The views expressed in this report do not necessarily reflect the views of the United Nations Children's Fund.

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THE ROLE OF COMMUNICATION IN COMMUNITY DEVELOPMENT IN BURMA

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THE BASIS FOR COMMUNICATION IN DEVELOPMENT

FOREWORD

The present report on "The role of Communication in Community Development in Burma" is a side-product from a three months' consultancy with UNICEF Rangoon. The main task of the consultancy was to work with the PSC/PI officer in UNICEF, to give him an insight into relevant communication theories and practices to enable him to support the Government projects which UNICEF is involved in, with the necessary communication back-up.

Thus, it was not within the scope of the consultancy to undertake a comprehensive analysis of the status of communication work in Burma.

During our work, we became closely involved with a number of projects, at various stages of their planning and implementation. To the extent possible in each case, we worked closely with the Central Health Education Bureau (HEB). For a number of health and nutrition projects, working groups were established, consisting of project planners/implementers, HEB and UNICEF.

Through this work, which involved several field-trips to remote and less remote parts of the country (see Appendix 1), some observations were made regarding the communication situation in Burma. Furthermore, the need for communication support to the different projects we visited, was analysed. Some of these observations and analyses are offered here - not as statistically founded statements, but rather as indicators of where some attention might be placed in further discussions and analysis of the status and direction of communication work for social development in Burma.

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I would like to give special thanks to our Burmese colleagues in all the projects we have been working with, for their active interest in communication and for their infinite patience with a newcomer's ignorance to a country. The work has been a real learning experience, and I hope some of the thoughts provided in this report might be of some help. I hope some of our colleagues may find that their efforts in communication has been worth the trouble, and that they will find that their projects become more successful.

The critical comments are made very freely, though hopefully constructively, since I experienced a real openness to criticism during our work with the different projects. I hope the comments made here will be taken in the same spirit, and that they may help in the constant struggle to improve development projects to serve the people of Burma.

September 1982/ Ane Haaland
Communication Consultant to UNICEF, BURMA.

LIST OF ABBREVIATIONS

BCG	-	Immunization against Tuberculosis
BHS	-	Basic Health Staff
CNC	-	Community Nutrition Centre
DHO	-	District Health Officer
DMR	-	Department of Medical Research
DPT	-	Immunization against diphtheria
EPI	-	Expanded Programme of Immunization
ES	-	Environmental Sanitation
GCP	-	Goitre Control Project
HEB	-	Health Education Bureau
HEO	-	Health Education Officer
HNC	-	Hospital Nutrition Centre
KAP	-	Knowledge, Attitude, Practice
ORS	-	Oral Rehydration Solution
PSC	-	Project Support Communication
PSC/PI	-	PSC/Public Information (officer) - a title used for UNICEF's communication/PI man
TMO	-	Township Medical Officer (physician)
UNDP	-	United Nations' Development Programme
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
VHS	-	Voluntary Health Staff
WHO	-	World Health Organization

1. DEVELOPMENT COMMUNICATION - WHAT DOES IT MEAN?

Communication has always been a stepchild in development, because nobody is really sure of where exactly it came from, and nobody is willing to take the full responsibility for it, even though everybody has an opinion about its state of health, its nutritional need, and its behaviour, or rather - lack of proper behaviour.

Project Support Communication (PSC) is indeed a troublesome and complicated stepchild. He has all the adolescent or teenage problems of someone who is conceived as an offspring of Western theories, brought with his parents to a developing country, lives partly in a "Western" environment in an international agency, and is supposed to understand and function in a rural society which bears no resemblance to anything he has seen or experienced before. When there is trouble anywhere, he is usually the one to be blamed, or he is the one who is called in to "make things right". But even though people ask his opinion, he is often not listened to, because everybody is an expert on communication, and his right to exist is not really approved anywhere.

It is not easy to be PSC.

But what is this "stepchild" meant to be, what is the idea behind it, how has it come to develop the way it has? A definition of some concepts and a brief look at the history of development communication might give some answers to these questions. (Note: "PSC" and "development communication" are in this report used as meaning the same thing - i.e. communication support, in various forms, to development projects. The difference in terms stems from the fact that the theories and practices developed initially (in the late 1960es) were termed "development communication", or "development support communication", and these terms are most often used in academic literature as well as by a majority of development agencies. The term "PSC" was adopted by UNICEF in the early 1970es, and has continued to be used by this agency.)

Communication is a two-way process. It is a means to create a shared meaning with another individual, through exchange of opinions, ideas or information. The ways and means used to obtain the exchange can vary. It can be a discussion between a health worker and a group of mothers, with the aid of a teaching poster, or a planning meeting between village leaders and a

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representative from the water department, to discuss the possibilities for building a water system for the village. It can also be a policy discussion in the office of the minister, using video tape from a village discussion about a certain problem as a means of communication.

Briefly, we could say that development communication has gone through four main stages (for a more thorough discussion on the theoretical background, see e.g. J.E. Diaz Bordenave: Communication and Rural Development). Firstly, development communication professionals adopted the mass media techniques from the West and used them to try to persuade rural people to change or adopt technical innovations. Secondly, extension agents and outreach workers were employed to spread information to farmers in a more effective way, using interpersonal communication techniques and visual teaching aids.

In both of these approaches, "communication" was seen as a one-way street, and the beneficiaries of the various projects were assumed to be a mute mass who would happily and blindly accept what the central level development programmes had defined as being their problems, and the best solutions to these problems. It was assumed that the planners and decision-makers knew better than the villagers, and that there was no need to consult them on any matters. If they followed the advice of the mass communication and extension worker messages, they would be "developed", and happy.

It took a few years for the development planners and the bulk of the communication professionals to discover that these approaches did not help much to "develop" people in the villages. Important lessons were learnt during this phase from the vast number of project failures in the majority of the developing countries. Thus, in the third stage development planners turned to the social sciences. Communication was studied in the context of the society, as a part of the social interaction that takes place in a village or town where people have some relationship to each other, and this relationship defines how and about what they communicate. The extension worker and the radio were not necessarily the most effective communication channels - if a young health worker talked to a mother with five children about better weaning food to avoid malnutrition, she might not take the health worker seriously, because she rather looked to a respected older woman in the village for advice. Communication became more of a tool to find out how the society

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functions, what people know about a problem, what they do to solve it in their traditional way, and why they do it this way. Problems were no longer looked at in isolation from each other - it was recognised that rural people do not function according to the development programme structure where health is separated from water and sanitation, or from agriculture.

In the fourth stage, the observations and practices described above are carried further - to the practice of community development. Communication is seen as a vital tool in establishing a two-way contact between the developers and the ones to be "developed" - as an instrument to facilitate, but not dictate, social change. The "beneficiaries" are to be involved from the very first stage of a development project, from the planning stage through all the implementation stages. It was discovered that in projects where such an approach had been taken, there were hardly any problems with maintenance or continuation of the project, because the villagers saw it as "their baby". The community development approach recognises rural people as whole human beings in a society that functions well with what they have; they have dignity and the right to make their own decisions about the directions of change to be introduced into their society.

This sounds simple. Or doesn't it? It is actually quite messy to work with development this way, because it means that the "experts" can no longer sit around a table and design a project or a poster, and then implement it on the "target" population. It means in most cases that the "experts" have to go to the village or society and discuss plans with the village leaders, and reach an agreement about whether the project should be implemented - and how it should be done. This takes time, and it takes a different attitude to development work.

During the late 1970s, the community development approach was widely accepted by development planners as the most viable approach to development, and with it - communication as a necessary tool. The policies changed in several agencies. Then why has not more happened, why are there so precious few real changes in the implementation of the development projects?

There are a number of possible answers or explanations to this question. The change has happened mainly on an intellectual level among the decision-makers and project implementers - there have been enough good examples of

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the success of good community development projects to warrant policy changes. But this does not mean that people working in development necessarily change, if they are not given the structured opportunity to do so. There is a vast difference between sitting safely in an office and dealing with people from the same social, economic and educational background as oneself, drawing up project plans based on theories studied in an intellectually stimulating milieu at the university; and trying to discuss project plans and possibilities with down-to-earth farmers in a village one has reached walking through muddy rice-fields.

Most often, neither the project planners nor the implementors on the field level (e.g. health workers) have been trained to deal with the latter situation. Nor is the administrative project structure in many cases changed to accommodate the community development approach - the structure is most often based on a top-down approach. With obvious disparities between a pronounced "community development/community participation" approach and the possibility of incorporating the villagers' suggestions into the project plans, villagers will feel that their opinion was not taken into account, and will probably be disappointed and cynical and not co-operate with the project implementers more than they have to, to avoid punishment.

Now why all this as a background in a communication document? Because "communication" or "PSC" is only as good as the project it is supporting. It is a waste of money and effort to support a project that has little or no basis in the social reality of the "target" population, with sophisticated or well designed communication media. PSC is a part of the programming function - it is the social and human side of the technological projects. PSC may also support the project with media and/or teaching materials, based on sound knowledge about what the media and the materials can and cannot do. Educational materials are only a small part of the PSC input - and sometimes the question or problem at hand cannot be helped with media.

Preventive medicine is one example where media alone has very limited effect. To see clear results takes a long time, it takes the right communication approach, and it takes implementers who care about the people with whom they work - health workers/educators who engage in a dialogue with the villagers about their problems rather than scold them for doing the wrong thing. The health worker needs patience, and empathy - ability to put herself

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in the situation of her client. This is vastly different from diagnosing a disease and giving out pills to cure it. The results are much slower, and often difficult to measure. The pressure on health staff to show "what they have done" often prevents them from even venturing into a more effective, but slower teaching/learning process with the villagers.* Their supervisors are apt to ask "How many health education sessions did you give" (give - meaning one-way), and "to how many people have you explained about weaning food", rather than "what are the effects of your health education work on the community members?" Numbers are so much neater to deal with than changes in health behaviour and attitudes.*

In this light, the "media approach", where centrally conceived messages and ideas are promoted through various kinds of persuasive methods, has outlived itself. People cannot "be developed". They have to develop themselves.

PSC can be a powerful tool in a number of ways in this process. It can help inform people about the development choices they do have; it can be a link between villagers and project planners and implementers, thus facilitating community development; and it can assist in training people in the social and human aspects of their work, thus helping them to become better educators and change agents.

When applied this way, the communication process becomes a means to an end - not the end itself.

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* See also Appendix 2 and Appendix 7.

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2. BACKGROUND ON COUNTRY PROBLEMS

Burma is a socialist country in the South East Asian region, with a population of 34 million people. The main problems, as related to social and technical development, are the following(summarized from "Development of Basic Services for Mothers and Children in Burma (1982-1986). PLAN OF OPERATIONS, UNICEF) :

1. The main diseases in the country are diarrhoea, malaria, protein energy malnutrition, other respiratory system diseases, and cholera.

2. Children under five years are the most at risk regarding diarrhoel diseases, with peak incidence in children under one year.

3. Malnutrition affects the age group 1-3 years most severely.

4. Other diseases prevalent among children and mothers include trachoma and skin diseases, especially in the Dry Zone, and goitre and cretinism in the hilly and mountainous regions (incidence up to 90% in endemic areas.)

5. It is estimated that only 16% of the rural population have access to safe drinking water. Water problems range from scarcity (Dry Zone) to excess (Delta region) and contamination of water sources.

6. Less than 13% of the rural population use sanitary latrine facilities.

7. Many primary schools are overcrowded, with lack of adequate sanitation facilities. Local communities are responsible for construction and maintenance of schools, and lack of resources result in buildings and facilities that provide a poor learning environment.

8. Primary school enrollment rate range from 34% to 98%, with an average of about 65%. Many students repeat at least one grade. Only 27% of the children complete grade IV.

9. There are not enough teachers to cope with the expansion of the number of primary schools as well as the population increase.

10. There is a shortage of proper child care facilities, especially in the urban and peri-urban areas. Of the women between 15-60 years, 35.3% are in the labour force.

It is in this context and to these problems this report addresses itself, by analysing how PSC can be instrumental in helping to solve or alleviate some of these problems.

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3. PRESENT WORK IN COMMUNICATION

a. International Aid Organizations

The political infrastructure in Burma focuses on community development. On all levels, development aims at improving the people's standard of living. Thus, the climate for extensive work in communication support to projects, should be ideal.

Various aid-organizations support Government efforts through their emphasis on community based projects. In UNICEF's Plan of Operations (1982-86), in the "Basic Strategy of Programme", it is stated: (34) "The planned interventions are directed towards activities at the village and/or township level, wherever possible. ..." (36) "Active involvement of communities feature in every activity in the Plan. ..." (40) "All activities in this Plan will have a supportive component of communications strategy so that the impact at the community level will be enhanced".

WHO is assisting the Central Health Education Bureau (HEB) through a health education course for AHEO's which started in September 1982. The course focusses on the solution of health problems through understanding existing health practices, attitude and behaviour change and the communication processes involved, in addition to the technical information needed about diseases and their cure and prevention. The thirty participants are Asst. Health Education Officers (AHEOs) under HEB, and will greatly strengthen the work of the bureau.

(Note: No other WHO project was studied, nor WHO's policy in this field. This is a spotty observation and may be entirely out of context).

UNDP is also supporting the upgrading of health education personnel. Burma aims at starting its own health education course in the School of Medicine in 1986/87. The UNDP-assisted project finances overseas studies for a number of health educators who will develop and run such 18 month courses in Burma.

USAID has supported various health education training programmes with equipment and training consultants. In 1981, they supported a workshop to develop communication materials for nutrition projects. USAID is now also getting more closely involved in training support for voluntary village health staff.

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b. Government projects

The need for extensive communication support to development project is recognised by a large number of professionals in the fields of health and nutrition in Burma. (Note: The reason for concentrating on health and nutrition projects in this report is simply that we worked closely with these projects, and had no opportunity to analyse the situation in education and welfare programmes, and only to a limited extent in water and sanitation programmes. We hope there are as many devoted communication believers in these fields as there are in health and nutrition).

The Central Health Education Bureau (HEB) is set up to meet some of these needs. However, manpower and budget shortages have created difficulties for HEB. While able to meet some of the projects' need for educational materials and training, the demand for assistance has escalated quicker than HEB has been able to follow with their limited facilities to develop and produce educational materials.

The consequence of this situation has been that a number of projects have attempted to develop and produce their own visuals to meet the demands of their projects and their field workers for teaching aids of different kinds. Thus, health professionals with limited knowledge of communication processes and learning problems have developed their educational messages for the projects, and then struggled with professional artists pleading for simplicity in the visuals rather than coy artistic self-expression.

The results of these struggles have been varied, but most of the project people have learnt a lot in the process. The attempts by several projects to produce their own visuals have certainly not been in vain - neither from the process or product point of view.

However, spotty production of visuals usually does only a mediocre job of solving the pressing development problems at hand. Furthermore, it does not help to build up a professional capacity to produce good educational teaching aids. Most probably, the people who have taken the initiative to produce such visuals could certainly have become very good at this task - if they had had time to pursue it. However, in most cases, the production of educational materials is an added burden onto their already too busy work schedules.

