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**Communication in a Decentralized Health Sector:
Communication Strategies in Immunization Programs in Colombia**

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To my family, for their company and support.

To my country. Because difficult situations should not make us bend our heads, but
instead raise them as high as we can to dream and to propose.

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ACRONYMS

COPACO*	Communitarian Participation Committees (Comités de Participación Comunitaria)
DANE*	National Administrative Department of Statistics (Departamento Administrativo Nacional de Estadística)
DHS	Demography and Health Survey
ECLAC	Economic Commission for Latin America and the Caribbean
EPI	Expanded Programme of Immunization
HSR	Health Sector Reforms
IADB	Inter American Development Bank
IGAC*	Geographical Institute Agustin Codazzi (Instituto Geográfico Agustín Codazzi)
INS*	National Health Institute (Instituto Nacional de Salud)
LHP	Local Health Plans
MSP	Ministry of Social Protection
NID	National Immunization Day
OPV	Oral Polio Vaccine
PAHO	Pan American Health Organization
RIP	Routine Immunization Program
SGSSS*	General System of Social Security in Health (Sistema General de Seguridad Social en Salud)
SUPERVIVIR*	National Plan for Infant Survival and Development Plan Nacional para la Supervivencia y el Desarrollo Infantil
UBN	Unsatisfied Basic Needs
UCI	Universal Child Immunization
UNICEF	United Nations Children's Fund
WHO	World Health Organization

* This abbreviation is in Spanish, as there is no official use in English

1. INTRODUCTION

Communication has been part of development programs throughout the world since 1950s. Especially in the field of health it has played an important role promoting social change in the search for healthier societies, which has become a key factor for development.

Over the years, communication has changed its role according to changes in health conceptions. This has strengthened each time more its presence in the sector turning social communication strategies into a main component of health programs.

However, this hasn't been the situation always. In several countries the health sector went through structural changes in late 1980s with decentralization and Health Sector Reforms (HSR), but many communication strategies continued recreating the dynamics of a centralized health sector.

1.1 Background

Until the 1980s, Colombia's health sector was centralized and the central government was the sole provider of health services. In this context, communication strategies were focused on inviting the population to demand health services and to adopt healthy behaviors.

Between late 1980s and early 1990s, decentralization and HSR changed the dynamics of health services' supply. Now it was the responsibility of local governments and was administered by both private and public health service providers. These changes in the health system increased the complexity in the country's provision of health services, as

new actors such as local authorities (departmental and municipal)¹ and service providers appeared.

Despite very few cases², communication strategies in health continued focused on changing population's behaviors. These strategies didn't recognize neither the new dynamics of a decentralized health provisioning, nor the new actors in it.

Further more, although the process of decentralization generated several positive effects related to the increasing autonomy of local governments, it also affected negatively the health services' supply. Municipalities and departments inherited weak infrastructures for the health provisioning, and many were inadequately prepared to face and improve this situation. Therefore, inequalities among regions increased.

Communication strategies didn't recognize regional disparities in the health sector; they continued based on a centralized idea of communication promoting only national health objectives.

Finally, HSR considered Social Participation mechanisms as an important factor. Guaranteeing the population's participation in demanding and controlling the supply of services and their quality, was a way to diminish decentralization's negative effects. These mechanisms promote the role of the communities in health more than just as users of health services, allowing their participation as citizens.

However, communication strategies continued focused on the population's role simply as "users".

The context of decentralization and the problems that the health sector has been facing since its implementation requires a review of communication's role in it.

The use of fixed communication strategies, which means applying to all the programs strategies previously used in different moments or in other contexts, diminishes the importance and impacts of communication.

¹ Colombia has a political and administrative division of its territory in 32 departments, 1098 municipalities and 4 districts (including Bogotá which is the Capital District). Departments (equal to Provinces in English) are formed by the municipalities. Data taken from the websites of DANE and IGAC.

² These cases will be analyzed in this paper.

The relation between communication strategies and their context can determine their pertinence and success. De-contextualized communication strategies divert public attention from structural problems in health provisioning and divert the allocation of public resources and efforts.

To review communication's role in health, wider knowledge is needed of communication theories. Understanding the scope of possibilities they offer can contribute to propose alternative communication approaches more responsive to the health sector's current situation. These approaches are called to include the new actors in the health system and to promote Social Participation.

This debate has already been taken to some extent into the theoretical arena. However, the realities of the practice of communication in health programs tell us that it is difficult to find a "blue print" for the implementation of communication strategies, as it largely depends on the nature of the context and the different actors involved in it.

1.2 Problem Statement

This paper will analyze the changes of communication strategies in Colombia's Expanded Program of Immunization (EPI).

