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2. ADVOCACY FOR PHC

2.1 Introduction

There are three broad areas of advocacy for PHC, depending on the status and development of PHC in a given country. In practice, these three are not clearly distinguishable, but represent a spectrum of overlapping situations.

A. Advocacy for the acceptance and adoption of the PHC approach as the most effective means of achieving health objectives,and of providing essential health care. This applies to countries committed to conventional, high technology, medical care systems.

B. Advocacy for aspects of the PHC strategy requiring specific organizational or budgetary changes, in situations where the policy has been accepted in principle, i.e. to make PHC a reality in the country context.

C. Advocacy for priority to be given to specific programme components within PHC, particularly for vulnerable groups such as mothers and children, or those in particularly deprived areas of the country. This also includes the promotion of relevant technologies, etc.

2.2 Situations Requiring Advocacy for PHC

A-type advocacy is needed in the following circumstances:

a) Countries which are sceptical about PHC and about introducing change in general. They are satisfied with the current system of health care and believe PHC to be second class health care and inappropriate for their country. Well established and strong professional groups who are concerned with the maintenance of technical 'standards' (often 'western' standards) may be the major influence.

b) The PHC approach may be viewed as requiring expansion of the health infrastructure with all the managerial and resource implication this would entail. Fear of inability to meet rising expectations of the public, or controlling communities' demands may also influence decision makers.

B-type advocacy will be required in the following circumstances:

a) Countries which have adopted the PHC approach as a matter of policy without a full appreciation of the implications for change, e.g. increased community participation, decentralization of decision-making and control of resources, organizational and budgetary reforms in the system, re-allocation of resources and re-orientation of health personnel. In this situation, advocacy for specific aspects of the strategy may be needed.

b) After the government of the country has adopted the PHC apprch and is making efforts to implement it, there may be some professional groups or influential leaders such as parliamentarians, who still remain opposed to PHC.

c) Bilateral and other donor agencies may continue to direct their funding towards the high technology curative institutions which drain government human and financial resources away from their PHC efforts. Since UNICEF funding is very limited in comparison with other agencies, advocacy efforts directed towards these agencies, as well as government may be required.

d) Even when the PHC approach has been adopted, most governments are likely to need constant nudging to actually implement the major structural changes required for PHC, as this takes considerable political courage. The recent WHO/UNICEF study on Decision Making for PHC* illustrates that even politically committed governments are experiencing difficulties in implementing these changes.

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* WHO/UNICEF Joint Committee on Health Policy. National Decision Making for PHC, WHO 1981, Geneva.

e) The impact of PHC is likely to be long term and lack of concrete successes and results may be cause for some resistance and doubts about its effectiveness. Evidence for this is already apparent amongst some international health agencies, especially donor institutions. This is related to the difficulties in scaling up from small successful pilot projects to national programmes, involving wider organizational changes which are often politically difficult to implement.

Type-C advocacy is needed constantly, to draw attention to priority programmes for vulnerable groups, to sensitize governments to the availability of newer and more cost-effective technologies such as ORT, or to emphasise the importance of tackling the weaning problem, promotion of breastfeeding and the need for a code to control advertising of breast milk substitutes; the need to use different approaches for health education; or to promote ideas and action which has proved successful elsewhere.

It goes without saying that successful advocacy requires a great deal of political sensitivity and tact, and an indepth understanding to the culture and conditions of the country, in order to recognize what is relevant, feasible and affordable, in political terms as well as financially and managerially.

2.3 Processes Preparatory to Advocacy

There are some thorough analytical processes that need to be undertaken in order to have correct and relevant information for advocacy. The assessment of the National Strategy outlined above can provide most of this. Particularly relevant issues are:

- Quantified information on the limitations of the current approach to health care e.g. low coverage of vulnerable groups. The number of deaths attributable to preventable diseases.

- A review of past advocacy for PHC, especially involvement in WHO promotional activities.

- Examples of successful PHC programmes in other countries.