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The involvement of the social sciences in the process of development communication has also not been developed to its full extent in Burma. While a major stumbling block to the success of development programmes is removed from the start with the Government's strong emphasis on community development and community participation, the success of the projects could most probably be further enhanced by using a stronger and more structured communication support input from the planning stages onwards. This means the acceptance of communication as a process throughout the project, not only as the visible product - the teaching aids and promotion materials.

Co-operation between social science specialists, who are often primarily researchers; project planners, who may be administrators, economists, physicians or planning specialists; and visual communication specialists who may be educators, artists and printing technologists, present a series of potential problems. Yet, obvious project successes where such co-operation has been attained leads one to believe that it might be a dynamite combination. Lack of success in "traditional" development project approaches leaves little doubt that new ways and models have to be found. Development communication can, at its best, combine the approaches mentioned above to a comprehensive process.

HEB already has a number of people who in addition to their strong production skills have a background in some of the social sciences. However, there are limited opportunities to study social sciences in Burma on a graduate level - social and medical anthropology, for instance, are not among courses that are offered. The recent focus on health education diploma course for 30 new Health Education Officers (HEOs), combining social science with technical health orientation, is an important step in the right direction. However, the HEOs will remain on the implementation level, and it will take time before the education level of all HEB personnel is upgraded to start teaching in the health education course at the School of Medicine in 1986/87.

The direction is definite, though, and this may also encourage a stronger emphasis on adding a combination of social science and communication techniques and concerns at the planning level of development projects, to give especially the health and nutrition projects, as well as water and environmental sanitation projects, an added dimension.

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4. COMMUNICATION IN THE FIELD: SOME BASIC ISSUES

a. Social Organization in Burmese villages

Dr. U Khin Maung Kyi* has some interesting observations about social organisation in Burmese villagers: "... one of the important characteristics of Burmese villages is its singular lack of social organisation beyond the family the village informal social organization which could channel and distribute information effectively is lacking: each individual usually goes his own way and he may tell a few friends or neighbours what he has heard or seen in the town, and that is all there is to it. (...) Burmese individualism at least inhibits one's taking an active initiative to seek help from others." The researchers investigated the villagers' ability and interest in adopting new ideas from various sources, including the influence from the nearest big town, Rangoon. They also investigated the influence of local officials, organisers and extension workers. They found that "Except for the health assistant whom most villagers know by name and the peasant council member who is also from the same village, the names of other development officials and organisers are almost unknown to the villagers, and personal relationships between development workers and common villagers do not seem to exist."

Since the development workers function - or should function - as an integral part of the society; knowledge of the structure, with whom to work closely, how to work with people, and how people with low level of literacy learn and are inspired to change behaviour, are all important parts of their education. The process of communication in development can link all the pieces together in a comprehensive whole that may greatly improve the effectiveness of e.g. health education.

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* "Process of Communication in modernization of rural society." A survey report on two Burmese villages.

** Nepal : Communication in Bhaktapur, part II, 1979 by Ane Haaland and Datta Roy.

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b. Visual perception in Burma: Basic research is lacking

Pictures of various kinds are found in most villages in Burma. The health centres, both rural and urban, also have a variety of posters to support their different activities in health and nutrition. Big posters of blond babies, printed in Thailand, were also found in the South (Pegu and Rangoon divisions). In the North (Kachin), there are fewer pictures in the villages. In the bigger towns, however, the "climate" is highly visual with advertisements and posters of all different kinds.

This implies that the possibilities for using visual aids effectively are probably good. People are used to visuals. But - just how much does it mean, in terms of assumed "visual literacy"? Can we deduce from this that Burmese villagers will automatically understand centrally produced teaching aids that are distributed for use by the health staff, and furthermore, that they will learn and take action from such visuals? Not necessarily so.

A parallell to literacy and its effect on reading and level of information might be useful here. In their study*, U Khin Maung Kyi and Associates found that while literacy rates in the villages studied were high (93% and 75%), about 60% of the people in both villages read nothing at all. The authors state that "... it is not a rudimentary literacy but functional literacy that counts. Mere literacy is a necessary but not a sufficient condition for the acceptance of modern knowledge. In other words, a person must have enough literary skill as well as fundamental general knowledge so that he can understand modern events and apply modern technology to his problems. It is quite probable that most respondents who are classified as literate are barely functionally literate in fact, and most do not have enough literary skill for effective use." (p.28). The authors also tested the effect of seeing educational movies, and found no significant relationship between seeing such films, and the knowledge thus acquired by the villagers (p.).

Another consideration that might be relevant in this context is whether villagers with low level of verbal and visual literacy actually see pictures as a teaching medium. A study on visual perception in Nepal

* Ibid.

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(Communicating with Pictures in Nepal, NDS and UNICEF, 1976), found that villagers generally saw pictures as representing an object, rather than teaching something about it. This is a major block to overcome before pictures of any kind can be useful as teaching aids in a rural community.

However, the situation in Burma remains a question. No studies have been done to date to assess the level of visual perception, the preference in picture style, the interpretation of signs and symbols, the comprehension of concepts visualized in different ways, the preference of colours, etc. Thus, the production of visual teaching aids and promotion materials is based on pure guess-work, and is probably not always understood by the "target audience" in the way it was intended. This is a fairly safe assumption, based on the results of visual perception studies in several different countries (see "Visual communication with non-literates: A review of current knowledge including research in Northern India", International Journal of Health Education, Vol. XXIV, 1981/4. Reprint available from UNICEF, PSC).

Some work was done to pretest various kinds of visual aids during this consultancy. Testing was also done by Government officials from different projects in health, nutrition and sanitation during a pretesting workshop held in August. (For a full report on the activities, findings and recommendations of the workshop, contact the PSC/PI Officer in UNICEF Rangoon). Visuals were also tested in several villages in Pegu Division, in Syriam (Rangoon Division), Sagaing Division and Kachin State. The results from the various tests indicate difficulties in understanding pictures in general, and increased difficulties with increased level of "sophistication" (e.g. abstract styles, concepts or ideas, and also signs and symbols). From this pretesting, the following "problem areas" can be summarized (from testing nutrition flipcharts, goitre control flipchart, teaching charts and posters of various kinds):

a) Illiterate people with low exposure to visuals see pictures as representing objects only, not as teaching or giving a message.
b) People do not correlate different pictures in a page with each other. They may also not correlate different pictures in a series (like a flipchart) with each other.

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c) Details are difficult to identify, especially when the details represent objects that are not drawn to scale.

d) Superfluous details and artistic blobs added for effect, confuse the villagers.

e) Drawingsdepicting people or objects very different from reality, such as a baby lifting weights to show strength, confuse people with low literacy level. Exaggeration of ideas meet with the same difficulty.

f) Some items depicted are interpreted correctly, but comments show that they are not relevant or affordable to most villagers (especially food items of high calorie and protein values).

g) Food is difficult to depict, whether it is to show the right kind, the right amount or the right style.

h) Cause and effect is difficult to visualize.

i) Abstract ideas are difficult to visualize and convey to villagers who deal primarily with very concrete and down to earth concepts.

j) A model in a series is not interpreted as being the same person, if slight changes in appearance is seen. It is not clear whether this is because people do not see pictures in a series as related to each other, or it was simply because there were too many differences between the different versions of the model.

k) New tools and machinery (e.g. a weighing machine) are not understood automatically.

l) Signs and symbols are often not understood.

m) It is not clear what kind of picture style people prefer in general: Cartoons, shaded drawings, painted drawings or photos. It is also not clear why there has been an almost exclusive emphasis on drawings as a poster style.

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The visuals were tested without the supporting explanation that accompanies many teaching aids, such as flipcharts. Thus, the visuals were put to the hardest test possible. This was done for several different reasons:

a) To attempt to establish whether pictures in themselves carry messages (which has implications for the effect of the large number of posters that are produced and are usually left to "function" on their own).

b) To establish whether people see the relationship between different concepts or ideas in one picture.

c) To investigate the general level of visual literacy.

d) To get an impression to what extent one has to rely on health staff interpreting as well as explaining the visuals to the villagers, and thus get an idea about teaching skills required by the health staff to get the messages across effectively.

From an educational point of view, it can be argued that pictures of any kind usually aid in the learning process, and that if a picture is explained well, people will usually remember the issue better than if it had been explained without using the visual (See "Communicating with Pictures in Nepal"). The old Chinese proverb of "What I hear, I forget; what I see, I remember; what I do, I know", illustrates the same point. However, a picture that is easily understood is a better educational tool than a confusing one: If the audience have to use all their attention to try to figure out what is going on in the picture, they will miss the very message the health educator is using the picture to convey in the first place. Unless the health educator is aware of this, and takes time to let everybody interpret the picture before the message is discussed, the effect of the health education session might be minimal.

As already noted, there is no hard data available in Burma to ascertain the visual literacy level, and thus the potential effectiveness of the teaching aids produced by the various projects. Hence, the production of teaching and promotion aids are based on assumptions that may or may not be correct. It can be argued, however, that without such data, the potential

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of visual aids to support educational programmes on all levels cannot be used to its optimum. Even with increased emphasis on pretesting of visuals before they are produced, for which there is now both interest and competency in a number of projects, the efforts in each case need to be extensive, since it is not known "from where to start" - i.e. the basic information of what is understood and not understood among people with different literacy levels, does not exist. Thus, there is no doubt that pretesting will greatly enhance the level of usefulness and understanding of visual teaching aids, but the efforts needed by each project could be greatly reduced if more was known about the standard of visual perception among villagers in different parts of the country.

However, the visuals themselves do not solve any problems for the villagers. If the villagers do not relate to the visual aids, or have only limited interest in them, this may be an indication of several factors that are related to communication in general, i.e. lack of emphasis on the social factors of the project, and an overemphasis on the physical facilities.

More specifically, it may be related to the way in which the programme or project has been introduced to them. Several books have been written on the topics of community development, community participation and identification of problems and their solutions in a community, and we can not possibly give these topics due credit in a brief communication report.

For an analysis of how visual teaching aids can be put into the proper context, please refer to part II in this report. In part II practical application of communication support to projects is described, and a checklist of considerations for project planning is provided.

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5. SUMMARY OF OBSERVATIONS

a. Planning

1. Burma's national development policy focuses on community development and community participation in the majority of the projects. This paves the way for a strong communication component, since the concept of community development is built on a two-way interaction between the community and the project planners and implementers.

2. Communication support work in Burma has so far been conducted with great interest and enthusiasm, but needs more careful planning based on adequate analysis of the social, cultural and economic situation in the communities in which the projects are to be carried out. While this is a good start, it may now be time to move into a phase of more structured planning and analysis of the type of communication support that is needed.

3. There is not enough emphasis on analysis of the possible implications of a project intervention on other parts of the life of project beneficiaries. This often leads to unexpected results that may be harmful to the community, and may outweigh the positive effects of the original project.

4. The target for health education is most often mothers only. This practice fails to recognize that much of the advice given to mothers suggest changes in household organisation or in the allocation of resources within the household. Such decisions are often taken by the fathers, or at least greatly influenced by the male members of the family. Thus, if they are not convinced of the necessity for a change, there may be no change in the actual health practice(s).

5. Project planners and implementers tend to emphasize the "ideal" solution to a problem. This solution is often not affordable or reachable for the majority of the villagers, and thus, they may disregard the advice. Even though project planners may know the field situation well, there is a natural resistance against a "compromise".

6. The community's organisation and the perception of themselves towards the rest of the world is usually not taken into consideration by development projects. The community members' existing ideas, concepts and beliefs are also to a large extent ignored. The results are often projects that fit the planners rather than the villagers.

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7. There is a very limited collection and use of communication feedback from projects in the field. A system to gather such feedback should be developed as an integral part of the programming feedback.

B. Visual aids

8. Visual aids for teaching and promotion purposes have not been developed and produced based on knowledge about villagers' perception of such visuals. There is to date no study to assess such visual perception in Burma.

9. Pretests that have been conducted in various parts of the country indicate that villagers with low literacy level have severe problems in understanding the visual as well as the verbal message of teaching materials.

10. There is a strong "equipment orientation" to health care. People in the field believe that instruments and medicines will solve the health problems.

11. The "equipment orientation" is also apparent in the strong demand for visual teaching aids such as films and slide shows. This demand is based on the belief that projected materials are somehow more effective than printed materials and other teaching aids in bringing across the message to people.

12. The visuals in the health centres serve as wall decorations rather than as teaching aids. They are hardly ever taken down from the wall and used on home visits.

13. The knowledge of possibilities and limitations of visual aids in health education, and in particular in reference to behaviour change, is not very widespread among the health staff. Without clear guidelines about how to use the visual teaching aids they have been equipped with, there is a tendency to believe that the visuals will "do the job" for them - i.e. looking at a picture will make people change. From a teaching/learning point of view, this is a false belief.

14. There is a tendency to overburden both visuals and "health talks" with too many messages, and thus confuse the learner. People with low literacy level generally have a low capacity to retain a large number of messages if they are given at one time.

15. A co-ordinated multi-media approach in communication support has not been attempted in Burma. The emphasis has been on a print media, and on posters in particular, with limited use of radio.

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16. The pretesting efforts need to be co-ordinated and followed up to ensure a continued dialogue about the development of communication support materials.

C. Health Education and training

17. There is a strong emphasis on curative medicine in practice. Even though health education is recognised in principle everywhere, the status given to health education, and the facilities and time provided for it, places it below curative medicine.

18. The health staff are using "ready made" solutions to health problems, rather than trying to analyse the health situation and the cause of the problems together with their clients. If a person does not fully understand why he or she has certain problems with their health or the health of the children, he or she will rarely engage in any action to change their behaviour in order to solve the problem(s). Thus, the "solutions" provided by the health staff are most often not adopted as permanent behaviour changes.

19. A mother is rational in her environment, she knows how to function, and how to solve problems her own way. The lack of knowledge as defined by the health worker, is not perceived by the mother. Here lies an initial communication gap that may inhibit or prevent exchange of ideas, and learning.

20. The health staff does not seem to make full use of the communication channels in the village to increase the effectiveness of their work - i.e. they do not work intensively with the individuals to whom many villagers go to seek advice on certain matters, e.g. on health and nutrition problems.

21. The voluntary health workers in a village are not taking over a tradition. They are building a new one, and this takes time. The traditional healers have their status, and their established place in the community. They are part of the old village elite, which is now slowly being replaced

22. There is a lack of background materials on health issues in the field - among physicians as well as among health workers.

23. A good health worker needs much more than technical knowledge about prevention and cure of diseases. Basically, he or she needs the attitude of a social worker, and this is rare to find in any country. (See Appendix 2 "How to find a good health worker").

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24. Knowledge of theories separate the ones who know from those who do not. This is often used as a weapon rather than as a tool to help solving problems.

25. A majority of the villagers we talked with seemed to rely very much on traditional healers - either exclusively, or in combination with modern medicine.

26. There are important differences between the way modern medicine and traditional medicine view illness and the person affected by it. This has important implications for the mode of treatment a patient will seek. (See Appendix 3 "Differences between traditional and modern medicine").