This specific program is interesting as after having achieved coverage rates over 93%³ in 1996, they decreased critically in the period from 1997 to 1999. Several studies point out that this was mainly due to the intensification of decentralization processes in this period (Jaramillo, 2002; Ayala Cerna & Kroeger, 2002; PAHO, 2000). Communication strategies have played an important role in increasing coverage rates again through extraordinary strategies called National Immunization Days (NIDs).

However, after decentralization, the EPI is facing problems in the regular (daily) provision of immunization services in every municipality, demanding urgently the

³ Immunization coverage rates refer to the percentage of children that are completely immunized. Lately, the WHO has defined 95% as the minimum percentage in order to have useful coverage rates.

strengthening of the Routine Immunization Program (RIP). This challenges traditional communication approaches and demands a new role for communication in the EPI.

1.3 Research Objectives

The purpose of this paper is to research about an alternative role for communication in a decentralized health sector, through the case of Colombia's EPI.

More specifically, this paper intends to research about the role of communication strategies in strengthening the Routine Immunization Program (RIP), as a clear requirement of the EPI's decentralization process.

1.4 Methodology

This is a qualitative research, mainly based on literature review and secondary data.

The steps taken were the following:

- Identification of the problems that the EPI faces since decentralization and HSR.
- Review of communication strategies implemented in the EPI before and after decentralization. Analysis of their failures in addressing a decentralized program.
- Review of communication theories on which these strategies were based on.
- Review of alternative communication theories that can offer new approaches for communication in a decentralized health sector.
- Analysis of the "Puye" campaign, which developed a new approach for communication in the EPI.

1.5 Structure of the paper

This paper will be organized in the following structure:

Chapter 2 defines the general concept of communication and its role in health.

Chapter 3 talks about Colombia's EPI and the effects of decentralization in it, identifying its main problems.

Chapter 4 reviews the role of communication strategies in the EPI since its onset, explaining the theories on which they are grounded and analyzing critically why these strategies have failed to respond to the EPI's necessities.

Chapter 5 develops ideas for a new approach in communication by reviewing communication theories in health and the role of communication in a decentralized health sector.

Chapter 6 presents the "Puye" campaign which implemented a new approach, analyzing its strategy and achievements.

Finally, Chapter 7 concludes about the lessons that can be learned from the way communication strategies have been applied in the EPI, in order to propose a new role for communication in a decentralized health sector.

2. COMMUNICATION

2.1 What is communication?

Communication is a human action and a social process; it is a dialogue between two or more participants in which they share information, knowledge, emotions, ideas, views and values. This process of sharing through communication facilitates change, either individual or social, as dialogue allows participants to debate, learn and possibly come to a mutual agreement about an issue.

“In a broad concept of communication, it is clear that it has the capacity of creating cognitive effects and of socially distributing them. Communication can favor the exchange of knowledge which, enriched by adequate flows of information, helps to understand reality and build new knowledge. Finally, communication has the capacity of consolidating views of the world, which goes beyond knowledge and enables doing things in a different way, in a ‘reconstructed’ way. In other words, communication is capable of moving to action” (Cotes & Salamanca. 1997:16).

Communication has three basic functions (Cotes and Salamanca 1997:16):

- Information: The capacity of distributing information.
- Education: The capacity of being pedagogical. It goes beyond the knowledge exchange and allows also symbolic and cultural exchange, enabling the construction of new knowledge and learning. This function transcends the information, and allows formation and transformation.
- Mobilization: The capacity of stimulating action in diverse forms (social participation, demand and control of services and self care, among others).

2.2 Approaches to Communication in Health: Behavior Change Focus

In the field of health, communication has played an important role for decades. In the following section, the main approaches to communication in health are presented.

2.2.1 Health Promotion

The main link between communication and the health sector was related to the concept of Health Promotion, raised in the First International Conference of Health Promotion taken place in Ottawa, Canada (1986).

The Letter of Ottawa (1986), summary of the Conference, states that “health promotion should provide the people the necessary means for improving their health and to exert a greater control over it (...). In the same way, it specifies that the means to achieve health promotion are related with active participation in health, which is based in the following areas: the elaboration of a healthy public policy, the creation of favorable environments, the reinforcement of communitarian action, the development of personal aptitudes and the reorientation of sanitary services” (Cotes & Salamanca. 1997:7).

This concept of Health Promotion was broad enough to cover different determinants of health. However, the wide range of possibilities has slowly been narrowed down to the high importance given to individual behavior (personal aptitudes).

“Health promotion was dominated by the view that individual behavior was largely responsible for health problems and, consequently, interventions should focus on changing behavior” (Waisbord. 2003:11).

Individual behaviors are considered one of the major determinants of health.

The way people eat, take care of their bodies and their environment, exercise, demand health services in a preventive way, among others, exemplify how individual behavior can determine being healthy and preventing disease.

Behavior Change theories recognize communication as a necessary strategy when trying to influence the change of behaviors, because it can generate action and foster individual and social change. Therefore, the promotion of healthy behaviors that should be adopted by the population, has concentrated the interest of health communicators in the past decades.

