Abstract

Communication for Child Survival, or HEALTHCOM, is a worldwide research and development project grounded in the theory of health communication—a health education approach which attempts to change a set of behaviors in a large-scale target audience regarding a specific problem in a predefined period of time. The HEALTHCOM Project seeks to institutionalize its methodology so that further implementation is sustainable. This paper describes the project's history and methodology, articulating a set of issues regarding institutionalization. Briefly highlighting country successes, the paper also discusses challenges to sustained behavior change from a woman-in-development perspective.

About the Author

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Diffusion and Development: Challenges to Institutionalization from Women in Development Perspective

by

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DIFFUSION AND DEVELOPMENT: CHALLENGES TO INSTITUTIONALIZATION FROM A WOMEN IN DEVELOPMENT PERSPECTIVE

INTRODUCTION

In 1978 the United States Agency for International Development (A.I.D.) initiated a project to apply state-of-the-art knowledge about communication and social marketing to selected child survival practices. The Academy for Educational Development, a Washington, D.C.-based educational service organization, was contracted by A.I.D. to implement the project under the name Mass Media and Health Practices (MMHP).

From 1978 to 1985 MMHP developed a methodology for conducting public health education in developing countries to effectively reach large numbers of people and applied it in six project sites--Honduras, The Gambia, Ecuador, Peru, Swaziland, and Indonesia. The methodology integrates communication (radio, graphic print materials, and interpersonal communication) and social marketing with traditional channels of health education, training, and product distribution. It relies on the systematic development, testing, and monitoring of communication strategies, messages, and products to bring about positive changes in health-related practices. All of the original country programs focused on the promotion of oral rehydration therapy (ORT) and other key objectives of national diarrheal disease control efforts.

In August 1985 A.I.D. extended the project under a new name--Communication for Child Survival, or HEALTHCOM. The Academy was contracted to administer HEALTHCOM for an additional five-year period, and the project's mandate was broadened to include additional countries and a range of child survival technologies, in addition to ORT. The project continues to be jointly managed by the Office of Health and the Office of Education in A.I.D.'s Bureau for Science and Technology.

HEALTHCOM's primary purpose is to increase our understanding of how best to use modern communication, social marketing, and behavior analysis to modify existing child care practices. HEALTHCOM's experience to date, as well as that of health communication programs in other countries such as Egypt and Bangladesh, has shown clearly that communication strategies can improve child care practices.

HEALTHCOM pursues a significant research and development agenda which includes a series of country-specific studies. Each HEALTHCOM intervention is designed to provide some significant insight into one or another of several key issues.

HEALTHCOM's current objectives include: to complete development of the HEALTHCOM methodology by applying it to an expanded array of child survival technologies and to multiple practices that influence child survival; to complete the integration of social marketing, product promotion, and consumer education into the health communication methodology; and to expand the applicability of the methodology to further support the process of institutionalization.

METHODOLOGY[1]

Social Marketing: The Organizing Principle

Philip Kotler defines social marketing as "the design, implementation, and control of programs seeking to increase the acceptability of social idea or practice in a target group."[2] Like commercial marketing, social marketing relies on analytical techniques (market research, product development, pricing, accessibility, advertising, and promotion). Social marketing sells products and practices by appealing to people's needs and preferences; however, it encourages changes in behavior which will benefit society as well as the individual.

In international health programs, social marketing may involve both the selling of a commodity and the selling of an idea or practice. In fact, social marketing almost always begins with promotion of a health-related attitude or belief. It builds upon that to make recommendations for a new product or service, and to provide instructions of effective use. The fact that little or no money changes hands in such marketing efforts--that what is exchanged may seem intangible but heavily value-laden--can make these programs considerably more challenging than conventional marketing.

Although socially beneficial products (e.g., condoms and oral rehydration salt) are often subsidized, the actual selling process can be critical because it raises consumer motivation, stimulates entrepreneurial activity among wholesalers and retailers, increases the potential for long-term program self-sufficiency, and is a simple measure of program success. Marketing techniques are also essential to the "selling' of new practices. The consumer must make complicated trade-offs between old and new beliefs, between familiar and unfamiliar practices, and make investments of time and effort to achieve unverifiable and sometimes unpleasant short-term results.

