a country intervention. In the long term, positive changes in health knowledge and in behavior are the most appropriate indicators of project success.
2. The project's midterm evaluation is primarily a diagnostic tool to identify both strengths and weaknesses of implementation to date and suggest appropriate midcourse changes.

V. SUMMARY COMMENTS--

Mr. Robert Clay
Public Health Advisor, S&T/H

Mr. Robert Clay, Cognizant Technical Officer of the HEALTHCOM project, summarized the major views expressed during the project's second annual TAG meeting. The meeting reaffirmed strong interest in the HEALTHCOM project and reflected the growth evident after ten years of work in child survival and communication. The broad interest and participation in the TAG by A.I.D. personnel also reflected the agency's continuing commitment in this area. Mr. Clay then outlined specific goals for HEALTHCOM to focus on in the next years:

- To be aware of the dangers involved in spreading project efforts too thin, and to keep a long-term perspective on possible expansion.
- To continue weighing the relative advantages of working at the national and regional levels in specific countries.
- To be sensitive to in-country constraints.
- To assess necessary and available resources when establishing individual country goals.
- To exercise caution in developing interventions related to complicated child survival areas such as malaria, nutrition, and ARI.
- To continue to develop the HEALTHCOM methodology as the project expands its experiences in additional countries.
- To document and disseminate the lessons learned by the project to the broader international development community.
- To strengthen efforts to institutionalize the HEALTHCOM methodology in assisted countries so that sustained programs will be developed.
- To continue to coordinate communication activities with other organizations and projects.

**HEALTHCOM PROJECT
TECHNICAL ADVISORY GROUP MEETING
February 9, 1988**

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

Morning

MODERATOR: Dr. Kenneth Bart

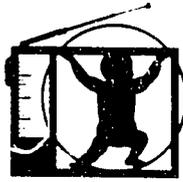
- 9:00 a.m. Opening remarks Dr. Nyle Brady
- 9:10 a.m. Management Review of Project Mr. Mark Rasmuson
- 9:20 a.m. Introduction of Issues Dr. William Smith
- 9:30 a.m. Issue 1:
Policy Change and Communication Planning Dr. William Smith
- How can large-scale health communications programs best adjust to shifts in bio-medical policy such as the growing emphasis on home-available solutions in CDD Programs?
- 10:45 a.m. Issue 2:
Research and Development Dr. Robert Hornik
- Where should HEALTHCOM focus its R and D efforts in the future? What are the key policy issues emerging around communication for child survival programs which HEALTHCOM should help address?
- 12:15 p.m. Summary comments Dr. Clifford Block
- 12:30 noon Luncheon Embassy Suites Hotel (next door to the Academy)

Afternoon

MODERATOR: Ms. Anne Tinker

- 2:00 p.m. Issue 3:
Program Priorities Dr. Robert Black
- Should HEALTHCOM focus its resources in a smaller number of emphasis countries rather than continuing expansion? Is the project committing its resources to the right mix of interventions?
- 3:30 p.m. Issue 4:
Project Evaluation Dr. Robert Northrup
- What criteria should be used in HEALTHCOM's mid-term evaluation? Which project objectives--campaign results, methodology development, or institutionalization--should be emphasized and form the basis for evaluation in different countries?
- 4:15 p.m. Summary comments Mr. Robert Clay
- 4:30 p.m. Conclusion of meeting

ISSUES



Issue 1

POLICY CHANGE AND COMMUNICATION PLANNING

At their best, systematic health communication programs can help teach specific new health skills to large population groups. In some public health programs, the desired behavior changes may be difficult to induce although they are straightforward and of proven effectiveness--stopping smoking, for example. In the case of several of the most important child survival interventions, however, the technologies or behaviors being promoted are still evolving in nature. Research continues, for example, to find more effective oral rehydration solutions--a super-ORS--and more efficient technologies for immunization, growth monitoring, and ARI.

This poses both practical and ethical issues for a large health communication program. How should a health communication program deal with a new health product or practice which, while safe and effective, may nonetheless be changed dramatically or replaced in the course of a few years?

In Nigeria, for example, current official national policy for ORT calls for the aggressive promotion of sugar-salt solution. This policy is under review and may shift in the next year in the direction of emerging international policy--towards a diminishing emphasis on SSS, increased promotion of home-available fluids, and increased access to ORS packets.

In Indonesia, the communication component of the ORT program is required to support a three-step approach: home fluids for "beginning diarrhea"; ORS products for "diarrhea plus weakness"; and treatment at a clinic for "moderate to severe dehydration." The complexity of this message is seen by HEALTHCOM staff as significantly confounding achievement of measurable impact.