- The structure of health services in the country, and to what extent they are orientated and capable of supporting PHC.

- How far the PHC strategy is understood, at the central planning level.

- Is there awareness of the needs of deprived groups and willingness to devote more resources to these groups?

- To what extent are central planners prepared to decentralize decision-making and planning? Are they willing to involve communities in decision-making?

- How far are bilateral aid agencies supportive to PHC.

- To what extent are communities involved and ready to accept responsibility for their own health.
- Are health attitudes of health personnel conducive to PHC, i.e. are they orientated to health goals and to working with, and in, communities or are they more concerned with the provision of curative care and the maintenance of institution-based health services?

- How far are the known, cost-effective technologies for priority health problems being implemented.

- Are health resources allocated in accordance with stated priorities?

2.4 The content of PHC Advocacy

The themes for PHC advocacy will be determined by the answers obtained from the above analysis. Some important messages are:

- the consequences of continuing conventional systems of health care and not adopting the PHC strategy;
- the cost-effectiveness of PHC and returns on investment in PHC;
- the contribution of health to development;
- the political advantages of increasing coverage and access;
- the logic and justice of PHC;
- the political imperative to reduce child mortality and improve child health.

2.5 The Methods of Advocacy

a) Demonstration. Take decision-makers and health planners on study visits to countries which are successfully implementing PHC. Promote a demonstration PHC programme in a limited area in the country or persuade decision-makers to visit one that is already on-going, possibly run by an NGO.

b) Mount a public information campaign, using the media, demonstrating how PHC would overcome the constraints which have been identified through the above analysis, and documenting successful programmes in PHC In other countries.

c) Raise issues with government during meetings, especially programming and review meetings, and in intersectoral meetings or with ministries of Finance or Development and Planning sectors.

d) Use all opportunities of meetings with national leaders such as head of state and prime ministers. Good opportunities can occur when senior ranking officials of UNICEF and WHO visit the country who can discuss PHC related issues with national leaders.

e) Promote the development and implementation of relevant information systems and the use of information for decision-makingg. Ensure politically influential leaders have access to results of good studies and relevant data.

f) Hold PHC workshops for professional groups, at which the effectiveness of PHC can be demonstrated if possible including field visits to PHC projects. However, any field visit which is well structured, can illustrate why PHC is important and what it means even if no PHC programme is operating.

g) Assist with evaluation studies and publicise the results.

h) Popularize PHC priorities both inside and outside the health system (e.g. ORT, nutrition issues, immunization, hygiene, maternal care, etc.) using mass media.

i) Arouse peoples power, and desire to improve their own health through more popular channels such as songs, drama, dance, etc.

j) Promote the idea of national days, weeks, or even year, for certain PHC related concerns to arouse public awareness, e.g. like the year of the disabled. Why not a "PHC year" (as is planned in one country in 1974) or one day a year for children under 5, focussing on different themes.

2.6 Audiences for PHC Advocacy

The different audiences for advocacy are discussed in the next section dealing with communications support for Advocacy.

2.7 Skills and styles conductive to successful Advocacy

Political sensitivity has already been mentioned. It also requires a good understanding of the problems to be addressed in PHC and a credibility resulting from professionalism in development and broad health concerns, an understanding of the decision-making and planning processes, and the way

government works, as well as an understanding of the processes which contribute to high child mortality. In UNICEF offices, where there is a PSC officer it is expected that they would participate in supporting the advocacy process through communication skills and knowledge, and by assisting with the methods, according to audience. Particular skills needed for advocacy are:

1. Ability to assess particular audience or target groups' perceptions and knowledge of a subject, in order to be relevant and interesting.

2. Ability to identify the most appropriate channels, and methods of communication and make maximum use of them.

3. Manage time to allow sufficient opportunity for advocacy activities. This means planning for advocacy.

4. Have an ability to continue advocacy in such a way as to continue to be interesting and relevant and find new innovative ways to motivate decision makers.