Socially beneficial products, or "social products," are different from commercial ones in important ways. For example:

- Social products are often more complex to use than commercial ones.
- They are often more controversial.
- Their benefits are often less immediate.
- The market for social products is difficult to analyze.
- Audiences for social products often have very limited resources.

These extra challenges mean that the research and planning stages of a social marketing effort must be particularly sound.

Social marketing relies on a fundamental consumer orientation. The consumer is not only the primary audience, but also the measure of whether activities are appropriate, desirable, and successful. The consumer is systematically consulted throughout the communication process and provides the data for key marketing decisions.

Before a new offering is introduced, the environmental and psychological factors which will affect an audience's attitude toward the offering must be thoroughly researched. The audience will be comprised of various subgroups, each with unique views, values, and needs. Research therefore begins with

audience segmentation--a process of identifying subgroups and determining which media are most prevalent and appropriate to each. Subgroups are usually determined by: (1) demographic characteristics--age, sex, income, education, literacy, social class, family size, occupation, religion, race, or culture; (2) geographic characteristics--region, size of place, population, density, or mobility; or (3) psychographic or behavior characteristics--lifestyles, values, or stages of product "readiness."

Child survival efforts put great weight on considerations of parents' or caretakers' income and "product" readiness. The primary audience generally consists of lower income populations--those most in need of health products and services. This group, however, may include individuals in various stages of awareness, ranging from ignorance of the offering, to unenthusiastic acquaintance with it, to various levels of enthusiasm. Understanding the readiness stage of different audience segments is essential in positioning a product correctly.

Social marketing perceives the consumer as the center of a process involving four variables: product, price, place, and promotion. A successful program is organized around a careful analysis of each variable and a strategy which considers how they will interact.

A proposed product, whether a commodity, idea, or health practice, must be defined in terms of the users' beliefs, practices, and values. "Product position" is the term social marketing uses to describe the mental and market niche created for each promoted item to distinguish it from competing products or ideas. Extensive audience research guides the development of the product (its name, packaging, tone, and rationale) and the portrayal of its benefits.

Price can refer to a monetary expenditure, an opportunity cost, a status loss, or a consumer's time. The fact that a rural woman pays no money for a vaccination does not mean that it costs her nothing. Indeed, the day of travel, the inconvenience to family, or the risk of a child's reaction may seem more costly than the perceived benefits.

Place refers to the channels through which products or offerings flow to users and the points at which they are offered. Product availability and distribution may involve not only retail and wholesale supply systems, but also the efforts of health providers, volunteer workers, friends, and neighbors. Child survival products and services are frequently not as easily available to users as competitive, less appropriate products, because of weak public sector supply systems. An important planning task in a public health communication program is the choice of appropriate and powerful channels for bringing products to intended audiences. Every "place" has its "price" and the challenge is to reduce that price as much as possible.

In any social marketing activity, promotion requires extensive consumer education to assure appropriate use of products. While public health communicators use marketing tools to increase the impact of promotional efforts, they must also draw from principles of instructional design to teach complicated consumer skills. Motivational strategies are also essential in encouraging adoption of new ideas and social products. Particularly in closely-knit rural areas, community activities can be effective promotional devices.

Behavior Analysis: Selecting Messages and Improving Instruction

Behavior analysis provides public health communication programs with a rigorous focus on the consumer. It acts as a microscope to reveal what people are actually doing with regard to a particular health problem, and why. Behavior analysis is the study of environmental events, or determinants, that maintain or change behavior patterns. It offers systematic methods for observing and defining behaviors, for identifying behaviors which are conducive to change, and for bringing about and maintaining behavior change. Its principles have been successfully applied to a wide range of health issues including prevention of heart disease, dietary management, smoking cessation, and, recently, diarrheal disease control.

Within the context of child survival, an individual caretaker--usually the mother--is faced with difficult choices between existing practices and new behavior. Recommended practices may require her to take a well child to a health center to be stuck with a needle and possibly become fitful all night; to remember the correct preparation of home oral rehydration solution; to remember when to introduce weaning foods, and to determine which ones are best. She may have to determine whether her child is malnourished or just small. She may also discuss having fewer children with her husband who wants another male child. Each decision or response to a given situation is determined by a complex set of behavioral influences. Whether a new pattern of practice is easy or difficult to adopt, it may not be easy to accept. Behavior analysis can help probe for the reasons that a given practice persists and can determine how alternate behavior might be best introduced--how the behavior can be introduced and encouraged, to ensure it is adopted and maintained over time.