2.2.2 Social Marketing

Social Marketing also promotes behavior change. However, this model didn't come from the field of health communication, but instead from marketing.

“Social Marketing consisted of putting into practice standard techniques in commercial marketing to promote pro-social behavior. From marketing and advertising, it imported theories of consumer behavior into development communication” (Waisbord. 2003:6).

According to Cotes & Salamanca (1997:25), “Social Marketing needs to ask for key questions: who is the client, what is the product, the price and the place of the product that is being merchandized”.

The translation of these questions to health communication strategies would mean:

- Client (Targeting): Selection of audiences is important for effective communication strategies. This means directing messages only to those that should change their behavior.
- Product: Defining the exact behavior to promote.
- Price: Refers to the obstacles that people face when changing behaviors. If the price is too high, which most of the times means changing a way of life, communication needs to focus on the benefits that a healthy behavior can bring, in order to make it worth for the population to pay the price.
- Place: In health, defining the place means identifying clearly when and where people can change their non-healthy behaviors and adopt healthy ones.

Marketing bases the definition of strategies over research about consumers. In social communication, this is done through the KAP methodology adopted from social science. Getting to know the Knowledge, Attitudes and Practices of the population towards certain behaviors, gives important inputs for communication strategies based on the recognition of the receiver and what determines its actual behaviors.

The application of marketing techniques to social communication strategies hasn't been always successful, especially when it ignores the socio-economic conditions on which

new behaviors are promoted. However, it is important to recognize that it brings key elements for the effective design of communication strategies.

2.2.3 Reality of communication practice

Although Waisbord (2003) as well as several other authors insist on differentiating these two approaches of communication for behavior change, my experience as a practitioner in the field has led me to define that they are not very easily differentiated.

Social Marketing shares with Health Promotion the interest in behavior change. Further more, the contributions of Social Marketing in communication for health leads to see it not as an isolated model, but more as a mechanism that can benefit Health Promotion interventions in the definition of effective communication strategies to promote healthy behaviors.

Even Waisbord (2003) and Cotes & Salamanca (1997) recognize that the concept of Health Promotion goes beyond individual behaviors, considering also social and environmental conditions that influence people's health or allow them to adopt healthy behaviors.

“Health promotion became no longer understood as limited to educational efforts and individual changes. It also includes the promotion of public policies that are responsible for shaping a healthy environment. The goal of health promotion is to facilitate the environmental conditions to support healthy behaviors. Individual knowledge, as conceived in traditional approaches, is insufficient if groups lack basic systems that facilitate the adoption of healthy practices... (Bracht 1990, Rutten 1995)” (Cited by Waisbord. 2003:12).

Therefore, Health Promotion currently integrates Social Marketing interventions within itself, as well as Social Mobilization among other approaches. Even more, some Health Promotion strategies use many of them at the same time.

2.2.4 Social Mobilization

According to Waisbord (2003), the concept of Social Mobilization was introduced by UNICEF and implies mobilizing all possible sectors of the population towards a development objective. It raises public awareness about an issue, involves decision-makers and institutional actors (both public and private) to support a certain program or objective, and mobilizes the community to participate and demand.

“Emphasis on social mobilization to improve general conditions doesn’t mean that behavior change models are absent in health promotion but, rather, that they need to be integrated among other strategies” (Waisbord. 2003:12).

2.3 Communication in context

This study’s purpose is not to evaluate the different health communication theories isolated from the context in which they are applied. According to Cotes & Salamanca (1997), each communication strategy needs to be defined according to the specific development objectives; in this case it means defining communication strategies according to the each health program.

This is especially important considering that the situation of health of the population not always depends on their individual behaviors, but also on the way the health services are provided.

In Colombia, HSR changed the provision of health service from centralized to decentralized. Further more, the changes in the health system vary according to each health program. Therefore, this study will focus on the EPI, analyzing the specific situation this program faces after these changes in order to determine a new role for communication within it.

3. HSR AND DECENTRALISATION IN THE EPI

3.1 What is the EPI?

The EPI was created in 1974 by the World Health Organization (WHO), aiming to reduce infant morbidity and mortality by focusing on six transmissible diseases that were immune-preventable: tuberculosis, polio, diphtheria, whooping cough, neonatal tetanus and measles.

Globally, it “has achieved to reduce the percentage of total disease burden among children under five from 23% during the decade of the 70s, to less than 10% in the 2000. The cost of vaccinating a child against the six diseases is approximately of US\$17, which makes the EPI one of the most accessible and cost-benefit interventions in the health sector” (IADB. 2005:4).

