

HEALTH EDUCATION THROUGH INTERACTIVE RADIO:
A CHILD-TO-CHILD PROJECT IN BOLIVIA

Michelle L. Fryer¹

Infant mortality in Bolivia is the highest in Latin America, and has increased from 150/1000 in 1972 to 213/1000 in 1984. The highest rate is found among the Quechua population living in the high valleys (277/1000)². During the 1980s, Bolivia initiated massive campaigns promoting child survival themes among the adult population, particularly in the area of vaccinations. In spite of these efforts, diarrheal disease and resulting dehydration is responsible for two-thirds of all deaths in children under the age of five. In 1985, the Bolivian Ministry of Public Health estimated that 24% of all children in this age group suffer from the occurrence of diarrhea at any given time; and as much as 50% of the population may not yet be immunized against polio, diphtheria, and measles. Malnutrition is a major contributing factor to other causes of death in children. The National Institute of Alimentation and Nutrition estimates that one in two Bolivian children under the age of five suffers from some degree of malnutrition.

Physicians and medical anthropologists agree that two of the principle obstacles to improved health in Bolivia are (a) the synergism that exists between malnutrition and infection, and (b) resistance to non-traditional interventions because of widespread misinformation, a general lack of knowledge, and poor intercultural communication. Both of these barriers can, however, be overcome through appropriate education. In 1989, the USAID/Bolivia funded Radio Education Project (REP) decided to test the feasibility of using an alternative-instructional model called "interactive-radio instruction" (IRI) to teach easily applicable health concepts and behaviors to upper primary-school children.

By using interactive radio to target children in the formal school environment (rather than traditional media to reach parents in the nonformal environment), we were able to develop an effective

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² Ministerio de Salud Publica, La Paz, Bolivia.

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instructional methodology which integrates basic knowledge in health with practical activities that children can do for themselves. The result is a combination of attitude modeling and behavior change. "Diarrhea Prevention and Oral Rehydration" was selected as the subject of the test module because of its relevance to ongoing Child Survival activities in Bolivia. Cochabamba, a city in the high central valley, was chosen as the test site because of its large bicultural/bilingual population (Quechua), proliferation of squatter settlements, and notoriety for problems relating to water contamination and availability.

The Child-to-Child Approach.

In departure from traditional projects which target the adult population, particularly women of child-bearing age, the Radio Health curriculum was designed for upper-primary-school children in the 8-13 age group (fourth and fifth grade) who often act as caretakers for younger siblings and engage in household activities relating to food preparation and sanitation. These older children have a major influence on the health and nutrition of their younger siblings, and it is critical that they have the ability to make informed decisions and to provide responsible care. In addition, children who learn basic health concepts and practices at a young age are more likely to maintain them as parents.

Interactive-Radio Instruction.

Experience in a number of projects around the world has demonstrated the "interactive-radio methodology" to be a cost-effective mechanism for improving the efficiency, accessibility, and quality of education systems in developing countries. Previous projects have shown that interactive radio can effectively teach mathematics, science, reading and writing to children in the formal and nonformal setting; however, its application in the field of health had never been tested.²

² The most extensive research-to-date on IRI can be found in the three-volume collection *Radio Mathematics in Nicaragua*, Patrick Suppes, Barbara Searle, and Jamesine Friend, eds. (Stanford, Calif: Stanford University, Institute for Mathematical Studies in the Social Sciences, Vol 1, 1976; Vol 2, 1978; Vol 3, 1980). For information specific to the application of IRI in Bolivia see Michelle Fryer, *First-Year Summative Evaluation: Second-Grade Mathematics by Radio, Bolivia, Radio Learning Occasional Paper Series* (Education Development Center, 1989). Dean Jamison, Barbara Searle, Klaus Galda, and Stephen Heyneman compare the effects of IRI and of textbooks on student learning in *Improving Elementary Mathematics Education in Nicaragua: An Experimental Study of the Impact of Textbooks and Radio on Achievement, Journal of Educational Psychology* (Vol 73, No. 4, pp 556-567, 1981); whereas Marlaine Lockheed and Erick Hanushek assess the efficiency of IRI

Interactive-radio lessons are designed to provide direct instruction to students. Traditionally, each interactive-radio lesson consists of a 25 minute radio broadcast which is reinforced by the teacher during a 20 minute postbroadcast session. The programs, which are broadcast every day of the school year, help to enliven the classroom atmosphere through the use of stories, songs, learning activities, games, and physical exercises which invite the active participation of students in the learning process. In addition, teachers' own knowledge of basic subject matter is reinforced through the instructional-radio programs and complementary postbroadcast activities.