Not all health practices which sound promising in theory are practical in real life. In the first place, behavior is often more complex than it initially appears. What may at first seem to be a simple practice often turns out to be a complex cluster of behaviors made up of many separate steps, some of which require new skills or engender costs to the individual. One of the most significant contributions of behavior analysis has been the focus on the complexity and sequential nature of the behavior required of a target audience. It has also provided us with tools to break down practices into their component and observable parts, so that they can be more readily addressed in an instructional program.

A change in behavior may require the target audience either to modify an existing pattern or to learn a new one. In either case, program designers need to understand the full context in which a new practice or set of practices will occur:

- What are the environmental events which precede or stimulate the behavior, that is, its antecedents? Are there any natural antecedents (such as a child's thirst when dehydrated) which could stimulate a new behavior (such as giving ORT)?
- What are the characteristics of the behavior itself? How simple or complex is it? How frequently must it be performed?
- What is the nature of events which follow a behavior, that is, its consequences? Are they readily apparent, rewarding or punishing, immediate or delayed? How will they affect the repetition of the behavior?

By breaking down health practices into these component parts, planners can gain a clearer idea of where along the chain of events to focus program messages most effectively.

The behavioral approach identifies existing practices that are compatible with new ones, to look for approximations of new practices already known in current behavior, and to evaluate the actual costs and benefits--both social and economic--or adopting new practices. Behavior analysis helps identify positive consequences which follow adoption of a new behavior and suggests ways to avoid or eliminate negative outcomes. It emphasizes that, while there are many means of shaping a new behavior pattern, positive consequences, or at least the avoidance of negative ones, are essential to its maintenance.

The process of learning entails not simply the acquisition of knowledge, but also mastery of new skills and entire patterns of action. Behavior analysis stresses the importance of testing new behavior in real-life situations, much as marketers test new products, to identify problems that individuals may encounter in adopting them. It also emphasizes the need for careful instructional design in accurately teaching and reinforcing new practices. Critical behavior principles used in designing instructional programs include modeling of new behaviors; repeated practice; discrimination between correct and incorrect performances; and use of positive reinforcement.

Anthropology: Behavior in Context:

Anthropology is the study of human beings, their cultures, and their relationships in society. While behavior analysis provides a kind of microscope for human actions, anthropology can explain the cultural context in which these actions thrive.

Every successful public health program must consider the cultural context in which it operates--the prevailing perceptions, beliefs, and values, as well as practices. Through the observational techniques, key-informant interviews, and other approaches of ethnographic research, health communicators can look clearly at the traditions of their audiences and develop programs compatible with them.

Anthropology can help us understand cultures different from our own. We often fail to recognize the importance of being sensitive to beliefs and value systems, however, when dealing with close neighbors. Anthropology, like social marketing and behavior analysis, reminds us that every audience is made up of subgroups having different characteristics, all of which determine how a promotional effort will be received.

All societies are in constant transition. In developing countries, the shifts are often more pronounced, and the contrasts more poignant. Societies may hold firmly to some aspects of the past while at the same time rushing to adopt new technologies and new behavior. Cultural differences result in different beliefs and practices regarding a particular health issue. Moreover, individuals change at different rates. Studies of early adopters often mislead planners into believing that change is easy, while analysis of late adopters can lead to skepticism about the possibility of change.

Techniques of ethnographic research, including observations, interviews, and methods of evaluation, can provide valuable information about a culture's perceptions, beliefs, and practices--and the meaning it attaches to them. Ethnography is the recording, reporting, and evaluation of culturally significant beliefs and behavior in particular social settings. Such research generally requires long periods of study and active participation in the day-to-day life of a group, community, or organization under investigation. Ethnographers work in the spoken language of those they study and generally tend to place a greater emphasis on intensive observation and verbal interactions with knowledgeable members of the community than on documentaries or surveys.