In 1978 all the countries members of the Pan American Health Organization (PAHO) were encouraged to create their own programs. Consequently, Colombia established the EPI in this year with the aim to protect children under five years old against major transmissible diseases. The program’s basic scheme started with the six diseases mentioned previously, and currently includes also hepatitis B, rubella, parotiditis, influenza and yellow fever.

3.1.1 EPI’s evolution in Colombia⁴

Since the establishment of Colombia’s EPI, infant morbidity and mortality have reduced. “There has been an absolute decrease in the infant mortality rate from 73 (1970) deaths per thousand born child to 30,6 (DHS 2000) (...). Great part of this decrease is explained by the introduction of vaccination” (IADB. 2005:4).

⁴ In 2005, the Inter American Development Bank (IADB) evaluated the EPI in Colombia with the purpose of formulating an improvement plan for the program. This study has been a great source for this paper.

In 1978 the coverage rates of immunization were of only 15%, but increased until 1996 reaching levels higher than 93% (Ibid:5). Additionally, polio was eradicated by 1994. The effects of the increase of vaccination coverage in children's health, although very difficult to measure, can be related to a decrease in the incidence of immune-preventable diseases in infant mortality. In 1972 almost 40% of the deaths could be related to an immune-preventable disease, and in 2001 it was only of 1,1% (DANE 2001).

From 1984 until 1996, big efforts were done to increase the national immunization coverage through Social Mobilization campaigns. These campaigns⁵, based on communication strategies, were very successful in pressuring an improvement in the supply of immunization services by mobilizing the population to demand them. By 1996 coverage rates were over 93%.

However, the coverage rates decreased to a range from 75% to 88% in 1997. This allowed the outbreak of already controlled diseases, including polio, and the increase of infant mortality rates (IADB. 2005:5). This crisis went until 1999; by 2000 the EPI reacted trying to increase coverage rates again.

The following Table 1 and Graph 1 show more clearly the comparison between the coverage rates in 1996 and the decrease presented in the years from 1997 to 1999. These have information about 4 main vaccines covered by the basic scheme of the Colombia's EPI. The vaccines and the diseases they are meant for are:

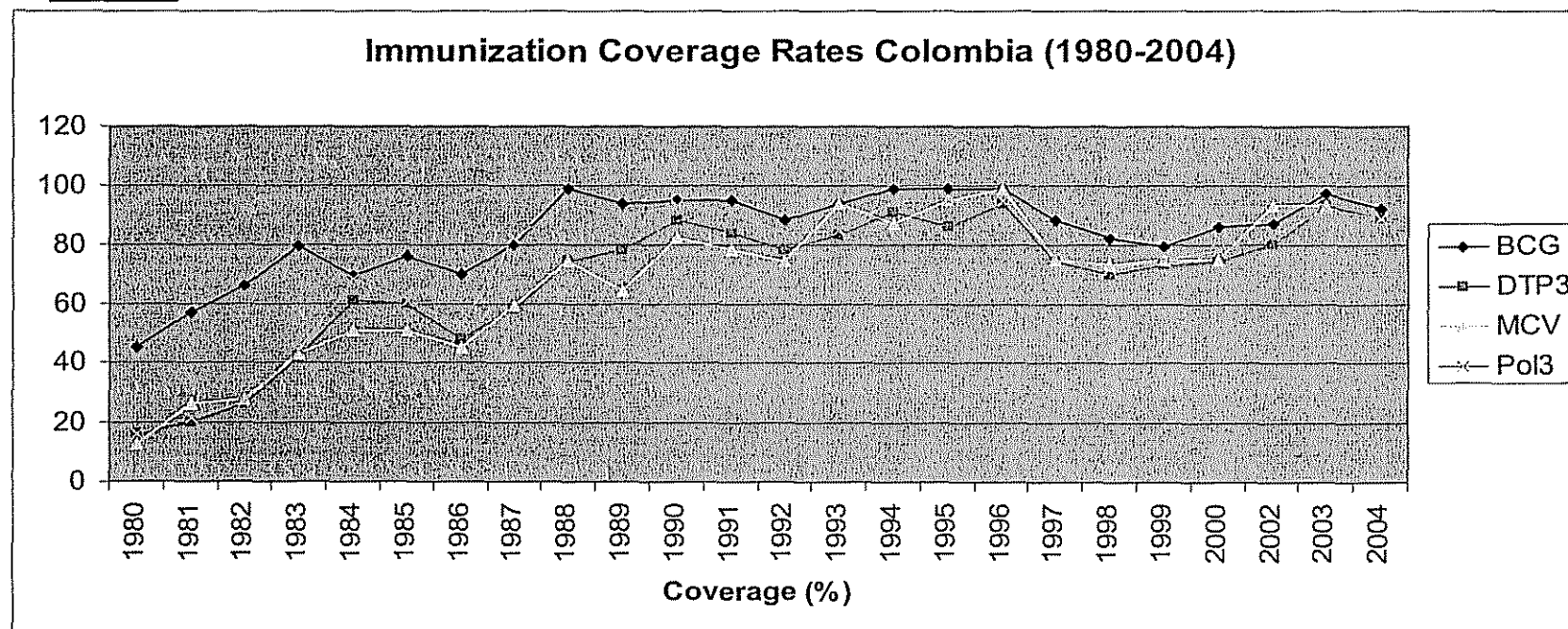
- 1 BCG: Tuberculosis
- 2 DTP: Diptheria, Whooping Cough and Tetanus
- 3 MCV: Measles
- 4 Pol: Polio

⁵ Chapter 4 presents more extensively these campaigns.