Interactive radio received its name from the creative approach of its broadcast style which gives one the impression of a rapid-fire dialogue between the "radio teacher" (RT) and the student. The radio lessons, which use programmed instruction to immediately question students about new concepts and to reinforce students' responses with the correct answer, lead students to subject mastery through inductive and participatory activities. On the average, children respond to instruction by the radio every 25 seconds. Each program calls upon the students to respond orally to questions presented in short stories and in drill and practice sessions, sing learning songs, write key concepts in their notebooks, read from the blackboard or from special worksheets, engage in problem-solving exercises, and join in physical activities. For example:

RT : Children, how much liquid should you give a young child with diarrhea?
Pause : ...(4" for student response - "One liter each day")
RT : And should you give children with diarrhea all of the liquid at once, or little by little?
Pause : ...(4" for student response - "Little by little")
RT : If you believe that you should continue feeding a child with diarrhea, raise your hand.

and other instructional interventions such as teacher training and peer tutoring in *Improving Educational Efficiency in Developing Countries: What Do We Know? World Bank Reprint Series* (No. 435, 1989). The use of IRI in second-language instruction is documented in *Teaching English by Radio: Interactive Radio in Kenya*, Maurice Imhoof and Philip Christensen, eds. (Washington, D.C.: Academy for Educational Development, 1986); and *Radio-Assisted Community Basic Education (RADECO)*, Ruth Eshgh, James Hoxeng, Johanna Provenzano, and Beatriz Casals, eds. (Pittsburgh, PA: Duquesne University Press, 1988) focuses on using IRI to teach children in the nonformal environment. The most comprehensive review of all IRI activities to date can be found in *Interactive Radio Instruction: Confronting Crisis in Basic Education, A.I.D. Science and Technology in Development Series* (Washington, D.C.: Agency for International Development, 1990).

Pause : ... (4" for student response, but few children raise their hands as this is not traditional practice.)

RT : Children, lower your hands and let us ask grandmother how she cares for children with diarrhea.

Gdmthr: ... (Four minute radio drama in which Grandmother, a traditional opinion leader in the Quechua community, answers the above questions and presents new information on which the children are later drilled.)

In 1987, Bolivia became the first country in South America to use interactive radio to teach mathematics at the primary-school level, and in 1989 they became the first country in the world to apply this methodology to primary-school-health education. This year, approximately 10,000 fourth and fifth-grade students in 250 schools will participate in the Radio Health lessons.

Target Audience Assessment.

Because of the sensitivity of teaching primary health care in a country as socially, culturally, and geographically complex as Bolivia, background research had to be conducted to establish a baseline profile of the target audience. Prior to starting any curriculum-development activities, current literature on diarrheal disease and oral rehydration was reviewed. In Bolivia, studies by the Ministry of Public Health and project documents relating to child-survival activities were analyzed and local experts with experience in health education were interviewed. All ethnographic and anthropological studies relating to cultural practices in health, specifically to diarrhea, were examined to gain insight into intervention acceptance and rejection by specific population groups. Based upon this preliminary data, the curriculum team was able to begin to define the socio-cultural context for developing the Radio Health lessons.

To ensure the design of an appropriate health-education curriculum which is both culturally relevant and practical, REP conducted extensive field research into the target population's perception of specific health problems and interventions. Since health practices and dietary habits are influenced by socio-cultural beliefs, an anthropologist was contracted to conduct individual and focus-group interviews with 50 parents from the target area. The objective of the interviews was to gain additional baseline data on parents' understanding of basic health concepts, their belief in myths related to diarrhea and nutrition, community health and sanitation practices, and sex roles relating to family health and nutrition activities and decisions. An equal number of children were also interviewed about their perceptions of health problems and practices, household responsibilities, home-life, and sibling care.

To gain first-hand knowledge of the contextual reality of the children in the target group, the health team visited participating communities to observe common sanitation practices; to evaluate how families acquire, use, and care for their water supplies; and to interview community health workers on outreach activities. They also observed classes in neighborhood schools to gather additional information about students' levels of scholastic achievement; and participated in recreational activities such as games and drawing to learn more about students' interests, motivations, and interpretation of specific words and images.