Ethnographic data can provide a wealth of marketing information, but credible ethnographic research requires flexibility, patience, a certain amount of trial and error, and long, hard effort. Some programs may not be able to afford intensive, long-term ethnographic research. However, program planners can benefit from tapping the professional expertise of anthropologists in conducting interviews with consumers and in designing research instruments. Moreover, the cultural and linguistic sensitivity that an anthropologist brings to the design of a survey or an intervention is invaluable.

In addition, ethnographic literature is quite extensive for many parts of the world. These secondary data, gathered by anthropologists living in program areas, can provide essential information on the economic structures of households and families, male-female relationships, traditional beliefs about health and illness, and specific health practices.

It is important to keep in mind that both ethnography and qualitative marketing research may be subject to a fundamental criticism: they depend heavily upon the individual expertise and experience of the persons doing the observing, interviewing, and analyzing.

A discussion of the methodology would not be complete without emphasizing that this approach relies on the use of integrated media and underscores the importance of qualitative research.

Integrated media is critical both to message delivery and behavior change. The mass media (usually radio) can reach large numbers of people in a short period of time and therefore serves to increase awareness. Interpersonal communication--usually interaction between mother and healthworker--is important for decision making. It is usually this interaction which serves as the persuasion point. Print materials add to the mix, providing reminders and instruction when a new practice is to be carried out.

Qualitative research ensures that public health communication programs are based on an understanding of target audiences. Research methods include sample surveys, intercept surveys, focus group discussions, in-depth interviews, ethnographic studies, and behavior observations. The results of this developmental research aid program planners in establishing measurable objectives and realistic strategies for the communication program. Qualitative techniques probe opinions, practices, and beliefs, while quantitative research measures and counts.

SUCCESSES

HEALTHCOM (including the Mass Media and Health Practices Project--MMHP), now has ten years of collective experience in communication for child survival. It can demonstrate a record or achievement in a variety of settings and cultural contexts. The following examples are illustrative but by no means exhaustive.

In Ecuador, the HEALTHCOM Project assisted the National Child Survival Program, PREMI, in the implementation of a seven-week radio course for mothers. The course employed several different types of incentives for both mothers and auxiliary nurses. It was designed for caretakers of children who live in rural and poor urban areas. The twenty minute programs were broadcast daily and began with a ten-minute episode of a soap opera based on child survival themes. Preliminary results show that the program was extremely successful. A total of 5,755 mothers, or 80 percent of those originally enrolled in the program, completed the four tests. After the completion of the radio course, the popular Saturday television show "Sábados para todos" interviewed mothers who had participated in and graduated from the radio course. These mothers invited other mothers to go to vaccination posts and explained the reasons why vaccination is important. In addition, eight mothers who attended a health center in Quito were brought to the program to take part in a question-and-answer program. These mothers were awarded educational scholarships for their participation.

In Guatemala, as in many other countries, HEALTHCOM provided the Ministry of Health (MOH) with short-term technical assistance to incorporate audience research into long-term child survival activities. National knowledge, attitude, and practice (KAP) studies of mothers with children under five were undertaken with the aid of the Annenberg School of Communications in Pennsylvania and INCAP in Guatemala. The results were used to update and inform Ministry of Health decision-makers, and hence to influence policy as well as to design messages.

Diarrhea case management training has been a HEALTHCOM priority in Indonesia. In the four districts in West Java where oral rehydration therapy (ORT) intensification activities have taken place, approximately 660 health center workers and over 15,000 volunteers have received formal classroom training, based on a revised training model developed in response to a HEALTHCOM-assisted evaluation of the previous training design. HEALTHCOM also assisted the Ministry of Health in the design of training materials and the planning of an additional round of training for 20,000 health personnel.

The Metro Manila Measles Vaccination Program in the Philippines used radio and television to encourage mothers to bring children 9-12 months of age to the health centers for measles vaccinations. Post-intervention data shows that television, followed by radio, was the main source of information regarding measles vaccination.