But for the time being, HEALTHCOM in both countries is faced with the dilemma of either actively promoting an official host government policy and practice which may soon be discredited or changed, or not promoting it and being in violation of current policy. Such situations are complicated by the following factors:

- o Communication planners in general and HEALTHCOM's advisors in particular are not (and should not be) policy decision-makers. While they can advise and encourage policy changes, they must await policy decisions by the government agencies they assist.
- o In many countries, however, official national policies lag far behind changes occurring among the international health community.
- o Experience and common sense demonstrate the difficulty of changing communication objectives frequently. Consumers will become confused. Shifts in consumer awareness are not easy to produce on a regular basis.
- o As the most visible part of a public health program, the communication component is most vulnerable to criticism and may be unfairly blamed for inconsistencies or shifts in program policy.

Two questions are posed for the members of the TAG:

1. **What are the most important changes likely to occur in the major child survival technologies (particularly ORT and EPI) in the near future that will have significant policy implications for health communication?**
2. **How can large-scale health communication programs best adjust to shifts in biomedical policy? Should programs, for example, back off from specific instructional objectives in favor of more generic approaches—e.g., from how to mix a specific ORS solution to why to give more fluids?**



Issue 2

RESEARCH AND DEVELOPMENT

HEALTHCOM's research and development efforts fall into three main areas:

1. Applications of the project methodology and evaluation of its impact in individual countries, as well as cross-country comparisons.
2. Resurveys in the two original project sites--Honduras and The Gambia--and analysis of the data to help determine long-term effects of the original interventions.
3. "Health Practice Studies" and formative research conducted in individual country programs to identify problems associated with the introduction of new health practices or materials and possible solutions to these problems.

The main research questions being asked in each of these areas are the following:

Evaluation of New Country Programs

1. What activities were actually carried out?
2. Were the messages learned and accepted?
3. Were practices themselves altered?
4. Was the campaign successful in bringing about desired health outcomes?
5. Who is likely to be affected by a broadcast message?
6. Did institutionalization occur?
7. How do characteristics of particular sites (e.g., administrative, economic) affect the program?
8. How does the HEALTHCOM methodology evolve as projects are implemented and evaluated?

Resurvey in Honduras and The Gambia

1. Has knowledge and practice of ORT been maintained over time?
2. What are the characteristics of ORT adopters and persistent users?
3. What are the characteristics of cases treated with ORS?
4. How accurate are mothers in mixing and administering rehydration solutions?
5. What is the relationship between knowledge and attitudes and behavior change?
6. What is the effect of campaign intensity on learning and adoption of ORT?

7. Is there a relationship between changes in diarrheal mortality and the HEALTHCOM intervention (in Honduras)?

Health Practice Studies

1. What quantity of ORS solution do mothers actually give their sick children (Mexico)?
2. How does the structure and quality of clinic health education about immunization influence mothers' knowledge and practice (Ecuador and Nigeria)?
3. What difference does a modular approach to EPI education and carefully tested teaching aids make on mothers' knowledge about immunization (Nigeria)?
4. What are current practices among mothers for treating acute respiratory infections (Honduras)?
5. What factors influence women's choices among health prevention/treatment options for their children (Zaire)?

Additional information on these research questions and activities is provided in the background papers at the end of this book.

The specific questions for the TAG in this regard are:

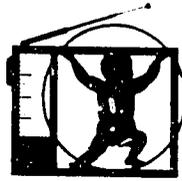
1. Are HEALTHCOM's current R-and-D efforts on target? Where should HEALTHCOM focus its research efforts in the future?
2. What are the key policy issues emerging around communication for child survival programs which HEALTHCOM should help address?



BEHAVIORAL STUDIES BY COUNTRY AND CONTENT FOCUS

	PHC DELIVERY	HEALTH ED. METHOD	ORT	EPI	ARI	VIT. A
LAC						
Honduras				X		
Ecuador			X			
Guatemala	X					
Mexico		X				
AFRICA						15
Zaire *	X	X				
Nigeria	X		X			
ASIA						
Indonesia *					X	
Philippines				X		
OTHER						

*Research plans are either under consideration or pending due to factors in-country.



Issue 3

PROGRAM PRIORITIES

HEALTHCOM's portfolio currently includes 15 countries of tremendous variety in terms of population size, disease patterns, infrastructure, public health programming, political and bureaucratic constraints, etc. The Project has a mandate to work in up to 22 countries over the life of the Project. The interventions HEALTHCOM is supporting, as the accompanying chart illustrates, continue to be primarily diarrheal disease control and immunization, although several programs also include interventions such as growth monitoring, ARI, and child spacing. A country program is usually planned as a two-year effort.