Curriculum Development.

Children living in marginal-urban settlements are frequently the victims of Bolivia's health crises. Health education, however, is not included in the official urban curriculum. Because Bolivian schools use the trimester system, we developed the Radio Health intervention using a modular format consisting of 10 lessons related to a common theme that could be taught once a week during science class, physical education, or home economics. In addition to modifying the format of the program, we also adapted the method used in the mathematics program to suit slightly older students. Individual rather than group responses were intensified, role-play activities were incorporated into the radio lessons, and stories were used to dramatically illustrate important messages.

Selection of the behavioral objectives of the module was the first task in the curriculum development process. Using the baseline profiles as a guide, the health team identified activities related to personal hygiene, household sanitation, and caretaking that children in the 8-13 age group can do for themselves, or that they can do for or teach to younger siblings. In order to select those diarrhea-related behaviors which could be influenced as a result of health education, each activities was evaluated using the following criteria, based upon the HEALTHCOM "Principles of Behavior" index⁴:

- (a) compatibility of behaviors with existing practices and beliefs;
- (b) perceived benefit by target audience (better health, self-esteem, credibility among peers and parents);
- (c) ease of instruction;
- (d) immediacy of benefit;
- (e) real and perceived costs (use of locally available materials);
- (f) ease of implementation;
- (g) impact (high);

⁴ For more information about activities and resources funded through HEALTHCOM, contact the Academy for Educational Development, Washington, D.C.

The final list of targeted behaviors included:

- (a) handwashing and the internment of personal waste;
- (b) garbage disposal and food preparation;
- (c) water acquisition, usage, and purification;
- (d) primary health care relating to the preparation and administration of oral rehydration solutions.

Identifying the knowledge and attitudes antecedent to the practice of the desired health behaviors was the next step in developing the health-education curriculum. Since health behaviors and eating habits are influenced by socio-cultural beliefs and attitudes, the scriptwriters' ability to integrate these beliefs into acceptable messages was critical for the effective design of the final curriculum.

TABLE 1.
Message Design, Module 1, Diarrhea.

1. Personal Hygiene

Behaviors:	Wash hands before eating and after going to the bathroom.
Knowledge:	Physiology of diarrhea
Attitudes:	Dirty hands lead to sickness
Behaviors:	Designate a special place for personal waste, bury waste when possible.
Knowledge:	Personal waste carries sicknesses
Attitudes:	Urine and feces are dirty, its bad to dispose of personal waste where others can touch it, or where it is accessible to flies.

2. Household Sanitation

Behaviors:	Water - Fill all containers, avoid contamination, purify for children.
Knowledge:	Microbes (sickness) can enter the body through water, microbes are killed when water is boiled.
Attitudes:	Small children are more susceptible to sickness, water can be a friend or an enemy.
Behaviors:	Garbage - Keep garbage in one place, free of flies.
Knowledge:	Flies carry sickness, flies live where there is garbage.
Attitudes:	Flies are dirty and dangerous.
Behaviors:	Food - Protect from flies, wash fruit
Knowledge:	Food can become contaminated by flies, when handled by dirty hands, when covered by dirt, or when prepared by dirty utensils.
Attitudes:	You can conserve food with little effort.
Behaviors:	Utensils - Clean and dry well, do not use baby bottles if possible.
Knowledge:	Dirty utensils can lead to sickness, bottles can cause diarrhea, a five-month old baby can drink from a cup.
Attitudes:	Baby bottles are not very good, clean utensils are healthier to use than dirty utensils.

3. Recuperation from Diarrhea

Behaviors:	Recognize the symptoms of diarrhea.
Knowledge:	Process of dehydration, humans and all living things need water to survive.
Attitudes:	Dehydration can cause death.
Behaviors:	Rehydration - ORS, homemade recipes, test
Knowledge:	Liquid lost needs to be replaced, ways of correctly preparing and administering ORT, salt and sugar helps absorption.
Attitudes:	ORS can help to make a sick child well.

Behaviors:	Feeding - Continue feeding children with diarrhea.
Knowledge:	Children need food to the strength that they have lost due to illness. A weak child will become sick again.
Attitudes:	Sick children can eat during their illness, feeding does not do harm to a sick child

Analysis of the knowledge, attitudes, and behaviors revealed six common themes that were used to structure the final lessons. Learning objectives to be achieved after the completion of all lessons were defined for each theme as follows:

TABLE 2.
Learning Objectives by Strand - Module 1, Diarrhea.