A health practice study was carried out in Malawi in the area of malaria treatment and control. The objective of the study was to determine whether traditional birth attendants (TBAs) could be trained to treat fever/malaria in children under five, and provide chemoprophylaxis to pregnant women to prevent malaria. In addition, the first set of primary health care materials on

malaria and diarrheal disease control ever to be designed in the country were developed, pretested, produced, and distributed. These materials included malaria and diarrhea booklets for community health volunteers; one liter ORS containers; training manuals for health workers; ORS mixing posters; a flipchart for health workers on malaria and diarrhea; and a manual on priority disease technical and communication skills for health workers and supervisors.

Much of HEALTHCOM's energy in Lesotho is devoted to institutionalization of the HEALTHCOM methodology. Particular emphasis has focused on strengthening the Health Education Unit itself by encouraging new positions and training for the Unit staff. Now in its third year, HEALTHCOM is helping the Unit adopt a management system appropriate to its expanded size and scope.

INSTITUTIONALIZATION ISSUES

One specific objective of the HEALTHCOM Project is to "further support the process of institutionalization," defined 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."[3] Acceptable indicators of institutionalization for HEALTHCOM include:

- personnel competency resulting from in-service training
- modification of routine procedures and job descriptions
- modification of management expectations reflected in policy and/or management directives, plans for future-year activities, and changes in staffing and budgetary allocations reflecting an ongoing accommodation of the methodology within the institution(s)

HEALTHCOM believes that the critical elements of its communication methodology to be institutionalized are: strategic integration of communication with other program elements; regular, comprehensive communication planning; use of formative research to inform plans and strategies; focused instructional goals established around a narrow set of behavior objectives; use of multiple, integrated communication channels; careful testing of all educational materials; and regular monitoring of program activities to identify and correct problems. Skills needed to implement these aspects of the methodology include research, communication planning, design and production, and management.

The many constraints to institutionalization range from the availability of technical assistance to print prejudice and fear of media. These obstacles need to be overcome through creative strategies which address such program components as financing, community participation, host country policy, program management, and appropriate program design.

In the course of its work, HEALTHCOM has identified three crucial issues related to institutionalization:

Institutionalization of What--Institutionalization may be operationally defined in a number of ways. For example, it may be defined in terms of at least three quite distinct aspects of implementation in HEALTHCOM country programs: (1) a specific child survival program: (2) a particular behavior change which the project is attempting to induce; (3) the communication methodology being developed by the project. Clearly, emphasizing one of these aspects over the others will result in quite different project activities and expected outcomes.

Institionalization vs. Mortality Reduction--Another of HEALTHCOM's primary overall objectives is to support the mortality reduction goals of particular child survival programs. There is significant tension between this objective and institutionalization. This tension varies according to the respective level of effort which a project advisor can devote to each objective. At one extreme, HEALTHCOM in a particular country could devote all of its energy and resources to program activities designed to bring about immediate, visible changes in the behaviors affecting childhood mortality. At the other extreme, the project could focus exclusively on the task of strengthening the capacity of health educators to conduct health communication routinely and expertly according to the project methodology and in a manner which could improve health behavior in the long term.

Institutionalization vs. Sustainability--The last several years have experienced the emergence of strongly articulated support in the international health community for a concept of sustainability. Sustainability may be defined as "a program's continuing to deliver services or sustain benefits after the donor's technical, managerial, and financial support has ended."[4] Thus, a fundamental question in discussions on program sustainability concerns" the distinction between sustaining the activities and sustaining the benefits." To date, no magical solutions to program sustainability have been identified. Buzzard concluded:

> A review of issues relating to the sustainability of A.I.D. efforts to improve the health of the world's poor found that sustainable programs are most likely to result when they are affordable (by the country and the community), when beneficiaries have a role in planning and managing them, when simple and effective management systems are in place, and when program objectives are focused but not limited to a single intervention. The truth is, however, that we do not yet know what contributes to sustainability. Each project is, to some extent, unique, and there may be no single variable that determines the long-term viability of a project.[5]

CHALLENGES

Buzzard's definition of sustainability and the distinction drawn between sustaining activities and substaining their benefits are key to an analysis of program objectives from a woman-in-development perspective. Further, in underscoring that beneficiaries must have a role in planning and managing programs, Buzzard illuminates an important principle which has been increasingly recognized, if only rhetorically.