HEALTHCOM recently conducted a broad internal review of its countries to identify priority efforts among them. The conclusion of this review was that HEALTHCOM should attempt to focus more attention and resources on a number of key countries: Nigeria, Zaire, Indonesia, the Philippines, Mexico, Ecuador. The major criteria used in selecting these countries were population size; need in terms of child morbidity and mortality; priority for A.I.D.; USAID mission support; and perceived opportunity for conducting a successful intervention with some positive measurable outcomes. A second list of countries emerged as secondary priorities for offering particularly unique opportunities for research and development and institutionalization--Honduras, Lesotho, Jordan, Guatemala.

The questions HEALTHCOM wishes the TAG to address are the following:

1. Should the Project focus its resources in a smaller number of emphasis countries rather than continuing to provide equal levels of support to all countries regardless of size or opportunity?
2. What are the criteria that should be used in deciding what emphasis countries should receive? Are the above criteria the most appropriate, and are the above countries the right emphasis countries?
3. How—through what mechanisms—can priority be given and resources focused? (For example, through multi-year extensions in priority countries?) What changes will be required in the current Project mandate?
4. Is the Project committing its resources to the right mix of child survival interventions?
5. Have we learned anything new about strategies for sustaining program efforts and effects over time?



PROGRAM OBJECTIVES

IN EXISTING AND PROJECTED HEALTHCOM SITES

	CDD/ORT	EPI	NUTRITION (Including Vitamin A, Breastfeeding, and Growth Monitoring)	MALARIA	ARI	FAMILY PLANNING BIRTH SPACING
HONDURAS	X	X			X	
ECUADOR	X	X	X			
MEXICO	X					
GUATEMALA	X	X				
HAITI	X	X				
PARAGUAY	X					
INDONESIA	X	X	X			
PHILIPPINES	X	X			X	
PAPUA NEW GUINEA	X		X		X	
JORDAN	X					X
YEMEN	X	X				
ZAIRE	X	X		X		
MALAWI	X	X		X		
LESOTHO	X	X	X	X		X
NIGERIA	X	X		X		X



Issue 4

EVALUATION OF PROJECT SUCCESS

The objectives of the HEALTHCOM Project, as stated in AED's contract, are the following:

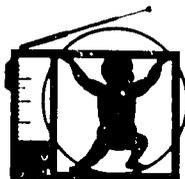
- o To complete development of the communication methodology through its application to child survival and the multiple practices that influence the survival of children, including diarrhea control, infant feeding, breast feeding, child spacing, handwashing and related personal hygiene, participation in immunization programs, the use of food rich in vitamin A, and cooperation with water and sanitation and vector-borne disease programs;
- o To complete the integration of two major emphases from social marketing-- product promotion and consumer education aimed at changing practices-- into the methodology;
- o To expand the applicability of the methodology by using it at approximately ten new sites representing different institutional and/or technological conditions (such as the absence of a strong health services infrastructure in the poorest countries, expanded reliance on the private sector, or the increased use of television in countries where television is prevalent);
- o To support further the process of institutionalization of the methodology at all project sites in so far as possible;
- o To undertake "diffusion" activities so that knowledge and use of the methodology is spread to other A.I.D. projects, U.S. academics and practitioners, and the broad community of donor agency professionals.

HEALTHCOM will be evaluated against these objectives at two levels: results of individual country interventions as measured by HEALTHCOM's evaluation subcontractor, The Annenberg School of Communications; and overall Project performance as determined by an external evaluation. The Project's midterm external evaluation is being scheduled by the Office of Health in mid-1988.

At the individual country program level, an ongoing dilemma for HEALTHCOM is to determine the relative weight to give the different Project objectives--obtaining campaign results, methodology development, and institutionalization. Different countries offer very different opportunities for and constraints upon achievement of each type of objective. In small resource-poor countries such as The Gambia, for example, institutionalization may be an important but rather unrealistic goal. On the other hand, in larger countries, with more sophisticated communications systems, such as Indonesia, methodology development and institutionalization may be easier but assessment of communication effects quite difficult. In some countries (e.g. Malawi), government bureaucratic constraints have literally pre-empted the implementation of a true mass communication campaign. It is the Project's position at this time that each of its country programs should clearly prioritize the objectives which it expects can realistically be achieved; allocate its resources according to those priorities; and be evaluated accordingly.

We would like the TAG to address two evaluation-related questions:

1. What criteria should be used in HEALTHCOM's overall midterm evaluation later this year?
2. In countries where priorities or constraints make quantifiable changes in health practices an unlikely outcome, what is an appropriate evaluation approach and level of effort for assessing accomplishment of other program objectives?



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