TABLE 1 – Immunization Coverage Rates Colombia (1980-2004)⁶

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2002	2003	2004
BCG	45	57	66	79	69	76	70	80	99	94	95	95	88	94	99	99	99	88	82	79	86	87	97	92
DTP3	16	20	26	42	61	60	48	58	74	78	88	84	78	83	91	86	94	74	70	73	74	80	93	89
MCV	13	26	28	43	51	51	45	59	74	64	82	78	74	94	87	95	99	75	73	75	75	93	93	
Pol3	16	22	27	44	68	61	53	82	94	90	93	91	84	85	95	95	95	76	72	75	78	83	92	89

GRAPH 1



⁶ Data taken from WHO, 2004. Note: 2001 was missing from the original data, so it was deleted from the Table. Also, the data for Hepatitis B and Influenza was omitted since they appeared until late 1990s.

Three factors affected the performance of the EPI during the period of 1997-1999:

- A. The complex process and problems that appeared with the HSR implemented in 1993, and specifically with the decentralization process which was intensified in 1997, affected the overall indicators in vaccination. These reforms will be analyzed ahead.
- B. The economic crisis of the period of 1997-1999 affected the health sector as the government's budget was reduced significantly. This also affected the EPI as the cuts in the national expenditure in health created an "under provision of vaccines during 1998 and 1999, specially in the latter in which cuts in the State's investment funds led to a decrease in the normal budget of the EPI, having to use emergency funds to supply partially the country's needs of vaccines" (PAHO. 2000).
- C. The internal conflict (present since 1950s) intensified in the decade of the 90s due to the increase of guerrilla and paramilitary actions and the violence generated by the war against and within drug-dealing "cartels".

Without denying the relevance of the economic crisis and the internal conflict, this study will only address the processes of HSR and decentralization. Since communication is the main focus of this paper, decentralization is the only factor that can be affected by communication interventions. However, recognizing these other two factors is important as they are part of the EPI's context on which communication strategies are implemented.

3.2 Changes in the Health System

3.2.1 HSR and Decentralization

Until mid 1980s, the country had a National Health System controlled by the central State, from the definition of policies to the provision of health services. However, since late 1980s the entire public sector went through structural changes, which affected the

health system as well. A process of State “modernization” was initiated through Decentralization and Sector Reforms.

According to the ECLAC⁷, there are two reasons that explain the decentralization in Latin America. “The first one is of political order: this is seen as a way to bring closer the government to the citizens and makes part, in this way, of the democratization efforts that were taking place; the possibility of promoting citizen participation in the local level is, from the political point of view, one of the arguments that justify the transfer of responsibilities to the regional and local governments. The second one is of economic order: within the process of restructuring the State, decentralization appears as a way to increase the efficiency in the provision of services by the State, especially of social services where there are no relevant economies of scale” (1998:9).

Colombia faced both reasons and there is a disagreement of which one weighted the most. While the PAHO (2002) sustains that decentralization in the country was primarily due to economic factors, the ECLAC insists that it was mainly motivated by political reasons.

However, neither denies the existence of both factors. Aside of the economic reasons behind decentralization, also political motifs fostered it. The presence of guerrilla groups was questioning the legitimacy of the State. Further more, the rise of civil society movements was questioning the central State’s capacity to respond to social demands and its role as sole provider of public services; they claimed for more democratic processes and autonomy for local governments.

HSR started legally in 1987 with the process of decentralization; they were legitimized by the Constitution of 1991; and finally were shaped by the Laws 10 of 1990, 60 of 1993 and 100 of 1993.

The Constitution of 1991 changed the idea that the central government was the sole provider of public services, and opened the way for private entities to enter in the provision of services.

⁷ Economic Commission for Latin America and the Caribbean.

The Law 10 of 1990 (Municipalization of Health) and the Law 60 of 1993 (Law of Decentralization of Resources and Functions) aimed for a closer relation between the State and the community, by widening the role of the municipalities and the departments in the definition and development of health policies and provisioning. A gradual process of decentralization of the municipalities and the departments was established by “certifying” those that demonstrated the capacity to receive and manage resources.

The Law 100 of 1993 (Law for the Reform of Social Security) replaced the existing National Health System by a new General System of Social Security in Health (SGSSS). This system included new actors in the local level: local authorities, public and private service providers, and citizens.