It is widely acknowledged that "hospitals, clinics, and health programs are less vital to the world's health than are the actions of women, whose key role in the home enables the world's inhabitants to eat and drink, to live in a warm, clean environment, and to work outside the home for wages."[6] When illness occurs, the mother's intervention is essential because she must recognize and treat common diseases or make/seek a decision to secure outside help. Thus, women have become principal "targets" of global programs to prevent disease and promote health.

But a woman's own health and nutrition are key determinants in her child's survival. In addition, her daily seasonal workload will largely determine how much time she will have to assess her child's growth or to learn about immunization and oral rehydration. Even with the best will in the world, women may lack time, energy or understanding to do their part in providing primary health care for their children. It is not easy to prepare special foods in addition to regular meals, or to leave the field to bring a baby to a health center for immunization or weighing. Often, when she gets to the health center, a mother may be chastised for waiting so long to come, or she may find that no health worker is present. Frequently, critical choices regarding resources must be made. For example, should a mother use her daily supply of water to prepare ORT for one sick child, or to cook a meal for her other children? If she takes the sick baby to the clinic, who will mind the others, and how will she recoup time lost toward food production?

As a result of these conflicts, mothers often feel guilty, confused, and powerless. One donor official was prompted to declare that primary health care programs are "creating a Third World version of Supermom. We tell women to stay at home to breastfeed, to go to the clinic to weigh the baby, to get involved in income generating projects, to learn oral rehydration, nutrition, and hygiene. And then we say we respect her cultural role which means she still has to fetch firewood and water!"[7]

Women's time allocation as it relates to child survival is a critical area for further study. It is well known that women in developing countries face severe time constraints, working an excessive number of hours and balancing the competing demands of work in the home, the field or market, and work related to child care. But assessing the time women spend on health care either in the home or via health services is far more difficult. These activities tend to be sporadic. "Reporting time spent by women on illness or health care utilization as an average amount of time per day tends to mask the true cost of periodically losing a day, or half a day, needed for home production or market work, particularly during the peak agricultural season."[8] Leslie points out that, to date, limited research on time costs as a determinant of utilization of health services has tended to focus on acute needs. Time costs associated with preventive strategies, likely to be repetitive and to require routinization, may represent a more important deterrent to sustained and effective implementation.

Little empirical data have been gathered on women's time costs for child survival strategies, or on whether these time costs are a significant determinant of the use of child survival strategies. An attempt to develop a model for research has been developed by Buvinic et.al. at the Washington, D.C.-based International Center for Research on Women (ICRW).[9] The research framework proposed by ICRW is specific to Sub-Saharan Africa, but provides the basis for more generic study. As outlined, the model

> shifts the focus of inquiry from issues concerning the beneficiary to issues concerning the implementor of child survival and development strategies. The model also distinguishes between factors influencing trial of a new childrearing strategy (initiation), and those influencing the sustained use of the strategy over time (maintenance). This framework suggests that contextual variables at the community, household and individual levels affect women's ability and motivation to choose to initiate a new childrearing practice or utilize a service. Anticipated costs and benefits of utilizing the service or practice also affect initiation. The model further suggests that the consequences to initiation, largely those derived from the characteristics of the services and practices themselves, will have a significant impact on whether women choose to adopt a new service or practice with regard to childrearing.[10]

Building on this paradigm, Marlett evaluated factors influencing the use of oral rehydration therapy in The Gambia, in a study related to HEALTHCOM's early work there.[11] Using data collected from 1982 to 1984, the study examined factors which might constrain or enhance a woman's ability to use ORT. The basic analytic objective was to investigate the relationship between initial and sustained use of ORT. (See Figure 2.) The study found that the most important variable in predicting repeated use of ORT was a mother's workload. The amount of time that a mother had available did not influence whether she tried ORT. However, once a mother had tried it, her work burden influenced whether or not she continued use of ORT. These findings were corroborated in a 1987 follow-up evaluation study conducted by Applied Communication Technology.[12]

SUMMARY AND CONCLUSIONS

Communication for Child Survival, or the HEALTHCOM Project, represents a pioneering research and development effort aimed at applying the principles of communication to global health-promoting strategies. The Project recognizes that communication, planned or not, is often the key to whether a development project succeeds or fails. And it knows that if a message isn't appropriate in terms of content, medium, or target audience, it isn't really communication. HEALTHCOM understands that one of the critical considerations in designing effective communication for primary health care is that the chief audience is women. Therefore, the most basic aspect of HEALTHCOM's approach is to find out women's concerns and beliefs regarding their children's health. In-depth qualitative research in relation to a particular health issue serves both as the baseline for monitoring project effects and as a planning device of communication programs. In addition, the role of women in child survival projects extends beyond "target audience." Women are recognized as health resources and health providers who are therefore in need of training, appropriate incentives, and rewards.