5. Integrity and enthusiasm.

3. COMMUNICATION SUPPORT FOR PHC*

3.1 Introduction

Communication enables people to share their knowledge and experiences, and to understand each others point of view. It is a two way process. Communication skills should be used to increase the effectiveness and enhance the impact of development programmes. This sharing of knowledge and experiences is of critical importance in PHC, where most health goals involve exchange of basic knowledge about health, and changing attitudes and behaviour about health. Strengthening the communications component of programme is one of the most urgent priorities in PHC.

*This term is used in preference to "Health education" which is narrower in meaning.

Unfortunately, communication is often viewed as a one way process which happens spontaneously, needing no special skills, training or application. Because we communicate everyday, everywhere, we tend to overlook the complexity of the process and the systematic ways in which different modes of communication gradually shape our perception of reality and our general world view.

It is crucial that all organized and planned communication activities take into account the predominant modes of communication of the population in the area of programme operations. In most of Africa for instance the modes of communication that are intended to influence people's beliefs about, and perceptions of specific aspects of reality tend to be informal, artistic and cultural. Consequently, the task of changing such perceptions once acquired becomes very difficult.

Instead of evolving innovative and imaginative approches of dealing with complex situations and processes, there has been a tendency to cling to Western based theories and models of communication. Since communication is a process, there is a need to emphasize the '<u>doing</u>' of communication as opposed to 'learning', 'talking' and even 'planning' of communications.

Many projects to improve health education or communications support more generally have emphasized the production of materials, supplies of equipment for communication (the 'hardware') and special training workshops on the principles of communication technology, etc.

Most of whatever training and motivation that has to be done, however, has to be through the <u>doing of communication</u>, i.e. learning by doing. Communication is a culture-bound activity (culture in its broadest sense) and as such can only be understood improved on and tapped (for whatever use) from within. Communication cannot be taught in isolation from specific country contexts and concrete programmes.

Because UNICEF's traditional partners are social services ministries with direct concern for women and children (Ministry of Health, and Community Development in the case of PHC), UNICEF's own communication efforts have tended to be tied solely to these ministries, at the expense of much needed support to the communication sector itself. There is a need to support all groups involved in improving the use of communication for development, e.g. the broadcasting services themselves, professional associations, theatre groups, etc.

It has already been pointed out that in Primary Health Care there is a special role for supporting communication activities. It is important that these activities be understood in all their complexity and diversity, such as supporting advocacy efforts, improving communication within the PHC management and implementing systems, influencing the development of a whole culture's perception of the problem of man's health, and not merely in the narrow sense of producing audio-visual materials for use by health workers in health education 'lectures'.

3.2 Categories of people involved in communication for PHC*

The goals and objectives of any organized communication activities define the various groups of people that are appropriate for the achievement of such goals. For PHC related communication, the following categories can be distinguished:

i) UNICEF personnel
ii) Political Leaders/Decision Makers
iii) Senior Civil Servants
iv) Mid-level Civil Servants
v) Professional Groups
vi) Powerful Mass Organization
vii) Non-governmental Organizations

*The term 'target' groups is deliberately avoided because it suggests one way communication process only.

viii) Special Interest Groups

ix) Donors

x) Mass Media

xi) Front-line Workers (Community based)

xii) The Community at large

xiii) Other UN Agencies

The above groups are not necessarily mutually exclusive in their interests and there is considerable overlap in the most effective ways of reaching them. Communication and interactions also take place within and between the groups themselves. Knowledge of how this occurs, and identification of the groups, defines specific objectives and the variety of communication channels for sharing information with and within these groups.

The same groups, and sub-groups within them, will also determine the modes of communication best suited for given purposes and objectives. It cannot be over-emphasized that the existing modes and styles of how communication occurs, takes precedence over all else in determining the methods to be used.

There are two main areas of communication activity, which are important in PHC:

a) Communication support for advocacy, and

b) communication support for programme areas.