3.2.2 Changes in the EPI

Dynamics in the supply of vaccination services were altered by HSR and decentralization, due to the municipalization of health and the inclusion of new actors in the local level.

The EPI is now marked within the Law 100 of 1993 in the following way: the Ministry of Social Protection (MSP)⁸ plays a normative role in defining the national policy for immunization, and is responsible of the consecution of resources for the program; local and regional authorities are responsible for the design and implementation of LHP and the EPI within them (IADB. 2005:10).

The participation of citizens is granted by the concept of Social Participation that was introduced by the Law 100. It offers mechanisms of individual participation and opens a space for collective action.

⁸ Previously called Ministry of Health until 2002.

3.2.3 Social Participation

The SGSSS develops a great component of Social Participation through the Decree 1757 of 1994, in order to ensure communitarian control and demand over the health sector. There are two defined possibilities of participation in the system: individual and communitarian.

Individual participation promotes spaces for interaction between service providers and users of health services, as a way to strengthen demand over access and quality of health services. The mechanisms for this type of participation are costumer service offices created by service providers, or user associations.

Communitarian participation promotes a relationship between civil society and the State (the municipality, in this case). It aims to increase the community's presence in the identification of public health needs and the design of public health policies. It also allows control and demand over Local Health Plans (LHP) as a way to prioritize public interest over political and private interests.

The mechanisms for this type of participation are Communitarian Participation Committees (COPACOs). They are in charge of planning, supervision, budget definition and development of the health system, rather than approaching health services.

Social participation mechanisms are important as they consider the population more than just as "users" of health services, but also as citizens with right to health and to participate in the system.

So far, these mechanisms have been very weak as several studies have shown (Mosquera et al. 2001; Vasquez et al. 2002). Not because of their structure as such, but because they have been under implemented.

Individual participation mechanisms like costumer service offices created by the service providers, or user associations, not always exist or are not effective.

The COPACOs, although highlighted as an example for other Latin American countries, can be questioned by how adequate is their representation of the population and their monopoly over communitarian participation.

3.3 Current challenges for the EPI

The complexity of the reforms that Colombia implemented has made difficult to determine whether they have been positive or negative in general, as it seems that they have been both.

However, the purpose of this paper is not to highlight all the diverse effects of decentralization in general in the health sector and specifically in the EPI, and neither it is to evaluate the process as such in order to define if it was positive or negative.

On the contrary, this paper intends to recognize what happened to the EPI after decentralization, in order to determine the challenges it is facing within the new structure of the health system.

Decentralization challenged the EPI as the municipalities and the new local actors were required to have proper knowledge and enough capacity to sustain the program. Achieving this was difficult whereas there are 1.098 municipalities in Colombia and the EPI is just one more of the programs in the public health system.

Further more, the process of decentralization widened the already existing regional differences (Málaga et al, 2000). Some municipalities and departments were in better situation (Unsatisfied Basic Needs-UBN, health situation, poverty, etc.) and better prepared (in terms of capacity and stronger institutions) than others.

The process of decentralization was very slow. By 1999 only 38% of the municipalities were effectively decentralized (PAHO, 2002:16).

But even those municipalities that were already decentralized, faced difficulties when implementing decentralization due to lack of capacity of local actors to cope with their

new tasks, and to coordination problems between the central government, the local authorities and the service providers. “Despite the goodness of the reform, its implementation and the process of decentralization have evidenced gaps and/or overlaps in the definition of the tasks between the different agents with negative incidence in the provision of the service (of immunization) and in the levels of coverage. In the organizational field we can observe deficiencies around: (i) the application of normative framework; (ii) the negotiation, control, coordination and follow-up; (iii) human resources and capacity building; (iv) articulation of the public and private sectors” (IADB. 2005:10).

Finally, achieving decentralization was the main priority in the health sector during this period demanding a concentration of attention and efforts in it. Therefore, promotion and prevention activities were reduced or weakly implemented. Immunization programs, as part of prevention activities, were affected as well.

It is possible then to identify three main problems that the EPI is facing after decentralization was implemented: regional inequalities, problems in the supply and lack of political commitment. Some of them are not consequence of decentralization, but were deepened by it; and they seem to continue in the present without being totally solved.

3.3.1 Regional inequalities

The crisis of the EPI in 1997 showed a major problem that lied behind national immunization coverage rates: local rates were highly unequal throughout the country. This situation had been present since the onset of the program but it increased due to decentralization, armed conflict and economic crisis, as mentioned earlier.