The HEALTHCOM methodology provides for an effective combination of social marketing, behavior analysis, and anthropological investigation. Social marketing provides the framework upon which to build a solid health communication program. Behavior analysis focuses on actual health-related practices and helps identify areas of greatest opportunity for change. Anthropological investigation uncovers meaning in the observed practices and

suggests mechanisms for linking new ideas to traditional values. Each discipline provides a significant contribution to program design.

At the same time, a broad and in-depth scientific analysis from a women-in-development perspective is required in order to understand fully the ramifications of such variables as time costs and time savings in the longer view of meeting primary health care objectives. Donors, planners, and policy-makers, while paying rhetorical homage to this perspective, continue in large part to operate superficially or on the basis of untested assumptions with respect to women's role in health maintenance and health-promoting behaviors. Systems analyses compete with, rather than complement, analysis of the individual in assessing the impetus for decision-making, trial, and practice. And change agents continue, in many cases, to impose their own agenda on the community they purport to serve.

Women, must finally be viewed not only as incubators and child caretakers, or "beneficiaries," "acceptors," and "target audiences," but also as full partners in the business of primary health care. The results of policy, planning, and program implementation cannot be fully realized until women's actuality is fully appreciated. Hoodfar, in an evaluation of child care and child survival activities in low-income neighborhoods of Cairo, said that "while [women] may not always choose the best practices from a medical point of view, their decisions are related to their own experience, knowledge, and resources. For those organizations that want to improve the situation, the approach must take women themselves fully into account."[13]