6. RECOMMENDATIONS

These recommendations pertain to the general situation of communication support for development projects in Burma. It was not within the scope of work of this consultant to come up with specific recommendations for the different projects, except in a limited sense, where these considerations have a direct bearing on the work of the PSC/PI officer. Thus, the recommendations can only point in a direction, and it is hoped that some of these "directions", together with the more specific observations and comments offered for some of the projects, (see "PSC in projects", page 28) might assist the project personnel in their discussions and activities in further communication work in Burma. The numbers in this section do not correspond with the numbers in "Summary of Observations".

A. Planning

1. PSC is a programming function, and should be treated as such. PSC as an idea should have no permanent life in UNICEF, but should be phased out as the programme and project staff gradually learn to tackle the social factors of programming themselves. This will most probably take at least a decade. However, the acceptance of this idea implies that PSC should aim at training programme/project staff both in the Government and in UNICEF much more frequently than is done at present.

2. A more structured approach to communication support to development projects should be sought, using communication as a process to analyse problems rather than as an end in itself, an end that at present mainly consists of

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visual teaching and promotion aids. Such an approach would include a more thorough analysis of the field situation prior to the launching of the project, using in-depth interview techniques in addition to traditional surveys. It would involve developing a new model for communication support to projects, a model that builds on the principle of community development with maximum participation, using communication as a vital tool in the process, from the planning stages onwards. Using this kind of approach would mean joining the most modern and effective trend in the field of development communication.

3. The development of a new model for communication support would make it necessary to have a closer co-operation between the research, planning and implementation sectors of the different projects.

4. A stronger emphasis on surveying and information gathering before launching a project should be used. This does not necessarily involve social scientists with a PhD in their subjects. The social sciences provide methods to analyse different aspects of a society, which may provide essential insight for a development project that aims at community participation. However, being short of an adequate number of professionals to guide such an approach at the moment, methods close to such a direction could be used. It would be advisable to look into examples from projects in other countries where such approaches have been used, and formulate questions based on an analysis of which aspects of the community would influence (directly and indirectly) decisions about the project in question. Useful information can be collected by applying good interviewing methods and interpersonal communication techniques, based on a similar set of concerns as those used for pretesting visual aids. Basically, the concern is to ask the right questions to the right people at the right stage of the project.

Collecting information does not always mean conducting big surveys. There are a number of people in a community who are knowledgeable about the social aspects of the people they live with and work for. Such "key informants" can be government workers of various kinds, teachers, shopkeepers, traditional healers, religious leaders, etc. Information from these people can also give important insights into the functions of the community. Such information will enable the project planners and implementers to make better informed assumptions about the acceptability and the relevance of the planned project, and thus secure a more people-oriented and effective direction in the social

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development of the country. (See also "PSC in projects, The Goitre Control Project," part II for a description of a KAP Survey).

5. The use of survey analysis methods should be carefully reviewed. With the availability of computers to analyse data from the field, the collection of such data tends to be dictated by the method of analysis, rather than by the nature of the problem or area to be investigated. For example, a KAP (Knowledge, Attitude and Practice) survey may be designed with a "yes-no" choice of answers, while the information that is needed about the attitudes to the problem may require an in-depth semi-structured type of interview that gives answers which cannot be analysed by a computer.

6. Communication support materials may be a part of such an approach in the majority of cases, but only as a means to an end, not as an end in itself. Such materials should be developed with a clear idea of what the visuals can do and cannot do - an understanding of the possibilities and limitations of the materials in terms of providing knowledge, promoting an idea, or changing attitudes and behaviour.

7. The list of posters, flipcharts, folders and flannelgraphs that has been developed as PSC support to the health and nutrition projects, should be analysed from a different angle to give answers to questions of concern to a more expanded communication support. Such analysis has been done with the Community Nutrition Centre and Hospital Nutrition Unit parts, and partly with the EPI (see part II project descriptions and Project Planning Checklist).

Some of the questions to be addressed in such an analysis are : What is the problem that the planned visual is meant to support in the solution of? What is present knowledge, attitudes and practice in different communities regarding this problem? What kind of effect is the visual expected to have, on what kind of audience, with what quality and frequency of use? On what basis was it decided to develop this particular form of visual (e.g. a flip-chart) rather than another form (e.g. a teaching poster)? How does the visual fit into the overall communication plan of the project, and which additional methods/interventions are planned to ensure that the project objectives are met?

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8. When designing projects in general and communication support materials in particular, planners need to take into account that most villagers think in concrete rather than abstract terms. Abstract ideas in educational materials are difficult to comprehend, and should be avoided to the extent possible.

9. When plans are made for development and production of visual aids for teaching purposes, plans should also be made regarding their distribution and use. The question about use of materials has implications for the development of the materials as well as for the need for training of the workers who are meant to use them - i.e. the educational background and the skills and experience in teaching with visuals has to be taken into account when developing these aids, so that the right amount of "sophistication" is attained in their design. Then, to fill the gap between skills held by the users and skills needed to use the materials in the most effective way, the proper training channels have to be alerted and equipped to provide these skills.

Finally, the distribution channels have to be secured. All too often, good visual teaching aids are stored at central level because nobody made the provisions for having them sent to the users in the field.

10. More effort should be made to make greater use of the capabilities and skills of the Central Health Education Bureau (HEB). The projects could e.g. continue to support the working groups already established with project personnel, a member from HEB and the UNICEF PSC officer for a number of projects (nutrition, EPI, Goitre control, Environmental sanitation), or suggest another form of co-operation. The advantage of having one person in HEB responsible for each project is that this person will gradually learn the content (subject background, problems, etc.) of this particular project, and will thus be able to provide better support to develop the health education approach. It will also enable the people in the working group to develop close interpersonal working relations that are essential for a creative and productive co-operation in communication support.

11. Attempts should be made to study and use traditional communication and entertainment channels in the villages to promote development issues in a more creative way. Using traditional methods, such as village theater or the pwe, would also ensure that humour is used more extensively in development

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work. Learning ought to be more fun and less serious, and humour as a development tool has not been used much - yet. Villagers have been known to react more positively to development thoughts presented to them through a forum they are familiar with, rather than through the alien posters or flipcharts, that do not yet belong in their culture.

Another idea for using traditional channels could be to look at idioms and proverbs, and visualize some of these that are relevant to the development issues at hand.

12. A better method of getting systematic feedback from the field should be developed. Presently, projects are implemented, and the central level planners receive inadequate information about problems, pitfalls and successes, and the reasons for these, from the field. Such a system should aim at using procedures that would require a minimum of time from the field personnel, taking into account the heavy workload they are faced with. The feedback system should also make clear to the field personnel how the information will be used, and how providing such information will be directly beneficial to the field personnel. A prerequisite for establishing such credibility with the field staff is that the receiving end at the central level is equipped to make use of the feedback to improve project strategies and implementation procedures, as well as the communication support.

B. Visual aids

13. Educational materials should be properly pretested with the target audience before they are printed. After each revision, a new pretest should be done. For a thorough background on the why's and how's of pretesting, see "Pretesting manual", available in Burmese from UNICEF Rangoon.

14. Pretesting is not only a technique to assess the effectiveness of visual teaching aids. It is also a means to contact villagers over issues (the pictures) that will often open up other topics for communication and for learning about their perceptions and their needs. It is a good way to get feedback to the project as well. It is recommended that more people be trained in pretesting techniques, which involve and build on good interviewing and communication techniques, and that pretesting be used extensively as a means to gather visual and verbal information that will be of use to the different projects.

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15. Very little is known about the visual perception of Burmese villagers, and the effectiveness of the different types of visual education materials that are produced. Pretesting should slowly give some direction in this respect. However, it is also recommended that a more systematic study of basic visual perception problems be considered. Such a study could build on similar studies done in e.g. Papua New Guinea, Ghana, Kenya, India and Nepal. The results of such a study could be of great help in improving the comprehension and effectiveness of communication support materials in development projects in Burma.

16. Films are not necessarily good educational tools, and the use and expected effect of such films should be carefully reviewed before launching into the production of films. The potential effectiveness of a film is e.g. dependent on the visual sophistication of the audience - many people with low exposure to visuals see film as an entertainment medium only, and do not learn any message from it. Given the lack of follow-up (most films are shown only once), it has very limited value as a teaching aid. It can only be used in certain places where there is electricity and a projector that functions. In addition, films are extremely expensive to produce. Given the limited resources available for producing visual teaching aids, the infatuation with film is rather dubious.

17. To support the educational artist presently working in HEB, attempts should be made to find more artists with an interest in developing their skills to become educational artists. The development of a team of such artists who ... interested in communication for social development rather than in expressing their ego, is essential for the systematic building up of capacity to make better communication support materials for the projects.

Artists who are famous in an urban setting have normally obtained their fame through pleasing a highly literate elite who can afford their art. They are usually not artists for "Most People" - for the people development projects most often have to reach with their educational materials. Thus, most famous urban artists are not necessarily suited for educational work, unless they have an interest in communicating with rural people, and in developing their skills towards making a message clear and simple to understand for people with low literacy level.

Training of educational artists can be a long and time-consuming task, but it is worth the effort. Part of the training should be in social development content, as well as in the communication and learning processes.

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An important part of the training is pretesting techniques. Such training will eventually enable the artist to go to the field with his or her materials, test them out with the target audiences, and bring valuable feedback to the project people.

The attitude of the educational artist is the most important if he or she cares about making other people understand, and about learning from people, the technical part is the least worry.

C. Co-operation

18. More effort should be spent on sharing information relevant to communication support between the different projects, as well as between HEB and the projects. Sharing of such information could be part of the agenda in the pretest co-ordination group, - participants from Government and UNICEF who took the pretesting course. A similar pretesting group that was established in Nepal almost four years ago, gradually developed into a communication group concerned with wider aspects of the communication processes.

19. Closer co-operation should also be attempted between the different aid organisations in questions of communication support to projects. To prevent possible overlap of efforts, and a waste of resources and time.

Project Planning Checklist

Throughout part I, the argument is made that "Visuals alone are not the answer to health education", and that development of teaching materials has to be put into the right framework and perspective during project planning. The following list* may serve as a checklist in project planning, whether on the village level or by planners on a central level. It can also be analysed in connection with the description of PSC in projects in this part of the report.

The checklist:

a) What is the problem ?

b) Whose problem is it (projection of problem?), how and by whom was it decided that the problem needs to be dealt with?

* The checklist is adapted from a chapter on problem analysis in "Communication Notes - Food for thought and practice", by Ane Haaland.

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c) How do people deal with the problem now, why do they deal with it this way, and with what results?
(Cultural, religious, economic, social or historical reasons - or a combination of several).

d) What kinds of changes are necessary for people to solve the problem in a better way (attitude/behaviour change, economic, social etc.?) Are any of the suggested changes contrary to local beliefs and practices? Can something in their old practice be encouraged while other things can be suggested changed?

e) Who needs to take action to change (who is your target audience?) Does somebody (e.g. grandparents) influence your main target audience - and do these people also need to be included in your plan for solving the problem?

f) Is it realistic to believe that people will change? Are the reasons for change better (from whose perspective?) than the reasons people have to continue what they do now?

g) Do people havethe resources needed for the change?

h) Does the problem need to be tackled from several different angles - e.g. social, religious, ecological, economic?

i) What do people in other parts of the country do to deal with the problem? Are there any visuals available on the subject? Any information about how these visuals have been used, with what effects?

j) What part(s) of the solution(s) to the problem can be communicated by visual aids? With what expected outcome, under which circumstances of use (every day, every week, every month?)

k) Who are going to use the visuals? What kind of background/training do they have? Do they need instruction in how to use the visual(s), in how people learn, or in how people change behaviour? Who can give such instruction? Where? For how long?

l) What is needed in addition to your visual(s) for the objectives of the programme to be met?

This report states that the community development approach is the only viable one for the majority of development projects to have a real and long term effect on improving the living standard of the citizens in developing countries, and that communication is a vital tool in this process.

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However, it must be recognised that change in many ways comes as slowly to development project planning and implementation as it does to peasants in rural societies, and that we will still see numerous projects planned and implemented solely by the central level decision makers. A possibly useful way for these projects to make fewer mistakes and have a higher acceptance on the implementation level would be to make extensive use of the communication tools to get in closer contact with and learn more from the people their projects are planned for - with the possible outcome that in the next "round", the planning will not be "for" but "with" the project beneficiaries. In both cases, the list of questions provided here might be of some use.

PART II

EXAMPLES OF AND IDEAS FOR COMMUNICATION

SUPPORT IN PRACTICE · Observations e.g.

1. PSC IN PROJECTS

Introduction

This part of the report attempts to describe how some of the ideas and concepts discussed in Part I can be put into practice in development projects.

The Goitre Control Project provides the most "ideal" example, since PSC was involved from a very early stage. Still, as the reader will no doubt discover, the support to this project does not provide a "perfect" example of how it should be done. Reality, time shortage, lack of resources etc., will usually prevent any project from reaching the perfection stage. However, as an illustration of a project where important questions were asked and considerations were given to communication, it may serve a purpose.

Following the Goitre Control Project, we look into some other health and nutrition projects, into water and sanitation issues, to discuss their communication support. The observations of these projects are in most cases quite superficial (compared to the GCP) in terms of time spent on project analysis with planners and implementors. However, the problem areas in the different projects are of very much the same type as those encountered in other countries where this consultant has been working. Even if the magnitude of the problem differs e.g. between Burma and Nepal, the communication issues are to a large extent the same. From this perspective, comments and observations on these other projects are offered here.

A. The Goitre Control Project

a) Background

The Goitre Control Project provided the perfect opportunity for planned PSC inputs from the very beginning of the project, with the two physicians (one Burmese doctor and a Nepali short term consultant) already convinced of the value and necessity of communication support to the project. They were just looking for information on how this support could be provided. The timing coincided with the start of this consultancy, and during the first three months of co-operation (which will be continued), the Goitre Control Project, HEB and UNICEF PSC and programming staff conducted surveys, field

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studies, task analysis, training programmes, production and pretesting of materials for education and information support - and learnt a whole lot in the process.

For those who are not "initiated" into the goitre problem, a quick outline of the situation might be helpful. Goitre is a swelling of the thyroid gland in front of the neck. The swelling varies in size and shape. It is caused by lack of iodine in the body. Iodine is essential for the harmonious development of the body, and is especially important for women. A women with goitre can give birth to a cretin child - a child who is mentally and physically retarded. This is the most serious effect of goitre. Goitre is found in the hilly and mountainous regions of Burma, where up to 90% of the population suffer from goitre. Goitre and the birth of cretin children can be prevented by supplying people with iodine. The Goitre Control Project will in 1982 launch a campaign to give 4.2 million people an injection of iodinated oil, which will last for five years. The project is planned for four years to cover the majority of the population affected by goitre and cretinism. The long term prevention is by iodized salt.

b) Planning

The planning phase lasted throughout the first couple of months, since many aspects were unclear and had to be replanned and re-designed as more information became available. The first phases of the planning looked like this:

i) Meeting with planners and implementers for preliminary discussion of role of PSC in the project. Orientation about organisation of the campaign. Discussion about field-trips.

ii) Review of information and studies on goitre control from Burma (Several studies done by Department of Medical Research (DMR), Rangoon) and from other countries, especially Nepal, where goitre control with a strong PSC component has been carried out for three years under the supervision of Dr. S.K. Bhattarai, who was the technical consultant to the Burmese Goitre Control Project for 2 months.