The armed conflict was a decisive factor during this period as it affected some regions more than others, specially rural and remote areas. “The problem of inaccessibility of vaccination, caused by the conflict (guerrilla and paramilitars), has increased in the last three years (before 1999). The number of deaths among the health personnel that

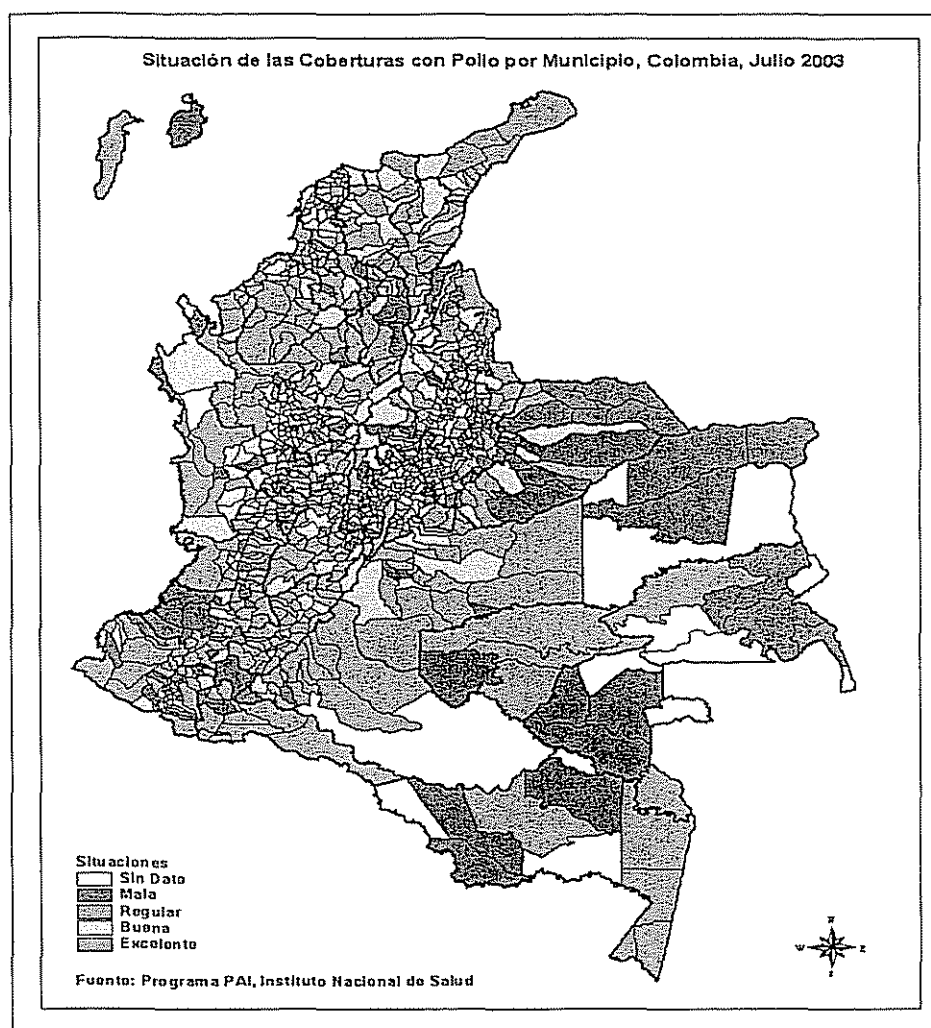
immunizes has increased, with the following abandonment of geographical areas where remote rural populations live” (PAHO. 2000).

The economic crisis and its incidence in the situation of poverty in the country marked regional inequalities of health indicators as seen specifically through immunization rates. “An analysis done by the PAHO in 1999 reveals that the coverage of vaccination has decreased even more in the departments with major percentage of Unsatisfied Basic Needs (UBN)” (Ibid). In 1998 only 15%-20% had coverage rates over 95% (Ibid). The departments with UBN higher than 70% (like Chocó, Vaupés and Vichada) faced drastic reduction, compared to other regions with lower UBN.

These regional inequalities, even though recognized since 1999, were not seen as an evident problem until May 2002 after a measles outbreak which showed that regional disparities continued to be a key issue, despite all the efforts that the program had done to improve this situation. The disease, which came from Venezuela, spread rapidly through the Colombian children who lived in the frontier and were not adequately immunized. The EPI reacted efficiently identifying the cases and stopped it from being a major epidemic with only 140 confirmed cases. However, this evidenced the vulnerable situation of remote, rural, poor and frontier regions.

Regional inequalities are evidenced in the following graph.

GRAPH 2 - Map of Polio Coverage Rates by Municipality, Colombia, July 2003



Source: MSP (2003). Categories from top to bottom: without data, bad, acceptable, good and excellent.

In this graph it is interesting to see the differences between regions in immunization coverage rates. If in 2003 national coverage rates were over 90%, according to Graph 1, this map reflects the inadequacy of a national average rate to represent regional performances.