3.3 Communication support for advocacy are those communication activities intended to support the advocacy efforts outlined in the advocacy section above. Advocacy is basically a one way process whereby carefully designed messages are directed at specially selected audiences with the intention of persuading the audiences to adopt a given point of view, i.e. the acceptance of the Primary Health Care approach, the implications of implementing it, and

specific programme priorities within it. This can be directed to all the categories listed above, but there are three groups that are of special interest, because they have power and influence:

a) Decision makers such as Heads of State, cabinet ministers, religious leaders, heads of donor agencies, directors of NGOs. National Health Managers and Senior Civil Servants in other influential sectors.

b) Mid-level management: Provincial medical officers of health, provincial health inspectors, chief nursing officers, provincial training officers, etc. This is the level that has day to day control of what really goes on in the field.

c) Local-level trend-setters: Primary school teachers, local government administrative officers, nurses, literacy workers, etc. These are people viewed by the local community as the enlightened and knowledgeable, in short, the models.

d) Professional groups: Medical and nursing associations, etc. A special group of 'trend setters' in the health sector.

Support for advocacy includes the public information function. In developing countries members of the public are usually starved of basic information. This can range from when and where to get a birth certificate, what their rights are in dealing with the local shopkeeper or the rude health worker at the health centre, to how diarrhoea is spread and where and when the nearest immunization clinic will be held. The need for a good working relationships with all branches of the mass media in supporting communication for PHC, can never be over-stressed.

The methods of supporting communication for advocacy are many and varied, depending on the groups involved. The following are examples:

a) "Blowing-up", e.g. in a meeting with the UNICEF Representative, a Cabinet Minister makes a one-line statement in support of PHC. This statement can be taken up and a whole newspaper article written up around it, in which you say everything about PHC, except now you are saying it "together" with the minister.

b) Distribution of PHC Literature. Both UNICEF and WHO turn out a ceaseless flow of literature on PHC. Make a list of all persons strategically positioned in the health sector of your country and periodically mail them all relevant literature. Reproduce more copies in your office if necessary. What is sent should be attractively produced and short - there is nothing more off-putting to read than a large turgid WHO or UNICEF document. In some situations an abstract is all that is needed.

c) Place materials into the media. Write feature articles for the press and where possible radio programmes. Some reporters will always pick it up if you ask them to "modify it" and let it go out under their name.

d) Brochures - Well designed brochures on glossy paper, with eye-catching colour pictures can also be very effective, if properly targeted.

e) VIP Visitors. Each time a UNICEF "VIP" like a Regional Director or Deputy Executive Director visits the office, use them to brief the press and media cameras for as long as possible, preferably in the company of national leaders.

3.4 Communication support for PHC programmes

This includes communication activities that are intended to support the planning and implementation of Primary Health Care itself. Communication here is a two-way process, as opposed to the one-way process in advocacy. Feedback is important and messages are more analytical and explanatory rather than persuasive because the process involves much more responsiveness to the knowledge, understanding and wishes of the community. It involves their active involvement in the process. It is crucial to identify the channels, modes and styles of communication in your country setting, in order to plugging into these. To improve them, add to them, or increase their effectiveness, must be done from within, and not from outside.

Communications support for PHC involves several essential requirements.

a) An in-depth understanding of existing modes and channels of communication ranging from the use of television right down to the traditional story and songs, and the channels of communication within and amongst the categories listed above. There is a need to identify the informal communicators in the community, local leaders, or the village gossips, etc.

b) It requires a process for arriving at good and relevant messages involving the disciplines of anthropological research, market research, technical health experts such as epidemiologists, public health administrators and communications expertise itself.

c) It requires a continuous monitoring and evaluation process, i.e. feed back on how much communication is actually occuring, and whether messages are relevant and feasible to adopt in order to achieve behavioural change.

d) It requires that messages be simple and consistent, and are re-inforced through the various different channels and modes. In practice, conflicting and obscure messages through different channels are the norm.