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iii) Design of information gathering strategies for the different groups to be involved in the campaign: Township Medical Officers (TMOs), Basic Health Staff (BHS), Voluntary Health Staff (VHS), and villagers. The strategies to be used: TMOs: General assessment of knowledge and motivation, as well as training skills and experience, through discussion and observation. BHS, VHS and villagers: KAP survey, and observation. (KAP is communication jargon... meaning "Knowledge, Attitude and Practice", i.e. through semi-structured questionnaires we assessed what people know about cause, prevention, cure and effects of goitre and cretinism; what their attitudes to the disease and to people who suffer from it are (any social stigma?); what their present practices in coping with the disease are; what they use for medicine, and why; and what they know about the connection between goitre and cretinism.) We also decided to observe the health education skills of the BHS and the VHS, to find out what kind of visual aids they would be able to make use of to support their project activities, as well as determine training needs in the field of health education methods.

iv) Design of KAP questionnaires, to be field-tested.

v) Preliminary list of topics to be covered by visuals, to enable gathering of photos in the field. The list was based on what we knew people needed to know about goitre and cretinism, and was also based on visuals produced in Nepal. The list would obviously have to be extended as soon as we got some preliminary results from the KAP, to cover also e.g. what people's beliefs about the cause of goitre would be. That is - if they thought the disease was caused by an evil spirit, we would photographically be in trouble, but we could deal with the belief that it was caused by dirty water. The collection of photos would enable us later to make a decision about what style we were going to use - photos or drawings. Photos make excellent materials to make drawings from, especially when one deals with topics an artist would not necessarily know how to depict (e.g. cretinism).

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c) Initial field work

i) Kayah state

HEB's Assistant Health Education Officer accompanied GCP's planners to the field to test the information gathering tools. Upon the team's return, meetings were held to discuss the initial assessment of communication problems. Adjustments were made in the questionnaires and in the strategies.

ii) Kachin state and Sagaing division

The team was accompanied by UNICEF's PSC/PI officer and the PSC consultant. Activities undertaken in the field: Meeting with doctors in the hospital; discussion with doctors during our three days visit to a rural health centre to perform an injection campaign as well as screening of goitre and cretinism prevalence; observation and assessment of communication and information gaps that would hamper the campaign between organisers, community leaders and villagers (e.g. almost everybody propagated the injection as being a cure for goitre); KAP with BHS, VHW and villagers; observation of the training process, the supervision of BHS, and the health education skills of the BHS; pretesting of visuals on different topics and in different styles. Furthermore: Collection of photos of all possible subjects related to goitre and cretinism, assessment of visual milieu in the villages (what kind of visuals were to be seen, where were the visuals placed, for what purpose), how many radios were seen and heard, and - what were some communication channels in the village (from where had people been informed about the campaign). Observation of language barriers in Kachin: Most people in the places we visited spoke only Jingpaw, and did not understand Burmese.

Note: A KAP and a quick assessment of the village situation (communication channels, visual milieu, preference of visual style, sophistication in visual perception etc.) is by no means ideal and sufficient for a project of this kind. All we could do was to gather enough information to make more informed assumptions about the situation. There was no social scientist available to undertake a more thorough study of a

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relevant sample of villagers from various locations, and there was no recognition that such a study was indeed necessary. We had to settle for the "quick and dirty" method, and build further study and assessment into the evaluation procedures, with education methods and visual teaching aids to be evaluated and reviewed after the first season's use in the field, and if necessary - changed.

d) Analysis of situation

Back from the field, we had several meetings to analyse the findings and discuss further planning of activities. Findings and observations were analysed and put together in the following way:

i. KAP survey. About 30 villagers were interviewed.
Summary of results:

I. People have no knowledge of the cause of goitre. They believe it is caused by dirty water, lime, dirty salt, etc.

II. No knowledge about prevention of goitre.

III. A variety of "cures" are being sought, mostly on the advice of the traditional healers. The cures include external and internal applications of medicine, both liquid iodine and herbs. Another "cure" is having an operation, which a few people have undergone.

IV. No knowledge about connection between goitre and cretinism.

V. Causes of cretinism were largely believed to be bad spirits, or mothers' neglect of their babies.

VI. Nobody knew of a cure for cretinism.

VII. There is some social stigma attached to having goitre, especially among young girls.

VIII. People differentiate between two kinds of goitre - "small" and "big".

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The BHS and VHW were only slightly more informed about goitre and cretinism than the villagers. Most BHS knew that goitre was caused by lack of iodine. They did not know about the connection between goitre and cretinism. They thought that the injection would cure all goitres.

ii) Task analysis. An overview of who is involved in the project on different levels with what tasks and responsibilities, was prepared. (See Appendix 5)

iii) Knowledge and communication gaps for the different groups involved in the project were analysed: What did they need to know to perform the tasks outlined in the project, what did they know already (what skills did they have), and what did they not know.

iv) Based on the above analysis, an assessment was made of the need for communication inputs in support materials and training. (See Appendix 6 for an example of this analysis for the BHS).

c) Development of communication support materials and training methods

Based on the analysis of the situation and discussions with project planners and implementers (in UNICEF and in the Goitre Control Project), a decision was made to develop the following communication support materials for pretesting with the audience:

i) Diagnostic chart (20 x 30 inches), depicting the different grades of goitre, and how they can be diagnosed. This chart is to be used by TMOs training BHS to diagnose goitre, as well as with central level professionals to establish agreed upon criteria for such diagnosis.

ii) Cretin chart (20 x 30 inches), depicting the connection between a pregnant woman with goitre, and the likelihood of her giving birth to mentally and physically deficient children. It also depicts the prevention of such effects - injection of iodinated oil. The chart is meant for the same audiences

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as the diagnostic chart, and in addition it is to be used in the health centres for BHS and CHW to explain this connection to villagers. It should also be distributed to schools.

iii) Flipchart, 10 cards, explaining the cause, effect and prevention of goitre and cretinism, using the discussion method. On the flipchart itself there are instructions to the BHS and CHW about how to use it (our observations showed that very few BHS and CHW had skills in how to teach with visuals). The flipchart is to be used by BHS and CHW with villagers.

iv) Goitre guide book, 12 pages, 8 x 11 inches. This gives more in-depth, but still simple, information about what goitre and cretinism is, the cause, prevention and cure of these, complications of the diseases, prevalence of goitre in Burma, the responsibilities of health staff, community leaders and villagers in the programme, and about the aims and plans of the Goitre Control Project. The guide book is meant for central level planners and decision makers, for TMOs and BHS as an illustrated support to their training manuals, for community leaders and for school teachers.

v) Illustrations for training manuals for BHS and TMOs on different grades of goitre, complications, examination method, etc.

vi) Slide show on prevalence, cause, prevention and cure of goitre and cretinism, as well as organisation of the campaign. The slide show is meant for central level planners and decision makers, training of TMOs and training of BHS. Possibly also for schools, on a higher level.

vii) Background articles on technical matters as well as on communication aspects of teaching and learning were cyclostyled and distributed to TMOs and to HEOs.

A goitre newsletter to inform the people involved in the campaign on various current events, problems, solutions etc. was discussed, but has not materialised yet. Such a newsletter might be a good way to keep the different townships informed, to share information, and to get feedback to the central level about how the campaign is proceeding, as well as

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suggestions on how to improve organisation and implementation. Such a channel does not presently exist, and even though the visuals have been quite extensively pretested (see below), there is no outlet for feedback of a more general character. Thus, such a newsletter could fill an important function - if it is used well.

The use of radio to promote the campaign and inform about goitre and cretinism, has not been studied. In Nepal, radio programmes have been used both to inform villagers about the arrival of the injection teams, about the necessity to accept the injection (interviews with acceptors and with health workers, doctors etc.), and about the prevalence of goitre in the country, to create an awareness of the magnitude of the problem among central level planners and decision makers. A similar use of radio to support the Goitre Control Project could be investigated in Burma.

f) Workshop for TMOs

The fourteen TMOs responsible for implementing the programme in the first year trained in project organisation and implementation during a four-day workshop in July 1982. The main part of the workshop was carried out in the field, in a goitre pocket area in Pegu division.

The PSC input in the workshop was the health education part, which is recognised by the project as a major part of the injection campaign, with one person from the four member injection team being responsible for health education only.

The health education part of the TMO workshop included the use of health education materials as well as communication and training techniques, to get the ideas and concepts across to the different audiences.

g) Testing the visuals

i. The first version of the visuals (a, b, c and d described under 5) were tested during the TMO workshop with the different user groups (GCP staff, TMOs, BHS, VHW, community leaders, villagers). The visuals were also tested by the TMOs. Based on this testing, and on discussions with the TMOs, revisions were made in all visuals.

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ii) The second version of the cretin chart, the flipchart and the guide book were tested by our HEB counterpart in Kayah state (hills), and then in Rangoon division (lowland) by members of a pretesting course. Based on the results of this testing, the final versions were prepared and produced.

Note: It would have been advisable to test the final versions as well before printing. However, in this case the time pressure (the Goitre Control Project is planning to start implementation in October 1982) as well as the fact that there were relatively few serious problems with the last versions, prompted us to go ahead with production at this stage. However, the pressure to produce at this stage makes proper evaluation and revision after the first season of use, even more important. Therefore, the visuals were produced in relatively small numbers.

h) Training

As a part of the training manuals for TMOs and BHS, chapters on communication, teaching and learning, and use of visuals are included. Advice on how to use the flipchart is also printed on the flipchart itself, as users tend to forget instructions they have once read in a manual if they are not reminded and taught a second time. Realizing the time - and work-pressure on both TMOs and BHS, for whom goitre control campaign is just another added job, the visuals are, to the extent possible, designed to be used independently of the training manuals. Needless to say, this may not result in "ideal" teaching, but the reality of the present situation necessitates a compromise on the "ideal". And - the situation for this project may certainly be brighter than for other similar projects, since the necessity of health education as well as the use of the teaching materials has been thoroughly discussed and practised with the TMOs who are going to undertake the training of the BHS to carry out the injection campaign.

This part of the communication input - the proper use of the teaching materials - is most often completely or partially neglected by programme planners, implementers and trainers. This neglect in many cases stems from the belief that visual aids by themselves somehow will "do the job" for

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whoever is using them. This is a completely false belief, (which is prevalent in a number of countries), and prevents the effective use of teaching aids as what they are - aids, not substitutes. Combined with a lack of recognition of the importance of good interpersonal communication techniques in teaching, production of visual aids is in many cases a complete waste of time and resources.

The TMO workshops for the subsequent years (to train the TMOs in the townships where the campaign will be implemented) will include orientation and discussion on communication and training and will address the above-mentioned issues, and how they can be dealt with in the Goitre Control Project.

i) Monitoring and evaluation

Several methods are suggested to be used in assessing the effectiveness of the communicating inputs in the Goitre Control Project. Some of them have already been mentioned (e.g. a newsletter for exchange of ideas between the field and the central level). Some other methods are :

i) Self -assessment by users of materials. As a part of the training manual, questionnaires will be included, requesting TMOs and BHS to give feedback to the project about the various visuals, with suggestions for possible improvements in the next printing.

ii) Observation by project personnel, and discussions with users and villagers. Project personnel and communication staff from HEB (and possibly UNICEF) should visit a training programme (TMO training BHS) to observe the communication techniques and the use of the teaching materials in the training programme, as well as in the village with the goitre patients. Such observations should be followed by discussions with the different groups (TMOs, BHS, villagers) about comprehension and use of materials as well as the communication techniques applied. Suggestions for how visuals and training techniques and practices can be improved, should be obtained.

Note: The techniques described above will give an impression about the understanding and use of the present products (the visuals), but it will give only very superficial information about the reactions

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of the community to the campaign and to the understanding and acceptance of the concepts and ideas the campaign is trying to get across (the PROBLEM/ TASK is not to get people to accept the injection, since most people seem keen to do so; but to get across the concepts involved in understanding the cause, prevention and cure of goitre and cretinism on a short-term (injection) and long-term (salt) basis, as well as the effects of the injection they have received.

To get a more in-depth understanding of how the community deals with these concepts, as well as an idea about how information and knowledge travels, a longer, more involved study is needed, using social science (especially anthropological) methods in addition to the traditional survey research methods. Such a study could be undertaken as a "before - during - after" the injection campaign in a few different communities, and would give valuable information and understanding that could be well used for the revision or re-thinking of the project approach after the first season of implementation. In addition to the medical data that is being provided by studies done by the Department of Medical Research, such "software" data should be collected, with a special emphasis on how to reach the most vulnerable groups of people in the community.

Note II: Communication support to a project is highly dependent on the attitude of the project planners and implementers to "those software-people who insist on making our work harder", i.e. good communication support into a programme usually means considerable delays in project implementation and in production of educational materials, because there is so much we need to know before we can go ahead and "DO" something (as defined by visible outputs). In this project, surveys, discussions and analysis of tasks and of communication needs met with initial surprise, interest, sometimes hidden impatience, but most of the time - whole-hearted support far beyond official "office schedules". The support varied from posing for photos with cretins (how can we know that this man is stunted?), getting the right people interested by getting them out to the field, putting up with impossible requests, scrounging for the best printing presses that had the least amount of dust on their negatives, giving ample time for health education and communication experimentation in the training workshop when everybody else wanted to go ahead with injections - to openness to every new idea or method we wanted to try out or find more

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information about. Without the support and contributions from Dr. Soe Thwin of the Goitre Control Project, and his consultant, Dr. S.K. Bhattarai, as well as from HEB, the experimental approach we have carried out in Burma could not have been possible. It is hoped that the follow-up and - finally - the results, will show that the efforts have been worthwhile, and that some of these ideas and methods could be used in other projects.

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B. Nutrition: Community Nutrition Centres (CNC) and Hospital Nutrition Centres (HNC)

a) Introduction: A behavioural issue

The central concern for communication support in nutrition programmes is usually one of changing behaviour rather than, as in the case of goitre control described above, to spread knowledge that does not require much action of any sort. This makes the job of nutrition communication support - and of course of the whole project - a much more difficult and time-consuming one. Giving people good reasons for choosing to change their behaviour in practices related to health and nutrition is one of the most challenging jobs in health education. And - it is a job that requires considerable insight into communication techniques and learning theories in order to do a good job. (For background information and examples of how attitudes and behaviour are changed, who can influence someone to change, how, etc., see e.g. E.M.Rogers: "Diffusion of Innovations", and Ane Haaland: "Communication notes - Food for Thought and Practice". The latter is available from HEB).

b) The situation in Burma: Problems identified by the project

The nutrition project had already produced a limited edition of two different flipcharts, as well as some posters to support their projects. At the time PSC started to work more closely with this project (July 1982), the visuals had not been field tested. A number of other posters were planned and budgeted for, but the project was struggling to develop, test and produce these visuals by themselves, with only minor co-operation from HEB.