BY COMPLETION OF THE RADIO HEALTH MODULE, THE STUDENT SHOULD:

1. The Concept of Being Healthy.
Know five characteristics of being healthy.
 2. Causes of Diarrhea.
Identify six causal agents of diarrhea.
 3. Diarrhea and Dehydration.
Recognize the symptoms of diarrhea and dehydration.
Explain the cause and probable consequence of dehydration.
Know how to prevent dehydration and when to seek medical advice.
 4. Rehydration and Recuperation.
Know where to get ORS, how to administer it, and the amount of liquid you must give a child with diarrhea.
Demonstrate how to prepare ORS and homemade recipes using correct measures. Describe how to adapt teas for rehydration.
Explain the importance of continued feeding for sick children.
 5. Good Habits.
Explain five good habits to avoid getting diarrhea.
 6. Child-to-Child.
Give specific examples of how older children can help younger children prevent diarrhea, help them recover from diarrhea, or teach them about hygiene.
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The final step in developing the Radio Health curriculum was to sequence the presentation of all knowledge, practices, and attitudes. For example, the preparation of an oral rehydration solution (lesson 5) should not be taught until the child knows the

difference between clean and contaminated water (lesson 4), and ways of purifying water (lesson 4). Other prerequisite knowledge and skills include understanding of the causes, symptoms, and results of severe dehydration (lesson 2) and the concept of rehydration (lesson 3). The most important concepts were reinforced over several lessons, and practical activities were taught in the postbroadcast session. Table 3 illustrates the final curriculum outline developed by the health team.

TABLE 3.
Content Outline - Module 1. Diarrhea.

LESSON NUMBER	BEING HEALTHY	CAUSES OF DIARRHEA	DIARRHEA & DEHYDRATION	REHYDRATION & RECOVERY	GOOD HABITS	CHILDREN TO CHILDREN	POSTER/VIDEO/TEACHER GUIDE
1. Being Healthy	Song 1. Characteristics of being healthy vs. being sick	Embedded in story (water, flies, feces)	Common illnesses Seriousness of Diarrhea	Recognizing normal health: state of body - skin, eyes, hair, mouth, body functions	Relationship between cleanliness & good health	Embedded in story (older child caring for younger child)	Discuss story relationship to real life Homework: Ask parents about no. of deaths from diarrhea in family.
2. Pers. Care	Song 1. More characteristics of being healthy	Dirt & microbes Feces & urine	Who is susceptible What happens in the body during diarr. Symptoms - when to seek medical attention	Parts of body where dehydration appear	What to do with feces & urine - latrines "special" places, burying	Teach younger children where to relieve themselves or clean up after themselves	Make a simple water filter cut 2 flowers put one in water, leave the other out
3. Pers. Care	Song 1.	Personal hygiene	Song 2. Causes, symptoms & results of severe dehydration	Concept of rehydration - prevent dehydration by giving liquids	Wash hands before touching food & after urinating or defecating procedure for thorough wash	Teach younger children where & when to wash	Make gourd doll to show dehydration Show examples of containers to measure 1 liter
4. Water & ORT	Song 1. We are in charge of our own health	Contaminated water	Song 2.	Adapting teas with salt and sugar How much liquid a child with diarrhea needs	Purifying water with sun or heat protecting clean water	Suggestions for care of a sick child	Sunning water Practice measuring liter & teaspoons Prepare teas using sugar and salt Homework: Is there a water committee in your community
5. Water & ORT	Song 1.	Contaminated water - house use	Home remedies for diarrhea	ORS Homemade Solution	Conserve water reuse if poss. Help family get water Encourage parents to work with community to acquire potable water	Teach younger children not to drink dirty water and to conserve water	Prepare ORS & homemade solution Homework: Write rhymes about the preparation of ORS