3.5 Learning Aids

Communications support also includes development and production of learning aids such as pictures, posters, flipcharts which tell a story, slides, tapes and films. These aids are used in formal learning situations, that is situations in which people gather for the exclusive purpose of learning. In using them to train health workers, it is important to accompany them with as much text as possible to avoid misinterpretation. Foreign obtained materials should be "contextualized" as much as possible.

Learning aids can also be used in training mothers but maximum effort should be made to present them within the context of traditional modes of communications in order to facilitate the learning process i.e. using the language of story telling or role playing. However, in deciding to use learning aids, it should be remembered that this only reaches those mothers who attend the learning group situations and we need to use other less formal channels to reach the bulk of the mothers. Health Educatin lectures have limited impact, whereas one on one use can relate to peoples' experience and be more relevant. Learn aids, like a flip chart or small illustrated pamphlet, which a health worker can carry to homes, or distribute to a mother who asks advice, may be much more effective.

There are however occasions when we need to reach a large group who might not normally be reached. The channels and modes of communication are determined by (i) the groups involved in the sharing of knowledge and experience, (ii) the nature of the problem or issue involved. An example follows: Mothers do not bring their children for immunization because they do not see whey it is important to take them to the clinic when they are not ill, especially when the mothers have so many other things to do.

Groups involved are:	Health personnel, fathers, mothers.
Resource Skills needed::	Artistis (i.e. painters) photographers, radio producers, local singing groups, school drama groups, local health educators (village health workers).

<u>Activities:</u>

i) Production and wide distribution of picture posters showing repercussions of non-immunization.

ii) Production of flip-chart on the diseases, and effects with drawings that have local motifs to be used invillage health education activities.

iii) Writing and popularising of songs that ridicule the mother who falls to take child for immunization and the child subsequently dies.

iv) Production of interesting radio stories and dramas on the immunizable diseases.

v) Children's humourous plays on immunization.

vi) Game and role playing activities at women's gatherings or adult literacy classes.

3.6 Training in communication for Health Workers

Training for health workers in communication should include both communication amongst themselves as well as communication with the rest of the community. Managers and supervisors of PHC activities should be clearly aware of the lines of communication from the centre to the remotest periphery of the PHC system and vice versa. They all need training in communicating information effectively, often linked with management training. In communicating instructions and information from a more central to a more peri-pheral level the language and forms of messages should be determined by the level of comprehension of the receiver. As an example a message originting from headquarters as a one-page memo may need to end up as five pages, in a local language, with illustrations, by the time it reaches the community health worker.

Most health services are actually implemented by the peripheral levels of the delivery system, by medical and health assistants, nurses/midwives and community health workers who comprise the front-line health workers. These are the cadres in direct communication with the mass of the people. It is

therefore essential that the training of these cadres include a strong element of the practice of communication. Since this has usually been inadequate, in-service workshops should be organized for this cadre in which emphasis is put on the ability to diagnoise the dynamics of communication in a given community, and plan their health education activities accordingly.

Emphasis during such training should be put on the health worker's capacity to use a wide range of communication channels innovatively and imaginatively, ranging from visual aids at health education clinics to popular songs enjoyed by everybody in the community. They also need to be trained in the use of learning aids.

3.7 A Summary of the Roles of a Programme Officer in Communications Support for PHC

The health programme officer should identify communications resource persons (professional communicatiors) and encourage, support and use them. Should there be a PSC officer in the country, he or she should be included in the programming team from an early stage in the programming process.

The programme officer should be sentitive to, and identify communication aspects in the planning and implementing process. The following are suggested areas for involving the PSC officers or communications expertise in UNICEF:

a) Advocacy
b) Analysis of the problem in the planning process
c) Programme previews
d) On-going monitoring of programme
e) Identification of external communications resource people

The programme officer should sentitize his government counterparts to the need for communications inputs, and what is involved in effective communication. The opportunity to work with the communications sector as a whole, and not simply the health education unit of the ministry of health, should be developed and exploited.

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