There was a strong interest in the project to use more communication support, but there was a lack of expertise and time to do so.

"Communication support" was interpreted mainly as production of visual teaching and promotion materials.

The CNC projects brought out the following problems or areas of concern for discussion: The awareness of nutrition needs is low, in the community as well as among decision makers and planners. CNCs are to be established to help alleviate the problems of malnutrition by being a learning/resource centre for mothers, especially in the semi-urban areas. TMOs should take the initiative to motivate the community to support the establishment of the centres.

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How could the TMOs be motivated to take on such a task? The community is expected to build and maintain the centres, or to provide space for the centre in another building. How do you motivate them to take on the responsibility? The BHS will run the centres, on a turnover basis. How do you motivate the BHS to be interested in this task, and how do you teach them to deal with the problem of malnutrition in such a way that a long-term solution to the problem can be found --a problem that the customary "health talks" won't do very much to solve? How do you teach BHS interpersonal communication methods that would facilitate work to inspire people to change behaviour?

It became clear through the initial analysis that the problems at hand could not be solved by production of visuals alone. There was more ground-work to be done.

The messages that were designed to help people improve nutrition practices, were formed by a communication workshop for nutrition in 1981. There has been no structured survey to assess the current practices in the different areas of nutrition. The project staff is aware of this; most of them have good connections with and knowledge about the field situation, but they are also aware of the shortcomings of the present approach, and aware of the need for more structured information gathering. They are aware that knowledge about practices and malpractices in nutrition is essential for a project to be able to decide upon the communication methods and approaches, as well as the support materials, that will inspire people to change. People will normally not change their behaviour unless given a very good reason to do so, by somebody they respect, and the reason for change has to be better (from their perspective) than the reason they have for doing what they do presently.

How do you find out what such reasons for change may be? Through whom they should be communicated (who is a good person for the BHS to work with in the village? How do mothers choose a reference group for learning?), by what means or methods of communication? Furthermore, how do you establish a feedback system that allows regular feedback from the field to the central level? And finally, how do you deal with the problem of teaching the BHS that a child with malnutrition needs attention, and his mother needs health education, and that the "cure" that is usually administered (milk powder, vitamins) is attractive and easy, but will not solve the problem in the long run?

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The project is aware of the needs. However, they do not have access to somebody who can undertake such in-depth studies, and the project personnel themselves, who are largely physicians, are too overburdened with work to do anything but scattered information gathering whenever they are in the field.

c. Communication activities started

What could be done by PSC in this situation? The following activities were started :

i) Preliminary discussions - identification of problems, limitations of present approach, communication support needed in different project activities.

ii) Review of background materials, especially for training in motivation and behaviour change techniques.

iii) Forming of working group, consisting of project personnel, HEB and UNICEF.

iv) Field studies in NRC (Nutrition Rehabilitation Centre), Thaketa, and HNC, Rangoon Children's Hospital. The sites were visited every week for six weeks, to gather visual and verbal information of malnutrition cases (longitudinal studies), as well as other subjects where visuals to support the NRC and HNC project were needed. The activities and functions of the NRC were studied, and discussions were held with the staff. Health education sessions were observed.

The objectives for these visits were several: One immediate objective was to gather enough visuals to produce mock-up versions of teaching materials for the training workshop to be held with BHS who would work in NRCs, in September 1982. Another objective was for the PSC officer in UNICEF to get more direct contact with an accessible Nutrition Centre, to learn more about the activities and problems of the centre, as well as about causes and prevention of malnutrition.

Through regular contact with the staff and with the mothers at Thaketa, a good working rapport was built up. Such a rapport is invaluable for closer studies of various problems, as well as for the testing out of different kinds of teaching materials and teaching methods.

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Thus, these activities were not an attempt at or a substitute for structured in-depth information gathering needed by the project.

Throughout the process, the discussions about visuals and training continued. Several of the visuals were changed, within the frame of the plan. Many promotion posters became teaching posters. The idea of teaching food groups was experimentally changed to the idea of teaching balanced meals, since studies in several places indicate that mothers do not relate to the abstract idea of the three food groups until they have reached a quite high level of visual sophistication and literacy.

As a part of a pretesting workshop conducted in late August for project personnel in health and nutrition, some of the nutrition teaching materials were pretested. The flipcharts were found to have some problems in style and content, and important lessons for future development of visuals were learnt. Pretesting is on the way to becoming an integrated part of the nutrition project's communication activities.

Training was accepted as an important communication tool, and constraints to BHS doing a good job were analysed. Training methods to help overcome these constraints were discussed, including how to create a good environment for learning (for trainees as well as for villagers.) One method the BHS needs to learn is how to work with a mother to analyse why her child suffers from malnutrition, and how to lead her into realizing what could be a solution to this problem.

As an attempt to motivate the TMOs and the village leaders to establish a CNC, a motivation pamphlet was discussed. The pamphlet should give basic information about what a CNC can do, why it is necessary, what the responsibilities of the community would be, etc.

And the communication support work has just started. The awareness of the need is high, and the project would undoubtedly make use of much more support - if it could be obtained.

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C. Oral Rehydration Solution - ORS

The communication support to promotion and preparation of ORS in Burma has to come from two different angles: One is to promote the packages of ORS that are most probably going to be distributed and sold by the co-operatives, and to prepare communication materials that will explain how to mix the solution; the second is to promote home-made preparation of ORS.

It is to the second angle or task - the communication support to the preparation of home-made ORS - that the following comments are made. This is not to suggest that the promotion of the pre-packaged ORS is not equally important, it is rather to suggest that much of the information gained by working for the support to the preparation of home-made ORS can also be used to promote the packages. Also, the packages are not yet on the market, and even production of several million packets per year will not fill the need for ORS as a vital means to prevent severe dehydration in infants and children all over the country.

The nutrition project has already prepared a poster with instructions on how to prepare home-made ORS. The poster has been tested on a limited basis, and the project has found that most people have difficulties in understanding it.

In other countries where ORS has been promoted, a poster has been found to be insufficient as communication support to explain to mothers how to prepare the solution, and why to prepare it. Demonstration is the best method, and particularly demonstration in people's homes, where the health workers has time and opportunity to let the mother prepare the solution herself, under supervision. Short of demonstration facilities, a flipchart or a visual that can show the sequence of preparation, is preferable to a poster. However, a teaching poster put up on the wall in the health centre or CNC can be a good reminder to the mothers, once the process of preparation has been demonstrated.

However, the crucial point in the ORS programme is to find out the local beliefs, knowledge, attitudes and practices to diarrhoeal diseases. This has been done in a number of countries, and good methods are available for development of a local survey to assess these aspects. (See Appendix 6 for an example of survey questions).

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Without such knowledge, the ORS programmes have a nasty tendency to fail, since they do not take into account mothers' reasons for not wanting to feed their children liquids when they have diarrhoea - they just explain how to prepare the solution.

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D. Expanded Programme of Immunization - EPI

a) Present problem: A communication task

This programme aims at reaching all children under five with preventive injections, i.e. BCG and DPT. A main problem for this project (excluding purely technical problems, such as those related to the cold chain etc.) is that mothers do not come back for the second and third doses of the DPT vaccine. Presently, the coverage is approximately 80% for the first dose, 45% for the second and 25% for the third dose. This means that only a small number of children are effectively protected against the "killer diseases" - diphtheria, whooping cough (pertussis) and tetanus.

To increase this coverage can be seen mainly as a communication support task. The following observations and comments are made from this perspective, and do not attempt to cover any other(technical) part of the project.

The EPI project has already taken a major step towards solving this problem. In one of their surveys, project interviewers asked the mothers why they do not come back for the second and third doses of DPT. Some of the reasons the mothers gave were: "We are busy with housework, there is no time to go to the centre". "My child had pain and fever after the first injection, I do not want that to happen again". "The centre is too far away from my house." "The time for injection is exactly the time when I must cook the midday meal."

Other reasons were identified by the project as pertaining to a lack of follow-up by the BHS and CHW (who are supposed to motivate the mothers to come back), and the fact that the babies are often left with their grandma during the daytime, and she often does not believe in these modern injections, and will not take the baby to the health centre.

What action can be taken from this information? Not very much. The interpretation of the survey results is simply that the mothers are not motivated to come back for the second and third doses of DPT, they see the reasons for not doing it as stronger than the reasons for coming to the health centre again.

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The communication support planned for this project is posters for the community ("Protect your child by immunization", "When to immunize your child" and "Immunize during pregnancy"); and a folder (signs and symptoms of EPI diseases), a manual and a calendar for the health staff.

These support materials will most probably not solve the problems at hand. The posters meant for the community do little more than making people aware of the need for immunization. The mothers are already aware of this (a large majority - 80% bring their children for the first injection). The EHS tell the mothers to come back. Still, this is not enough.

b) In-depth interviews needed.

How could the problem be tackled? A good way to go about it for a start would be to follow up the survey that has been done by the project. The survey, like most "fixed answer" - surveys, gives only a superficial explanation to the reasons for not continuing the DPT injections. Here, a more in-depth, semi-structured interview method would be needed, to get answers to questions like: Why did you bring the baby for the injection the first time? Why did you have time then, but not for the follow-up? What do you think can happen to the child if you do not give him the second and third injections? What did the EHS tell you when your child got the first injection? Has any of your neighbours gone back for the second and third doses of this injection? Why - or why not? What do people in the village feel about the service in the health centre? What would make you go back for the second and third doses of this injection? Have you got other children? Have they been sick with childhood diseases? Did they have the injections? Do you know of any children who died from these childhood diseases? Did they have the injections? Is there a traditional healer in this village? What does he think about these injections? And so on... Questions should obviously not be asked in this order, but questions of this type should be asked by interviewers with good inter-personal communication skills, as well as training in how to conduct such semi-structured interviews where the answers have to be written down verbatim, or a tape-recorder has to be used. One interview of this type will often take 1-2 hours. The objective should be to assess the mothers' real reasons for not bringing the children back -- not the excuses, which is mainly what the first survey recorded.

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Another group to be interviewed are the mothers who did bring their children back for the second and third doses of DPT. Often, we forget to ask "Why success?" and only concentrate on "Why failure". Similar questions as the ones mentioned above could be asked also to this group.

A third group to be interviewed is the BHS and CHW. What are their impressions about why mothers do not come back for the second and third round of DPT? What do they teach the mothers? How much time do they spend with each mother? (The injections we watched were not accompanied by any explanation or any motivation talks to encourage the mothers to come back or explaining to them what could happen to their children if they do not come back.) What do the BHS teach the mothers when they go home visiting? How do they try to motivate them to come back? What are some suggestions for motivating the mothers to come back? What kind of changes in the present situation are necessary to facilitate this? And so on.

Such in-depth interviews with mothers, grandmothers and health staff would give the reasons for the mothers not returning for the DPT follow-up. Based on this information, a communication support strategy can be worked out. Most probably, it would turn out that both training of health staff in motivation techniques and teaching/communication techniques would be necessary, as well as development of support materials to teach with. When it is a question of motivation, or of change of behaviour, a poster will not do the trick - neither by itself nor as a teaching aid. Usually, in such a situation the mothers will have to be engaged in a discussion, which can in many instances be encouraged by the use of a flipchart or another medium that explains in a sequence or in more detail why three doses of DPT is necessary, and what may happen if only one dose is taken. However, the training materials are the least important in solving these problems. The health staff will have to be trained properly in how to motivate mothers, as well as how to use teaching aids, and in teaching/learning techniques using the two-way communication process - i.e. discussing, rather than by a one-way diffusion technique, or a "talk" without involving the audience.

The EPI project is re-writing the training manual for the health workers and one important addition is planned to be a chapter on communication and learning. However, most of the staff will not change their ways of dealing with the mothers from only reading such a chapter, unless the content is also integrated into the training programmes for the EPI work.

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So far, the involvement of HEB in the EPI project has been unstructured, and has resulted in a mock-up version of a poster with the verbal message about when to immunize children against the different kinds of diseases. The poster will serve as a reminder to the health staff in the health centres, and can also be read by the literate mothers.

In August 1982, a working group was formed by EPI project personnel, HEB and the UNICEF PSC officer. Some of the issues described above have been discussed by the group, which will continue to meet and come up with an action programme for how to proceed with the communication support. It is hoped that the above considerations may be of some use in this work.

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E. Environmental Sanitation (ES) and Water

a) ES and Water - seen as technical issues

The situation and the areas of concern in this project is of very much the same type as the ones described above (EPI) - that is, from the point of view of communication support. The environmental sanitation issue is largely a question of gaining new knowledge (understanding the connection between dirty water, dirty environment and health), and, as a result of this knowledge, change behaviour (build a laterine, and use it, and use clean water).

Environmental sanitation and water programmes are still in practice seen largely as technical programmes - as a question of making the materials for building the latrines or the water system available, and then the rest will happen by itself. Examples from the field have shown that this is unfortunately not the case. While it does not make much sense to indulge in a large programme of changing people's knowledge and behaviour about environmental sanitation and the need for latrines, and then not supplying the materials for building the latrines (no programme would even dream of doing this), the opposite is all too often the case.

b) Lack of adequate training

In Burma, good attempts have been made by HEB in co-operation with the ES project and UNICEF to produce support materials for the health workers to use with villagers as well as with community leaders. Indeed, the ES project is highly favoured, compared to other projects that do not have the same amount and variation of support materials (seven different pamphlets and instruction materials were developed).

However, the materials do not seem to have solved the problems. An equal amount of emphasis as was put into developing the materials has not been put into making sure that the HEOs and other health workers know how to use them. Some HEOs and health workers, during a couple of field-trips, remarked that "We tell the villagers what to do about building and using latrines. They say "yes, yes", but they do not follow our advice. They stick to their own ways. We don't know why, and we don't know what to do". Another remark: "We don't understand what it is that really makes them change. Some of them build latrines because they are told to, but they do not use them." A third remark: "They regard us as outsiders. They are polite to us, but they do not take us seriously."

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These reasons are very familiar, and are related to communication support. They are reasons that most often prevent the planned behaviour change that will make a project truly successful on a long term basis, and reasons that are most often overlooked by programme planners and implementers, because they are quite bothersome to deal with. It is much easier to tell people what to do, than to give them good reasons for changing their behaviour.

It is not fair to reduce the problems in ES merely to a problem of changing behaviour and gaining knowledge, but from the point of view of communication support, this is the main concern. This is not to say that we are not aware of the technical problems, the problems of finding somebody (health workers of different kinds) who has the time and the skills to work in ES, the problem of supervision of the workers, the problems of supply and logistics, the question of including these topics into the school curriculum, and so on. Some of these activities also need communication support, but not nearly to the same extent as in the question of finding ways to encourage people to change attitude and behaviour. (For an example of such change, and the role of media, outsiders and close relations in influencing this process, see Appendix 7).

c) Evaluation of ES pilot scheme

The pilot scheme of the ES project, which aims at constructing 16000 household latrines in 11 selected townships, as well as establishment of Village Sanitation Committees and appointment of full time village sanitary workers, will be evaluated in September 1982, during a workshop in one of the pilot scheme townships. The workshop will compare what has been done with what was planned to be achieved. Based on this evaluation, recommendations for a continuation of such projects will be made.