LESSON NUMBER	BEING HEALTHY	CAUSES OF DIARRHEA	DIARRHEA & DEMYDRATION	REHYDRATION & RECOVERY	GOOD HABITS	CHILDREN TO CHILDREN	POSTBROADCAST TEACHER GUIDE
6. Home Sanitation & ORT	Song 1. Relationship of growth to health	Flies & Garbage	Song 2. When to seek medical attention	Song 3. Administration of liquids - method, pace, pos. adverse reactions, & persistence	Garbage disposal Protecting food, utensils, dishes & cooking surfaces from flies	Teach younger children where to throw garbage & monitor them	School clean up campaign, place garbage containers in key locations Form a school committee for clean up & monitoring
7. Home Sanitation & ORT	Song 1.	Baby bottles Protecting a baby from contracting diarrhea	Song 2. Babies are most susceptible to diarr. especially bottle-fed babies	Song 3. Administer ORT to baby using spoon not bottle - continue breast feeding during diarr.	Wash hands before feeding baby Use clean utensils	Teach babies to drink from a cup Avoiding use of baby bottle	Present a short play about garbage or hygiene to 2nd and 3rd grades
8. Nutrition	Song 1. Relationship of appetite to health	Relationship of malnutrition to diarr.	Song 2. Undernourished children are more susceptible to diarr.	Feed children during & after diarrhea - need for more food nutrients	Choosing healthy snacks Take advantage of food @ home	Choosing healthy foods for small children	Exercise in choosing healthy snack Make nutrition posters for school & for home
9. Nutrition	Song 1.	Fruit - green, spoiled, unwashed	Song 2. Folk beliefs	Good practices of folk healers	Choosing fruit & washing it	Teach younger children to wash fruit before eating	Show dirt on fruit. Practice choosing & washing fruit Homework: Write a story about a child who prevents diarrhea
10. Review	Song 1. Review	Review	Song 2. Review	Song 3. Review	Review	Review	Game: The Route to Preventing Diarrhea

Implementation.

The Radio Health module built upon the operational infrastructure already in place under the Radio Education Project. Schools participating in REP were used to field-test the IRI health module. Between April and June, REP field-tested the ten-lesson Radio Health module in five fourth-grade and five fifth-grade classrooms in Cochabamba. These classrooms represented urban, suburban, and rural schools with students from diverse social, cultural, and economic backgrounds. Approximately 450 primary-school children, mostly of Quechua heritage, participated in the field-test; and 20 school teachers and administrators were trained in the use of the interactive-radio health programs. Although the math lessons are broadcast over the radio, the health programs were tested using cassettes for maximum control.

Each lesson was used once a week and consisted of a 25 minute recorded program followed by a 20 minute period for teacher-led instruction. A teachers' guide, also developed through the project, provided teachers with practical hands-on activities to

strengthen children's understanding of basic health concepts. Take-home exercises were designed to involve family participation.

A brief, one-day orientation session was designed to train teachers in the use of the interactive-health programs. Special attention was given to helping teachers conduct the postbroadcast activities. Individual and focus-group interviews were conducted as part of the training session to document teachers' attitudes towards the intervention, and to assist in tailoring the post-broadcast activities to participant needs and available resources. Follow-up interviews were conducted throughout implementation.

Evaluation.

The field evaluation was designed to get an understanding of whether interactive-radio can be used to effectively teach upper-primary-school students easily applicable health concepts and behaviors. Formative evaluation was used on a regular basis to monitor the technical quality of the interactive-radio lessons, while summative evaluation was used to validate the impact of the instructional intervention, and focus group interviews were employed to gauge overall acceptance of the Radio Health program.

Formative Evaluation.

Wherever interactive radio instruction has been used throughout the world, children have responded with enthusiasm. Nevertheless, regular visits to classrooms using the radio programs were considered an important component of the evaluation plan in order to assess the teachers' utilization of the programs and the students' response. Trained observers visited an average of three participating classrooms every week to gather information on the:

- (a) audio quality of the programs including sound effects and voices,
- (b) pacing of the instructional material,
- (c) appropriateness of the language,
- (d) timing of the pauses,
- (e) level of student/teacher involvement,
- (f) errors in the radio lessons or printed support material,
- (g) clarity of instruction, and
- (h) student interest in and understanding of important concepts taught by the radio.

These observations were used to make changes in future lessons.

Formative evaluation was particularly helpful in identifying problems that teachers had in using the lesson guides. Our first three guides were four pages each and consisted of instructions for the teacher relating to the radio program, and the postbroadcast session. By the end of the third week, it became evident that many teachers were not reading the material prior to health class, and

were therefore caught off guard during certain participatory activities. Testing the hypothesis that teachers were biased against using support material in front of their students, we made various changes to the format of the next five guides including reducing their length to two pages, using large print that could be easily read at a distance, and presenting the teacher-led postbroadcast activity first. When this did not produce the desired results, a decision was made to minimize the role of the teacher during lesson nine; and in lesson ten, we included a worksheet for each student rather than a guide for the teacher. In the end, we concluded that teachers may have difficulty using their guides because they are unfamiliar with this teaching method and do not appreciate the importance of reinforcing concepts in the postbroadcast session. More emphasis on the teachers' guide during teacher training may be able to resolve this problem.