Figure 1

THE HEALTH COMMUNICATIONS PROCESS

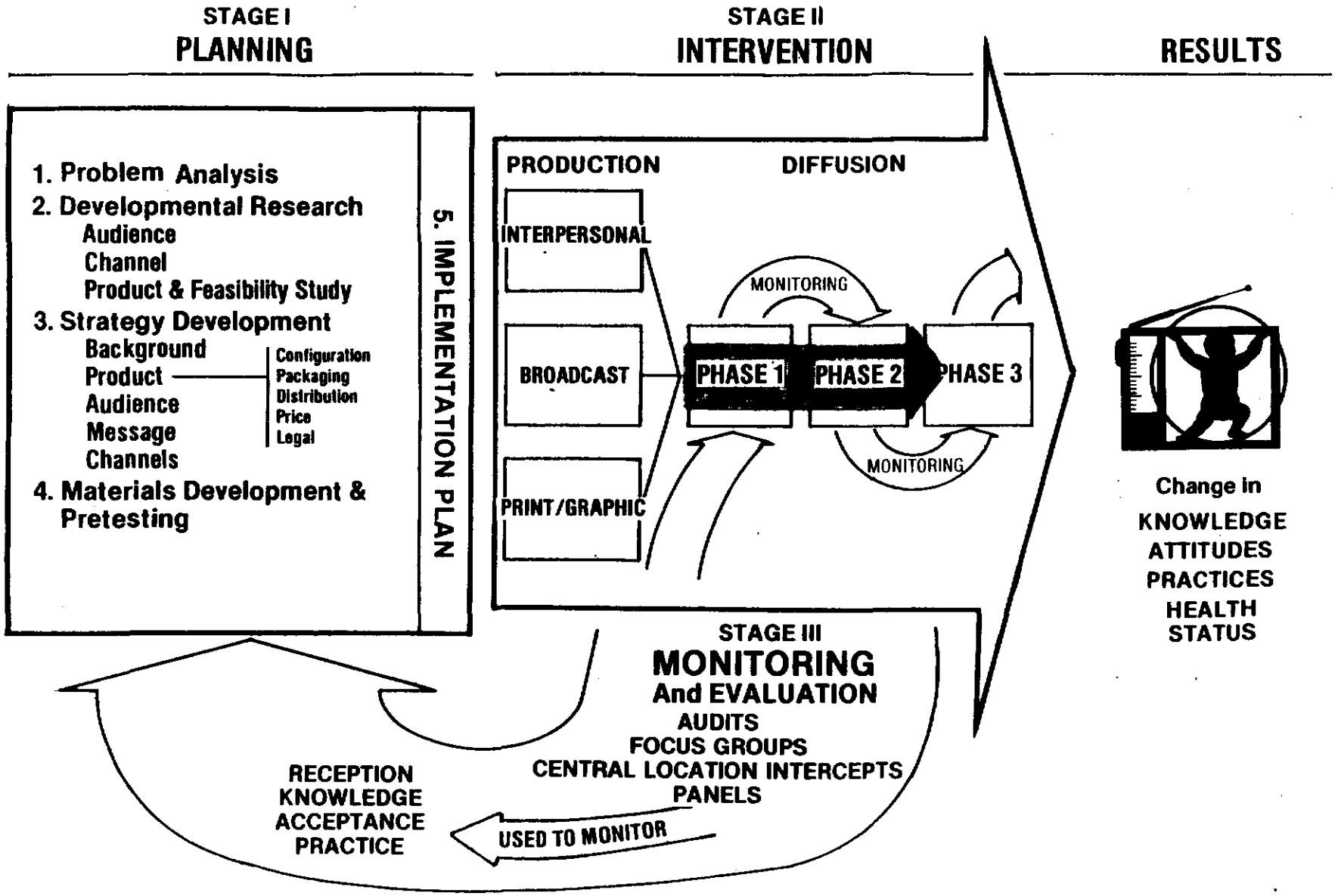
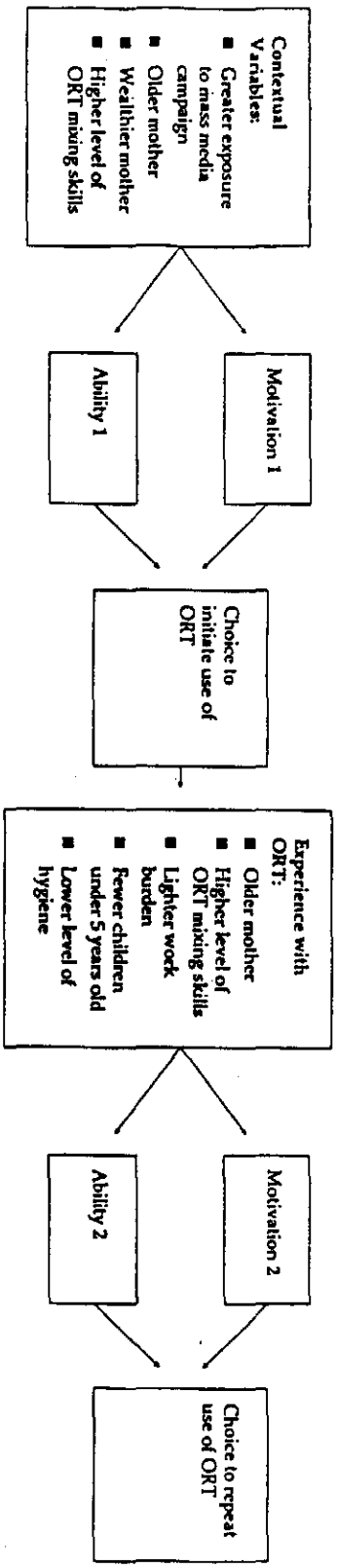


Figure 2

Factors Explaining a Gambian Mother's Initial and Repeated Use of Oral Rehydration Therapy During the MMHP



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The WID Program at Michigan State University began its *Women in International Development Publication Series* in late 1981 in response to the need to disseminate the rapidly growing body of work that addressed the lives of women in Third World countries undergoing change. The series cross-cuts disciplines and brings together research, critical analyses and proposals for change. Its goals are: (1) to highlight women in development (WID) as an important area of research; (2) to contribute to the development of the field as a scholarly endeavor; and (3) to encourage new approaches to development policy and programming.

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