It is hoped that such an evaluation will not only look into the number of latrines that have been built (even though the building of latrines is no minor feat in itself), but also attempt to evaluate if people have gained any knowledge about the relation between sanitation and health - and how they have gained such knowledge.

Furthermore, the evaluation should look into the question of whether or not the latrines that are built (private and public) are being used and maintained, and how this maintenance is organised.

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d) Why do people not change their behaviour in ES and water use?

Sanitation projects are most often heavily dominated by engineers who see to it that the technical part of the project is well planned and taken care of. Water projects have the same bias towards hardware. This often leads to the exclusion or underemphasis on the software questions. To quote from a report on "Communication and Community Participation" for the International Drinking Water Supply and Sanitation Decade, by Dr. Jane Bunnag, Regional PSC Officer in Bangkok, where she refutes a misconception about the Decade: "Rural inhabitants will eagerly use water supply and sanitation facilities provided for them". This, Dr. Bunnag states, is not necessarily so. The reasons for adoption depend on a number of social and cultural factors: "Are villagers aware of the connection between water supply and sanitation, and good health? They probably have a long-built, high tolerance of diarrhoeal and other water-related diseases. Do they perceive themselves as ill when they experience the symptoms of these diseases? Is such illness seen as part of the natural course of events, which cannot be changed?

What does "clean" water mean anyway? Is it more important to have "tasty" water? Or water that does not change colour when boiled? Or water that is convenient to fetch, even if "contaminated"? Are time-honoured social relationships involved in the questions of where to locate pumps and stand-pipes, of how decisions are made for their installation, and who manages the new facilities? Can water in a pump provided by the Government still have God's blessing? Is it possible to charge money for water, which has always been nature's gift?

(...) Can excreta disposal even be talked about, under the prevailing social mores? (...) In summary, there is a great need for sensitive and systematic study of water and sanitation-related beliefs and behaviours if projects are to be successfully planned and fully used."

The comments above are general comments of concern to communication support activities in water and sanitation, rather than project specific, since these projects were not looked into in detail by this consultant.

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APPENDIXES

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Appendix 1

List of Field Visits During PSC Consultancy

1. Pegu division, Thanatpin township. Observation of Environmental Sanitation Programme. One day, June.

2. Rangoon division, Syriam Station Hospital and EPI Vaccination posts. Observation of EPI Programme. One day, June.

3. Kachin state, Sagaing division, Mandalay division. Field work for Goitre Control Project. Twelve days, June.

4. Pegu division, Htantabin village. Training workshop for Township Medical Officers, Goitre Control Project. Three days, July.

5. Rangoon division, Mingaladon township. Pretesting workshop for health and nutrition projects. One day, August.

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Appendix 2

How to Find a Good Health Worker

Most health workers are not very effective in their work. There is a high possibility that the workers in Burma will be no better than the average. The following are some tools to assess the present knowledge of the health worker, as well as his possibilities to learn to become an effective worker. Training will be necessary - and most probably emphasis has to be given to the "software" side of training - how to work with people to make them interested in and motivated to change habits.

What characterises a good health worker?

Assess in terms of KAP - Knowledge, Attitude, Practice:

- He knows health problems and their solutions, based on practical reality.
- He knows teaching methods, how people learn, and communication techniques.
- He knows the possibilities and limitations of the system he is working in.
- He knows how the community functions - who makes decisions, who are influential people etc. He knows how the family functions, how decisions have to be made to put any suggestions for change into action.
- Attitude : He aims at self-help, rather than at securing his job and his status through making himself indispensable.
- He respects people on all levels, and cares about them. He makes himself accessible to the people by working in the community.
- He does not take the responsibility away from people, but rather works to show them alternatives that are within their reach and acceptance.
- He practises what he preaches, goes to the people to practise rather than hide in a clinic, and he learns from his practical experience, and adapts his methods accordingly.

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How to find him?

An informal interview is the best method to assess his skills, if possible - combined with him doing an actual demonstration of teaching something to a family. Find out what is his background, his training, his knowledge about health problems, his interest to work, his motivation and the reason for being motivated, his interest to learn, his feeling of status (does his attitude to the poor affect his possible effectiveness in his work?), and his practical experience.

One part of the interview could be to give him a practical task, e.g. what would he do to prevent diarrhoea in children? Look out for the following points:

- Will he approach the problem with curative and preventive measures? Does he have adequate knowledge about both?
- What is his knowledge about the present situation and the practices being used (e.g. mothers witholding fluid from children with diarrhoea)?
- Does he have adequate knowledge about the causes of diarrhoea?
- Does he have respect for people (e.g. how does he describe the cause of diarrhoea - does he refer to "these dirty people" or other derogatory descriptions?)
- Does he have knowledge about the education process? (How will he change the situation? Will he TELL the mother to change her habits and think he has done the job? How will he tell her? Will he use visuals? Will he follow up? How often?)
- Does he have practical knowledge? (Does he suggest practical and realistic measures to change the situation? Does he give people options for change that are acceptable socially, culturally and religiously? Is he aware that these aspects should be considered? Is he aware of obstacles to his solution ?

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- Who will he co-operate with? Is he aware of the influence of traditional healers? What is his attitude to them? Does he think he can work with them? How?

With such an interview, and possible demonstration, you should have a pretty good idea about whether this person should be trained, and in what areas training should be given. Another indication can be his own assessment of his training needs - if he is aware of what he lacks, he will probably be even more motivated to get these skills.

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Appendix 3

Some Differences between Traditional and Modern Medicine

When introducing sanitation and health education into a traditional society, many conflicts may arise - and the ones that are most difficult to deal with, are the ones on a sub-conscious level, or at a level where people do not express them or even identify them. This is true for both the people believing in traditional medicine ("How can the doctors know what is inside us? They do not know what they are doing") and for the doctors and health workers who are supposed to treat them ("these people are impossible - all they believe in is witchcraft, how can they not understand that diseases are caused by germs?")

A health professional and communication man, M.H. Logan, wrote about the situation in Guatemala: "Contact between modern and traditional medicine is characteristically marked by discrepancies and contradictions in theories of health specific to each form of medical knowledge. Physicians working with patients from cultures other than their own must realize that discrepancies and contradictions left hidden, or patently ignored, hinder optimal therapeutic success."

The understanding of the following differences is essential, both to those who are going to plan a health campaign, and those who are going to implement it. Part of a training programme for health workers and other implementers should deal with these concepts of traditional and modern medicine.

Some differences (the list is by no means exclusive):

1. Illness and healing in a traditional society is seen in connection with the whole cosmology - a person sees himself as part of the environment, and a healthy person is in balance with this environment. The basis of illness is social tension, and people lay themselves open to affliction by their way of living. Witchcraft and sorcery is seen as functional and socially acceptable, and there are ways to deal with them. Illness can be caused by a number of things (there is always an answer to the "why me? question), and the healing process aims at restoring the balance in the social system, of which the ill person is a part. The traditional healer deals with the spiritual, emotional and physical part of the patient, he deals with healing the mind as well as the body.

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In the Western system, medicine is based on science. The symptoms of the disease are often taken out of the social context, the disease is a physical "thing" that doctors with specialized knowledge will diagnose, and the result is an alienation of the disease from the sufferer. The diagnose is based on "what you can see", and emotions and/or connections with the life situation of the patient are often disregarded. The Western system is not concerned about giving the patient an answer to the "why me?" - question, because the possible answers would not necessarily be testifiable empirically, and therefore would have to be termed "irrational". That the question is of utmost importance to the patient, especially to the patient with a terminal disease, does not seem to concern Western medicine too much.

2. The care of the diseased and the dying is seen as a natural part of the family system in traditional societies, and thus provides physical and emotional support to the diseased. The Western system is built on institutions where strangers take care of the diseased in an alien environment, and where dying has become de-humanized and sterile.

3. Food habits in traditional societies are often built on age-old traditions that are linked to the notion of life and death, e.g. "hot"and "cold" food, or the notion of "yin" and "yang", which is built on the same principles. The diet is built up to maintain balance between life and death, hot and cold. There are certain foods that are good for old people, for children, for pregnant mothers etc., and these rules and practices vary across natural and cultural borders. A western or "modern" nutritionist who counts calories. protein and vitamins and tries to change the villagers' food habits, is obviously not going to make much sense to the local people.

4. Pollution has more significance as a religious principle than as a sanitary practice in traditional societies, especially in Hindu societies in Asia.

This list is just a beginning - to show that some of the concepts we are dealing with are very fundamentally different in the two systems. For those who are interested in more detailed knowledge and information on the subject, a reference list of books can be provided. (See e.g. David Landy: "Culture, Disease and Healing", a collection of very interesting essays).

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Appendix 4

GOITRE CONTROL CAMPAIGN

TASKS, ROLES AND RESPONSIBILITIES IN CAMPAIGN

1. Project Management	2. State/Division	3. TMO	4. BHS	5. Role of Community Leaders	6. Responsibility of VHW
a. Organize campaign in project townships	a. Logistics - Regularize flow of supplies	a. Organize on local level	a. Organize campaign with community leaders	a. Inform community about aim of campaign and time for injection	a. Motivate community
b. Supervise the programme in the field & evaluate performance of BHS	b. Suggestions for improvement/ feedback to Project Management	b. Supervise staff	b. Screen population to determine incidence of goitre	b. Organise community	b. Work with BHS on Injection Team
c. Co-ordinate state/ division and township level	c. To oversee final disposal of used syringes and needles	c. Co-ordinate in district	c. Fill out record cards	c. Give guidelines to officials	c. Health education follow-up
d. Select village/ townships		d. Train BHS & CHW in organisation of campaign, injection teaching, health education techniques	d. Give injections	d. Motivate community to co-operate	d. Feedback to BHS & TMO about knowledge and attitudes in community
e. Train TMOs in programme management		e. Inform community leaders	e. Fill out injection cards and give to community	e. Feedback to TMO/ guidelines for improvement	e. Work with health team
f. Supply injection syringes, needles to State/Directors and TMOs		f. Report to State Director & HQs.	f. Fill out register book		
g. Supply training materials (manuals & visuals) for TMO & BHS		g. Suggest improvements in campaign organisation & implementation	g. Give health education to community about cause, prevention & cure of goitre & cretinism, effect of injection, etc.		

1. Project Management	2. State/Division	3. TMO	4. BHS	5. Role of Community Leaders	6. Responsibility of VHW
h. Monitoring and Evaluation		h. Bringing syringes and needles to State Director	h. Bring needles and syringes to TMO i. Inform TMO about results(reporting forms) j. Feedback to TMO about difficulties/ suggestions for improvement.		
Reports to: National Goitre Control Committee (annually)	Project Management (quarterly)	Project Management (monthly)	TMO		

Appendix 5

Goitre Control Project/PSC :

Task Analysis - Basic Health Staff

Definition of training needs and communication materials

A. Job Title/Role: BHS (Basic Health Staff)

B. Responsibilities:

1. Organise campaign in co-operation with community leaders.
2. Give injections of iodinated oil to target population.
3. Determine grades of goitre and cretinism
4. Fill out record cards for incidence of goitre and cretinism, and injections given, as well as register book.
5. Inform TMO about results and hand over record forms.
6. Bring needles and syringes back to TMO.
7. Give health education to people in the community, including community leaders, about the following:
   a) Cause of goitre
   b) Connection goitre - cretinism, prevention of both.
   c) Content of injection
   d) Effect of injection on different types of goitre
   e) How long the injection works.

C. Present skills:

1. Organisational
2. Curative health skills

D. Needed skills:

1. Injection technique
2. Recognition/diagnosis of different grade of goitre and cretinism
3. Filling out forms properly (reporting system)
4. Health education techniques, including understanding of how people learn, and how to use educational materials.

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E. Functional relationship to other groups in the campaign:

1. TMO/DHO: Supervision, training, support, provision of materials (injections and visual aids)
2. Community leaders: Co-ordinate organisation
3. CHW: Supervise (?), Co-ordinate, get feedback
4. Community: Provide injections, give health education.

F. Aspects that may make problems in the work:

1. Too high expectations/goals in terms of number of injections to be given - this will mean more pressure to reach target and less emphasis on health education.
2. BHS attitude towards curative medicine will make them over-emphasize the curative effect of the injection, and raise false expectations among the patients with large goitre (grades 3 and 4) that they will be cured. This will in the long run reduce the credibility of the BHS, even though it might increase it in the short run.
3. Lack of health education skills. Such skills take a long time to acquire. With some of the BHS, it requires an attitude change - from seeing health education as a burden, to seeing it as essential in their work. This change is more difficult and may take longer time than the acquisition of the actual skills.

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G.

Suggested Training	Where	Communication Materials
1. Injection techniques	*OTJ	Part of training manual
2. Diagnosis of goitre and cretinism	*OTJ & **S/W	Part of training manual and visual charts (diagnostic chart and cretin chart).
3. Reporting methods	OTJ & S/W	Record forms
4. Health education:		
• How people learn	S/W & OTJ	Simple theory (part of manual?).
• How to use visuals	S/W & OTJ	Part of manual
• Symptoms, cause, prevention and cure of goitre	S/W	Visuals (flipchart, goitre guide book, manual).
• Connection goitre - cretinism	S/W	Visuals (flipchart, goitre guide book, cretin chart, manual).
• Effect of injection	S/W	Visuals (flipchart, goitre guide book, manual).

*OTJ = On The Job

**S/W = Seminar/Workshop

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Practical advice series: gathering infor

Carrying out a survey on attitudes to diarrhoea

Mothers' attitudes are critical to the success of ORT programmes. A survey to find out their beliefs should, therefore, be an essential step before developing a programme [1 and 2].

We recently received a study from Haiti offering practical suggestions on gathering information before starting a national oral rehydration therapy programme. The study was begun in late 1981. For a year before then, Haiti had been implementing a hospital based ORT programme [3]. Although attempts had been made to teach mothers about the use of oral rehydration solution for several years, community and home-based approaches to oral rehydration therapy were still new ideas.

The Research Section of the Division of Family Hygiene, Department of Public Health and Population discussed the situation with public health workers and drew up a list of simple questions to ask mothers. The questions were designed to give insight into attitudes to diarrhoea in the community and mothers' beliefs about its cause and cure. The questions included:

- How do you know when your child has diarrhoea?
- What causes it? What other names do people use for diarrhoea?
- Is diarrhoea a disease? Can a child die from it?
- Do you know a child who has died from diarrhoea?
- What do you do when your child gets diarrhoea?
- Should liquids and/or food be given when your child has diarrhoea?
- Why or why not?
- What are good foods/liquids for a child who has diarrhoea?
- Should you continue breastfeeding a child who has diarrhoea?
- Who in your community can help you if your child has diarrhoea? (doctor, health worker, traditional birth attendant, leaf doctor, traditional healer, etc.)
- Is there a particular medicine you give your child when he has diarrhoea? Which one?
- Would you like to learn how to treat diarrhoea with a solution of salt and sugar which you can make in your home?