Summative Evaluation.

The purpose of the summative evaluation was to measure the effectiveness of the Radio Health curriculum in terms of learning outcomes and behavior change among the children, and to assess the reaction of parents and teachers. Prior to initiation of the radio lessons, more than 400 students in all ten classrooms were given the pretest. Each student's age, sex, first language, position in family, and caretaking responsibility was also recorded. Upon completion of the ten-lesson module, the same test was administered a second time. The test was derived from the learning objectives developed for each theme and reflected the type of test most commonly used at the upper-primary-school level. It consisted of 47 questions including fill-in-the-blank, true/false, multiple choice, and short answer. Pretesting was conducted in La Paz, and the final version was recorded on cassette to avoid any variance in administration.

The results indicate improvement between the pretest and the posttest (Table 4). In particular, there were five areas in which we were able to note highly significant gains ($p < .001$) in student knowledge over the course of the pilot.³ These include:

- (a) Knowing the amount of liquid that an infant or child with diarrhea should drink (pretest=22%, posttest=89%)
- (b) Understanding the correlation between bottle feeding and frequent diarrhea (pretest=43%, posttest=72%)
- (c) Recognizing one or more symptoms of dehydration in a drawing of a baby (pretest=12%, posttest=80%)

³ *Final Report: Interactive Radio Health Education Pilot Project*, Dr. Judiann McNulty (Bolivia 1989).

- (d) Identifying one or more ways in which older children can help younger children with diarrhea (pretest=40%, posttest=80%)
- (e) Describing how to mix homemade ORT correctly (pretest=1%, posttest=46%)

TABLE 4.
Summary of Average Test Scores by Grade.

	4th GRADE		5TH GRADE	
	N	% CORRECT	N	% CORRECT
Pretest	224	51%	214	57%
Posttest	211	70%	199	76%

Observations by parents and teachers suggest that the radio lessons had a positive impact on children's attitudes and behaviors. Many parents mentioned that their children had talked about "health class" at home. Several parents noted that their children have become more responsible for their own health (more motivated about hand washing); and others talked about their children constructing water filters for the household and paying more attention to washing the hands and bottles of their younger brothers and sisters. Two teachers reported that their schools had also adopted the water purification techniques taught in the radio lessons for their main water supply. Most important, children are beginning to understand the concept of "being healthy".

The attitudes of teachers and parents towards the Radio Health lessons were documented through focus-group interviews and by questionnaires at the end of the field trial. In general, teachers commented that the lessons were effective in teaching children basic health concepts and practices, easily managed in the classroom, and perceived as a useful tool for enhancing their ability to teach difficult subjects such as health. The ability of children to adopt the prescribed behaviors, and their potential to teach these to other family members became evident through our interviews with parents. Parents seemed open to the messages brought home by the children and also collaborated in the construction of home water filters. In the end, parents requested that the programs be broadcast in the evening so that they could participate in the lessons with other family members.

CONCLUSION.

Since 1974, interactive radio has been used to teach mathematics, science, and language to primary-school children in 11 countries around the world. In 1989, Bolivia became the first country to test the feasibility of using this powerful instructional methodology in the area of health education. Through this experience we learned that children can be taught basic health-care concepts and behaviors, provided they are presented in a context that is socially and culturally relevant to the target audience. We also discovered that young children can be used as catalysts to transmit health related practices and knowledge to other family members. Interviews with parents demonstrated their acceptance of the health-education intervention as well as their desire to participate in the Radio Health programs.

Based on the strength of the pilot results, USAID/Bolivia has committed itself to continued support for Radio Education Project's development of additional modules for third through fifth grades in primary school, and sixth grade in junior high school. Areas of expressed interest include accident prevention and first aid, nutrition, environmental protection, narcotics education, and sex education. In the meantime, REP begun broadcasting the Radio Health pilot module over 18 radio stations in five of Bolivia's nine Departments.

About the author:

Michelle Fryer resides in La Paz, Bolivia where she is Chief of Party for Education Development Center's Radio Education Project.