Photograph by Michael McQuestion

Haitian mothers believe in continued breastfeeding when children have diarr

Survey in urban areas

These questions were translated into Haitian Creole and posed initially to half a dozen mothers living in or near the capital city. These mothers had already heard of ORT, knew about mixing a home-made solution of sugar and salt, believed strongly in continuing breastfeeding, giving liquids (boiled and carefully handled), and spoke of reducing heavy, fat foods but not eliminating food altogether. The families were also aware of the danger of dehydration from diarrhoea and knew they were dealing with a potentially serious health problem. They generally recommended seeing a doctor and knew specific health facilities where they could get help.

While the first interviews also provided ideas on foods and liquids that are traditionally considered good and bad in treating diarrhoea (diarrhoea is considered to be a "hot" illness in Haiti so "cool" foods must be given), the mothers had obviously already had some exposure to modern ideas.

Rural areas

Consequently, the next interviews were with mothers in more isolated rural areas. A total of 16 interviews lasting between 10–30 minutes were taped. Rather than transcribing all the data, the cassettes were replayed several times and notes taken on the most relevant points. The fieldwork in five different rural areas was done by the Haitian Center for Applied Linguistics, which was gathering data for a linguistic atlas of Haiti and offered to cooperate with the Division of Family Hygiene's Research Section.

The age of the respondents varied between 20 and 70 years. All the women interviewed recognized diarrhoea by the presence of liquid stools in great quantity and most saw it as a life-threatening disease. The majority said that food intake should not be stopped during diarrhoea, and generally had reasonable ideas of the type and quantity of food to provide.

The general consensus was that breastfeeding should continue in order to give the child strength and that

nation in the community

liquids (tea, juice, rice water, cow's milk) should continue as well. Half of the respondents had already heard of ORT.

The causes of diarrhoea mentioned included teething and 'spoiled' mother's milk as well as some modern beliefs related to poor hygiene. Treatment of diarrhoea begins at home but many of the mothers mentioned the need to seek medical assistance.

Results

The main results of this small study were confirmed in a larger nutrition survey of almost 900 mothers which included questions about their views on the nature of diarrhoea, and feeding practices to follow when it occurs. This supported a general feeling that mothers in rural Haiti are very favourable to the introduction of an ORT programme. There do not appear to be traditional attitudes and beliefs that are obstacles to a national effort to treat diarrhoea. Mothers seem to be quite ready to take action when diarrhoea strikes and are ready to accept an appropriate technology.

In Haiti a complex magico-religious system underlies views of health and illness and what can be done to resolve problems. While a simple study focusing on practical issues in ORT did not need to analyse this system in detail, a sympathetic awareness of the importance of traditional medicine (often all that people in rural areas have to help them in major crises) is very important. The team who carried out the study described here plan further work on this subject.

Study sent by Dr James Allman, Center for Population and Family Health, Columbia University and Dr Maryse B. Pierre-Louis, Division of Family Hygiene, Department of Public Health and Population, Port-au-Prince, Haiti.

(1) Rohde J E 1980 Attitudes and Beliefs About Diarrhoea: The Mother's Role. Diarrhoea Dialogue 2: 4–5

(2) Lozoff B, Kamath K R and Feldman R A 1975 Infection and Disease in South Indian Families: Beliefs About Childhood Diarrhoea. Human Organization Vol 34, No. 4: 353–358

(3) Pape J 1981 Introduction and Promotion of Oral Rehydration Fluids in Haiti. USAID, Port-au-Prince, Haiti.

General points to remember:

Many people dislike or distrust surveys. This is particularly true in poor communities which are frequently studied but rarely see any results. Proper organization of a survey and a sympathetic approach when carrying it out will make it far more likely that the end results will be acted upon.

- Try to find out what problems people feel are most important and see what ideas they have for solving them.
- **Only** ask for the **minimum** amount of information necessary for the survey. Make sure that people understand **why** you are collecting the information.
- Talk to enough people to ensure collection of a cross-section of opinion from within the community. The number of people you can reach will obviously depend on the questioners available. If you are training questioners, it is very important to spend time on this. An unsympathetic, abrupt approach when asking questions can produce forced answers and ruin a survey.
- Try to ask questions in such a way that people can learn something at the same time as they answer. Avoid asking leading questions and if a person does not understand what to reply, offer several different possibilities including an open response like 'none of these answers'.
- If possible, try to avoid using questionnaires when talking to people (small tape recorders were used in the Haiti study).

However, you will need questionnaires/checklists at some stage to set down the information gathered in a logical way. Apart from the questions listed on page six, the following topics could also be included in a diarrhoea survey:

- What household remedies are available for diarrhoea?
- Does each household have a supply of salt and sugar which could be used for making oral rehydration mixture?
- What containers are available for storing water, mixing up a solution and measuring salt, sugar and water?

Your survey could also include the local shops, pharmacies and the nearest dispensaries and health centres. At these places check:

- Which diarrhoea treatments are used.
- How much stock is kept and the turnover.
- Availability of packets of oral rehydration salts (ORS).
- If alternatives are used what do they cost and what is their chemical composition?

It is also important to examine water sources, storage of water and the use and maintenance of sanitation.

Summary of the important steps in a diarrhoea survey:

- Consider the questions that will provide the necessary information to improve the diarrhoea service.
- Set these out in a questionnaire and test them with and on local people.
- Choose and train questioners.
- Survey a representative number of people in the community.
- Summarize the results and apply them to modify and improve the diarrhoea prevention and treatment services.

Useful further reading:

Barker DJT 1976 Practical Epidemiology. Oxford University Press.

Bennett F J 1979 Community Diagnosis and Health Action. The Macmillan Press Ltd.

Cutting W A M et al 1981 A worldwide survey on the treatment of diarrhoeal disease by oral rehydration in 1979. Annals of Tropical Paediatrics 1:4: 199–208.

McCusker J 1978 Epidemiology in Community Health. African Medical and Research Foundation, Nairobi, Kenya.

Werner D, Bower B 1982 Helping Health Workers Learn. The Hesperian Foundation, PO Box 1692, Palo Alto, California, USA.

Appendix 7

Behaviour Change - Sanitation

Many health education projects fail because they do not take into account the way people learn and change behaviour, and what influences people to change in the different stages. The following is a brief summary description of how and why such changes happen, adapted from "Roger and Shoemaker: Diffusion of Innovations". Furthermore, a brief analysis of change is added - what may work for and against change in sanitation habits in a traditional society.

Behaviour Change

1. AWARENESS

   People become aware that lack of sanitation and bad hygiene make them sick. They become aware of some of the causes for the diseases, as well as the prevention and cure of these diseases.

   At this stage, they can be influenced by anybody or anything - from mass media to health workers and/or neighbours, local leaders, etc.

2. INTEREST

   People become interested in the subject to the point where they ask questions and see the relevance to their own situation, as well as the personal benefits for them. They may see that the changes that are needed are realistic and within their reach in terms of time needed, economy, social factors, etc.

   Influence at this stage can also be given by mass media, health and extension workers, and influential people in the community.

THESE FIRST TWO STAGES DEAL WITH THE INTELLECTUAL INTEREST - THEY ARE COGNITIVE STAGES. PEOPLE DO NOT HAVE TO TAKE ANY ACTION THAT DEMAND THAT THEY MAKE BIG CHANGES IN THEIR LIVES. THEY JUST THINK ABOUT THE CHANGES, AND DISCUSS THEM. IT IS RELATIVELY EASY TO INFLUENCE PEOPLE IN THESE STAGES.

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3. TRIAL

Some people in the community (the venturesome or "progressive" ones) will try out some of the suggested changes.

Influence to try out a new thing in practice usually demands interpersonal communication. Health workers or other community workers, and influential people in the community can influence here.

4. EVALUATION

Are the results worth the efforts? Are the children less sick? Do we use less money on medicines and traditional healers? If the answer to one or all of these questions is clearly yes, the individual will be at a stage where he/she can make a decision about whether to continue with the practice.

Influence at this stage is interpersonal communication with people you know and respect - an influential group being the family and/or neighbours.

5. ADOPTION/REJECTION

The benefits - or the lack of benefits - are clear to the people, and they will decide whether or not they will adopt the new idea or behaviour. Some influential people in the community are usually the first to adopt new ideas, and then the ideas will slowly be adopted by others.

At this stage, the influence to make decisions are also on an interpersonal level - from close relations or friends.

IN THESE LAST THREE STAGES, WE DEAL WITH CHANGES ON AN EMOTIONAL LEVEL, OR THE AFFECTIVE STAGES. THESE CHANGES ARE USUALLY MUCH SLOWER AND DIFFICULT TO GO THROUGH THAN THE FIRST TWO STAGES. INFLUENCES ON THESE STAGES COME THROUGH INTERPERSONAL COMMUNICATION: THE CLOSER YOU GET TO ADOPTING OR REJECTING THE NEW IDEA, THE CLOSER THE PEOPLE YOU SEEK ADVICE FROM WILL BE TO YOU.

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Let us then have a look at the situation in a traditional society, and what might work for and against change.

Situation: This is one of the most unhealthy places in the country (a small town). Sanitation and hygiene is poor, and the incidence of disease and malnutrition is high. There are many people working in the health field, compared to e.g. a remote village with the same incidence of health problems. Still, the situation does not seem to improve very much.

What works against change?

- People working for change do not understand the process of change, and why and how people change attitudes and habits. Therefore, suggestions for change are often unrealistic and useless, or very close to useless.
- There is a concentration on short term aspects - i.e. curative medicine, without at the same time working with preventive measures. Physical targets are the only focus.
- People are most interested in feeling good about themselves and their own achievements than in analysing the process and ingredients needed for change, objectively, and decide together with the "beneficiaries" what needs to be done.
- To many field workers, it is unacceptable to give up some of the status they acquire by education and by birth, by working with and respecting people of low class and status.
- Most people working in health education believe that teaching is telling.
- Changing means taking risks.
- Changing habits is very slow.
- There are no incentives for the field workers.

What works for change?

- To realize problems and perceptions of causes of these problems from the point of view of those people who suffer from these

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problems. The health worker/change agent needs to have a real interest in what he is doing, he has to be willing and able to share meanings and understanding with "the target", to try to understand the reality of the others. Only then will he/she be willing to share some of our ideas - if we suggest what makes sense to them, on their terms. And - the changes have to be realistic in economic, social and cultural terms. The reasons for change have to be better than the reasons people have to stay with their old habits.

- Communication lines within the community have to be respected - the health worker/change agent has to work within the system that exists and that people are familiar with, rather than creating his own new system.
- An understanding of the pace of change is necessary. Too much change in too short a time results in opposition, and in going back to old habits. Development projects often introduce changes too fast, and fail to understand why people revert to their old habits when the new ideas seem to "make so much sense" to the outsiders.
- Understanding how attitudes and habits change, and that attitudes most often operate on a sub-conscious level. The health worker/change agent has to be able to find out what people's attitudes are.
- Sensitivity to how your own attitudes and behaviour affect the people that you are working with. If the health worker judges the people as "dirty and ignorant", they will not listen to his suggestions for change.
- Motivation by the change agent/health worker to do the job, because of having the mentality/attitude of a social worker, or because of other incentives that makes the efforts and loss of status worthwhile.

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8/12/82

UNICEF INTERNAL REPORT

FOREWORD

This report is prepared as an attachment to the report on Communication for Social Development in Burma, which is to be used by UNICEF staff and Government personnel. The reason for writing this part is to describe and discuss some issues that concern UNICEF internally, as well as give an overview over the work that has been done during the consultancy. References are made to the "main" report throughout this part, to avoid repetitions.

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INTRODUCTION

The UNICEF office in Rangoon is a place that is highly conducive to and supportive of communication work in general. There is a strong belief in the need for PSC as an integral part of programming among all the international programme and project officers, as well as among their national counterparts. The interest in PSC is effectively backed by the Representative himself, who is a strong believer in PSC. This "climate" is mirrored in the Plan of Operations (1982-86) where PSC is a mandatory part of every programme and project.

The PSC/PI officer himself, coming from a PI background, with no previous training or experience in PSC prior to joining the Burma country office in September 1981, showed keen interest and lots of skills and talents for the various aspects of PSC work. In addition to tending to his regular duties in the office, he used every opportunity to learn as much as possible about PSC during the three months we worked together.

Such a situation is extremely rare to find, and it makes the job of a consultant a pleasure, as well as bringing out his or her best creative skills in training, analysis of the social factors, and the development and production of communication support materials.

This statement does not imply that there have not been problems in the PSC work during this time. Communication work has a curious tendency to attract problems. If the problems are not there already - i.e. if there are aspects of a project with communication implications that people have overlooked - communication professionals have a nasty tendency to dig them out and make people face them, by asking questions that demand answers. The concerns thus brought out are all too often of the character that, if they are taken seriously, demand much time and effort to deal with.

Some people prefer that such questions remain unasked. The openness with which the UNICEF staff has been willing to face and discuss questions of this type, has been remarkable. The same openness has been experienced in the majority of Government personnel whom we have worked with.

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I hope that the questions that have been asked and the analysis that has come up as a result will be of some help to the programme and project staff in their further work with the PSC/PI officer to continue the communication support to the various projects. The findings and recommendations are offered with hesitation where these involve criticism of the work that has been done, since documents of this kind are all too often taken out of the context of where they have to be applied, and relevant considerations to the problematic reality cannot always be given. I hope that the instances where this occurs may be forgiven, and that the suggestions will be taken as points for further discussion rather than as a blueprint for how PSC should be implemented in the UNICEF Burma office.

September 1982

Ane Haaland

BACKGROUND

Duration of consultancy: 3 months (June - September 1982)

Main tasks:

1. To give the PSC/PI officer in the UNICEF Burma office general training in theoretical and practical aspects of PSC, particularly with reference to the development, pretesting and production of simple PSC materials such as posters, flipcharts etc., with particular reference to goitre control, nutrition, EPI and environmental sanitation projects.

2. To design and pretest PSC materials required for the support of the Goitre Control Project in Burma.

3. Based on the above, to develop a pretesting manual for use by various departments developing PSC materials.

Summary of work undertaken during consultancy

Based on the above general terms of reference, training was given and practical work was done in the following areas:

1. Planning: Short-term and long-term planning as it applies to PSC input in projects assisted by UNICEF. In addition, planning of routine work and organisation of PSC/PI office.

2. Background knowledge in aspects of social sciences related to PSC work. Various topics have been dealt with in theory sessions, and then followed up in practical projects. Some of the topics are : Simple research (planning, design and analysis); formation and change of attitude and behaviour; value change; social psychology/behaviour; problems in health education and training related to social sciences; traditional and modern medicine - similarities and differences, and implications of this for health education; social change; motivation; communication needs and processes; monitoring and evaluation.

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3. Pretesting. A number of different kinds of materials (posters, flip-charts etc.) were pretested by the PSC/PI officer during the first three field-trips, to gain experience in the practice of pretesting. Throughout the work with the Goitre Control Project, pretesting was planned and carried out for the educational materials.

A pretesting workshop was conducted for middle level project personnel and UNICEF staff, focusing on health and nutrition topics and materials. One of the main results of the workshop was a higher awareness among the participants about the problems of visual perception among people with low literacy level.

A manual on pretesting has been developed. The manual will be translated into Burmese, and printed (with illustrations).

4. Development and production of visual aids and other support materials.

a. Photography. Basic skills in photography have been learnt and practised by the PSC/PI officer, with the accomplished aim to take pictures of a quality that can be used in development of visual teaching aids. Two workshops have been held for UNICEF staff on basic photography, including questions on how to use photography to support projects, as well as for PI.

A new system for cataloguing and organising negatives and prints has been designed and put into action, with the objective to enable all staff to find photos on any subjects or locations easily.

a. Layout. Basic principles have been learnt and practised on posters, flipcharts, information guide book and teaching charts.

c. Printing. Basic principles of offset printing have been learnt and studied in practice. This includes making a visual ready for printing, with the correct quality of photos.

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d. Visuals aids have been developed mainly for Goitre Control and nutrition projects. Some of the visuals have been printed. Others are in their final stage before going to press. For a list of these materials, see under the project descriptions in the main report.

e. PSC background notes. A series of articles and notes on various topics (described under 2), as well as technical articles on goitre and cretinism, have been cyclostyled and distributed as part of workshop materials, as well as for general PSC use. More than 20 different titles have been produced so far. Books and articles on other PSC related topics have also been included in the library.

5. Training. In addition to the three workshops mentioned above (photo and pretetesting), health education and training process support was given to a workshop for Township Medical Officers in the Goitre Control Project. The PSC/PI officer has gained experience in planning and running such workshops. With other projects, problems related to training in connection with development and production of educational materials have been analysed and discussed, with emphasis on factors that facilitate learning and factors that hamper learning.

Furthermore, the communication component in training of Basic Health Staff (BHS) has been looked into. A preliminary intervention has been the planning of inclusion of communication chapters into the training manuals for health staff in goitre control, nutrition and EPI. These chapters focus on basic ideas about teaching and learning, and about how to use visual teaching aids more effectively.

Personnel from the Central Health Education Bureau have at times been included in the training process that has been going on in PSC/PI this summer. Basic PSC materials have also been supplied to a WHO-funded training programme for 30 Health Education Officers, who will work under HEB.

6. A report/analysis of the present situation of communication for social development in Burma, with recommendations, has been prepared.

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SUMMARY OF OBSERVATIONS

1. There is a high awareness of the need for PSC in all programmes in the UNICEF Burma country office. This awareness has translated into the PLANOPS , where PSC is integrated into every project.

2. PSC is largely seen as product, i.e. teaching/promotion materials, rather than as a process that is a part of every project from the planning through the implementation phases.

3. There is a lack of awareness in the Government about what PSC is, what it can do and cannot do, and why.

4. Currently, a majority of the requests for PSC assistance from the Government is for supplies and hardware of different kinds.

5. The expected behavioural effects of the planned teaching/promotion materials have not been fully analysed. This has led to a possibility of having too high expectations about what these teaching materials will "do".

6. The long-term aim of PSC is social development. A focus on the products will emphasize the short-term goals at the expense of building up knowledge and attitudes, and motivation.

7. There is a pressure on the PSC/PI officer, both from outside and inside the UNICEF office, to produce visual aids. While a certain pressure is healthy to inspire good work, too much pressure for tangible results of the PSC work may put an undue amount of attention on the production side, at the expense of the "process" side which deals with planning, analysis, field studies, training, and pretesting, or rather - with the social factors of development projects.

8. The PSC/PI officer needs to strengthen his functional creditability with the personnel in the government projects. This credibility is being built up with the support to the Goitre Control Project and Nutrition Projects.

9. The UNICEF staff does not see and use the PSC/PI office as an information source and a communication resource, where ideas can be exchanged and problems regarding communication can be discussed. There is not much informal "drop-in", except when people want a camera or a film.

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10. The contact with and response from the PSC section at Headquarters is limited and slow. Headquarters does not function as a resource for field offices for advice or materials that are needed. Rather, the Headquarter approach resembles the one-way practice of communication - i.e the dissemination approach. Materials are more or less indiscriminately sent to the field as Headquarters sees it necessary and relevant, and this may or may not correspond with the needs of the field offices. The concentration on this approach seems to be so time-consuming that individual needs for materials and advice cannot be responded to on time.

11. The users of the teaching materials, their lack of skills to use the materials and the need to facilitate the development of such skills, have not been given as much attention as the production of the materials themselves. This may result in an ineffective use of these materials.

RECOMMENDATIONS TO UNICEF/RANGOON

A. Planning

1. A wider interpretation of the PSC function should be discussed and adopted in the programmes and projects assisted by UNICEF in Burma. The present focus on products, mainly posters, does not do full justice to the possibilities of PSC to support projects. (See main report, historical background of development communication, recommendations, and project analysis).

2. The recognition of the need for full audience involvement in the development process in order for the projects to be successful, is growing. UNICEF should continue to strive towards a wider application of such practices in the projects supported by the organisation. PSC is a vital tool in this process, and should be used more extensively than at present in this task.

3. The recommendations for more emphasis on information gathering are not a suggestion to UNICEF to become a research agency. Rather, they suggest that the agency encourage more national and international focus on the social and human aspects of development work, in addition to the technical aspects. More emphasis on the social and human aspects of development is crucial for the success of UNICEF's social development aims. By encouraging information gathering, UNICEF will assist in building up a body of knowledge about

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rural and urban communities and their social characteristics. For a start, information could be collected about knowledge, beliefs and attitudes in areas of health and nutrition, where some of the main problems in Burma's development lie, and where UNICEF is concentrating much of its assistance. Such information should be included e.g. in the "Situation Analysis", which presently is full of figures, but lacks behaviour or software parts of the problems.

4. The PSC/PI officer should be well informed about the general content and activities, as well as the problems relating to communication, of all the programmes and projects UNICEF is assisting. He should be involved in all aspects related to communication handled by the programme/project officers and the Government counterparts. He could possibly also be a link between the different programmes in the office, since good PSC is often a question of co-ordinating sources and resources. He should also be a link between UNICEF and other aid organisations in aspects related to PSC. Needless to say, this is an almost impossible job. However, the PSC officer is one of the few persons in the office, in addition to the Representative, who deals with all the different programmes and projects. As such, he can be an important "information centre", and has the possibility of linking activities and efforts together when needed, as well as making programme/project staff aware of relevant information he may come across.

To be able to perform this function satisfactorily, the PSC/PI Officer and the programme/project staff need to co-operate and provide each other with the necessary information - not only by sending reports and papers that may or may not be read, but also through frequent informal "briefings".

5. The PSC/PI officer should go to the field frequently. Good knowledge of the field situation and communication problems facing different projects, is a prerequisite for determining the direction and content of the communication support that is required. Besides, field knowledge helps a lot in the process of establishing credibility with Government counterparts.

6. A PSC workshop should be conducted for the professional staff in UNICEF as soon as possible, to give the staff more insight and skills in PSC. Such a workshop was requested by several members of the staff. One of the examples that could be used to shed some light on the "expanded view" of PSC

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is the work done for the Goitre Control Project. It is recommended that the Regional PSC Officer be invited to such a workshop as a resource person, and also to discuss and assess in what areas she can be of assistance to the Burma PSC/PI Officer.

7. A list of "Standard PSC Questions" to be asked in different stages of project planning and implementation should be worked out. Such an exercise might be a useful part of the suggested PSC workshop (e.g. as group-work), and could build on Guy B. Scandlen's "Eight Golden Rules of PSC" for a start.

8. The use of articles and books on communication issues should be encouraged. One way to make programme/project staff as well as Government counterparts who are involved in communication and pretesting work aware of the availability of materials, is to make a list of what is available, and distribute it. Even though most of these people are swamped with reading materials, good and relevant articles usually do not fail to catch the interest of some. The use of good journalistic methods plus humour and imagination in "marketing" the products is necessary and worth the effort. Building up people's knowledge and awareness of communication issues is a good way to pave the road for a wider and more constructive use of PSC in Burma.

B. Visuals and equipment

9. More effort should be placed on analysing if and where visual aids fit into a project, and what these visual aids realistically can be expected to result in, given they are properly used.

10. Efforts should be made to analyse needs and develop support materials not only for health and nutrition, but also for sanitation and water supply and for education and welfare projects. Project personnel in these sections have been trained in pretesting of educational materials. Their experience should be made full use of, in the development as well as the pretesting of support materials for their programmes.

11. More effort should be placed on looking into the use and the distribution of educational materials, in addition to their development and production.

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12. More effort should be placed on getting feedback from the field about the use and appropriateness of the educational materials. Such feedback should not only focus on how appropriate the selected type of media is, but also on whether or not the content of the messages is relevant to the needs of the community.

13. The PSC/PI Officer should build up his own skills and capabilities to develop and produce educational materials together with HEB and project personnel. Only by demonstrating that he has his own capabilities and skills will he be able to establish the necessary creditability towards his counterparts in the Government. Working in unison with Government counterparts at this task, he can capitalize on the joint learning situation to build good working relationships, as well as learning more about Burmese culture.

14. The PSC Officer should learn more about photographic processes, and how they can be controlled in a tropical climate, to enable him to obtain the best possible results from his black and white photography. This has become even more important as he has started to use such photos for educational materials to support the different projects. Presently, the office is having its pictures developed by a photographer who improved visibly under constant supervision. Availability of good quality photos will encourage wider and more frequent use of these in various kinds of project and programme support.

15. When requests for hardware/equipment are received from projects, more effort should be placed on looking into the projects possibilities of making constructive use of the equipment for educational purposes. Such questions will doubtlessly be met with resistance in the beginning, however, if it can be demonstrated that PSC also has the skills and the possibilities to assist in upgrading the capabilities of the project to make use of the equipment, the resistance may gradually turn to enthusiasm ... and to a higher awareness of the need for such skills.

C. Health education and Training

16. The methods used by health educators in the field as well as by trainers of such health educators should be carefully reviewed to assess possibilities for improvement. Such review could be done e.g. on the basis of the experience with the course of HEOs, which started in September 1982. Observation of BHS performance in the field should also be part of such a review.

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17. The co-operation with the Central Health Education Bureau should be continued on a regular basis through frequent meetings in the project working groups and the pretest co-ordination group, as well as with the Assistant Director of the HEB. UNICEF's role in this work should be to provide moral support as well as material and professional support. Assisting in the development of indigenous skills is usually slow and often frustrating for both parties, but it is the only way to go if the aim is long-term development and not only the production of a few flashy visuals to massage someone's ego.

18. Based on the guidelines for teaching, learning and use of educational materials to be included in the training manuals for goitre control, nutrition and EPI, a more general or standard chapter on communication for health workers in the field should be worked out. This chapter should only be designed after assessing the use of the guidelines in the above-mentioned projects, of which goitre control might be the most useful one to evaluate.

D. Regional office

19. The PSC/PI Officer should make use of the services of the regional office, where there is a competent Regional PSC Officer with social science background and experience.

RECOMMENDATION TO UNICEF HEADQUARTERS

A. Background

1. The job of a PSC/PI Officer in UNICEF is not an easy one. Without the necessary background in communication and related social sciences, he will often find himself in the frustrating position of being a poster producer, and reacting to the "PSC needs" as defined and specified by programme/project staff whose speciality is programming, not communication. All too often, their concern will have a heavy bias towards the technical and logistics side, which traditionally has been the stronghold of UNICEF's assistance for decades. Producing posters does not do much to counteract this bias.

2. A PSC Officer with the necessary background and experience in development communication as well as in PI will be a more constructive member of the UNICEF team. Such a person will be able to add a much needed social aspect to

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programme planning and implementation by including communication concerns and processes from the very first stages of a project.

3. The Representative in Burma was aware of this need when hiring a PI professional to do the PSC/PI job, and his plan included the training in PSC that this consultant has undertaken. Such training - applied theory and practice of PSC on a one-to-one basis, provides an excellent opportunity for an interested PSC/PI Officer to learn the in's and out's of the trade. However, it is probably fair to assume that such training as the PSC/PI Officer in Burma has been offered is an exception rather than a rule in UNICEF's PSC cadre, where a majority of the people come from a PI background.

4. Coming from a PI background myself (I was a photo-journalist when I joined UNICEF Nepal as a PSC Officer in 1975, a job I held for four years), it has become increasingly obvious to me that a heavy PI/promotion bias is not very helpful or constructive in working for social development, faced with the problems of how to reach the most vulnerable groups in the society - mothers and children - with the assistance that UNICEF provides. Without by any means claiming to have "the answer" to development problems or to the questions faced by UNICEF's PSC/PI Officers, I can only offer the experience that an added insight from the social sciences, and a better understanding of communication as a process rather than as a visible product only, has made me a more useful communication worker with more constructive knowledge to offer programme and project officers in development.

B. RECOMMENDATIONS

1. On this basis, it is recommended that UNICEF looks seriously into the needs and possibilities for structured training of the PSC staff. Such training would greatly enhance the agency's ability to be more effective in reaching its main target audience - mothers and children. The policy makers have already recognised the need for better communication support to the programmes.

One important way to ensure that this policy is implemented is by improving the skills and capabilities of the PSC staff members.

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2. Another aspect of equal importance to the provision of good communication support to UNICEF programmes, are the possibilities of future work for the PSC/PI officers, which serves as an incentive for doing a good job as well as for continuing in the organisation. The recommendation made by Dr. Fred Reed in his report on the PSC activities in the UNICEF Nepal country programme, 1974-1978, is still valid:

> "In order to maintain morale, give a sense of professional growth, and aid in career development, UNICEF Headquarters should give policy attention to the career development of PSC officers. Lacking such possibilities, there is a grave danger that competent PSC personnel will refuse to divert their careers for intermediate term employment".

3. Headquarters (PSC) should make an attempt to respond more and quicker to requests from the field for materials and advice. Materials or books requested by PSC are needed by the project PSC supports, and Headquarters is often the only possible source of these materials. Similarly, with the scarcity of communication professionals present in many countries, and certainly so in Burma, Headquarters and the Regional office are the PSC officers' only sources for professional advice.

C. POSTCRIPT

The most important recommendations have been given to the PSC Officer during our work together, which was aimed at giving him a thorough understanding of the process of communication in development. An important tool is knowing how to ask the right questions to the right people at the right time and thus avoid project planning and implementation assumptions that do not have a basis in the reality of the communities they are supposed to assist in the development of. This process will not be illustrated clearly in such a brief report. The findings and recommendations are thus only a summary of what PSC can be all about, and how it can be crucial and instrumental in making development projects reach the people they are meant to reach - in a way these people can understand and relate to.

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Notes

The first part of the report, "The Basis for Communications in Development" deals with: current work by international agencies and the Burmese Govt.; communicatiosn in the field - social roganizatino in Burmese villages visual perception in Burma; and makes recommendations for planning, visual aids and cooperation.
The second part, "Examples of and ideas for communication support in practice" analyses the communication situation in existing projects: goitre control; nutrition centres; oral rehydration; immunization; environmental sanitation - why people do not change their behaviour.
A summary of observations is given at the end of the report.

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