The most interesting trends that can be identified is that the departments in the right side of the map, which correspond to the least developed part of the country as are the Amazonas region and the extensive plains that go until Venezuela, are the most critical

ones; many are in bad or acceptable immunization state, and many others don't even report coverage rates.

The departments where we can see the majority of good and excellent performances are mostly located around the centre of the country where the capital city Bogotá is also located.

However, the purpose of this graph is not to analyze the reasons for these disparities as they can be many and can be a whole field for research. The aim of presenting this map is to recognize the big regional inequalities that exist in the country regarding immunization coverage rates.

The IADB shows that in 2005 still “subsist great geographical and population inequalities in the levels of vaccination. The poorest and furthest municipalities are way below the national and departmental averages” (IADB. 2005:5). The focus on average national rates has been hiding large regional inequities.

3.3.2 Supply rather than demand

There is a general belief that problems in the decrease of immunization are due to the lack of demand from the population. This belief is highly influenced by the increasing relevance given to individual behaviors as major determinants of health.

However, various analysis over the causes of the decline in coverage rates in Colombia have shown that, other than being specifically a problem of population's demand, it is more a structural problem in the supply of vaccination.

This is not only recognized for the case of Colombia. Gauri and Khaleghian, who did a study of immunization in several developing countries in 2002, stated that “the quality of a nation's institutions and its level of development are strongly related to immunization rate coverage and vaccine adoption, and coverage rates are in general more a function of supply-side than demand effects” (2002:1).

The problems of Colombia's health sector due to an uneven and unfinished process of decentralization, not only widened regional inequalities but also affected the provision of immunization services. Failures in the implementation of the EPI before decentralization were deepened after this process; if the national government was unable to solve them before, lack of capacity in local governments made it harder for them to solve these failures. Some of them are⁹:

- ✓ Infrastructure and materials: Many municipalities have inadequate infrastructure (health centers or posts), lack of trained personnel, and shortage of basic materials (syringes, vaccines, etc). Furthermore, in many regions the service provision is not responsive to the population's needs with health centers that are far and have non-flexible schedules.
- ✓ Cold chain: This system, which keeps the vaccines in the adequate temperature, is not well developed in several regions.
- ✓ Coverage rates: The denominator, over which they are calculated, is projected over an old census (1993). Calculating indicators of coverage over an outdated census has "a great margin of error at the municipal level due to the changing demographic situation of the country. The dynamic of displacement combined with scarcity of data of national and international migration, increase in urbanization, reduction of fertility and the aging of the population, difficult the estimation of a good projection of the population at the municipal level" (IADB. 2005:7).
- ✓ Absence of a standardized information system: Many departments lack adequate information technologies. "Only 18 of the 32 departments use software to register the information. (...) The rest of the departments face backwardness in the delivery of the information and under-reporting from municipalities" (IADB. 2005:6).

⁹ Information gathered from: Ayala Cerna and Kroeger (2002); IADB (2005); Jaramillo (2002); PAHO (2000).

- ✓ Inappropriate Vaccination: High levels of children are not vaccinated appropriately according to their age. This shows that the regular provision of immunization is still very weak or in some regions doesn't even exist. These regions rely mostly on extraordinary immunization campaigns which concentrate all the efforts in one day, immunizing the children according to this date and not to their specific individual needs.

The problems in the supply were inherited by the municipalities and departments from the central government. The national government provides the budget to all the decentralized departments and municipalities, as well as the vaccines. But the rest of the problems continue to be there.

Municipal and departmental governments had very little knowledge of how to manage these problems. They cannot be solved by the municipalities alone; acknowledgement and cooperation of the national government is needed.

National strategies trying to improve the coverage of immunization rates are either ignoring this situation or wrongly focusing only on the problems of demand. The provision of immunization services on a regular basis has not been achieved in great parts of the country due to structural failures in the supply.

3.3.3 Lack of political commitment

Even though decentralization can complicate provision of health services, Gauri and Khaleghian say that "it might also, under certain conditions, improve service delivery by making governments more accountable to and responsive to the needs of local populations" (2002:8).

But as Ayala Cerna and Kroeger (2002:1771) say, although the reforms had the potential of developing locally the health system, its exposure to local political interests was a limiting factor. In the EPI, it seems that local governments are still not accountable over

immunization coverage rates as they remain a national average and the local indicators are not publicly known.

Further more, immunization is not a political priority for municipalities; the IADB shows that “due to the low level of financial leverage between the Nation and the municipalities, some of them, in violation to the law, have used the resources transferred for vaccination in other municipal priorities” (2005:34).

Gauri and Khaleghian state that the political and organizational determinants of immunization programs depend less on the population’s demands and more on the actions of political and bureaucratic elites (2002:3).

“Several accounts of immunization policy have used the concepts of ‘political will’ or ‘political commitment’ to explain the success of moves to improve coverage, conduct polio eradication activities, or introduce new vaccines. Put simply, the implication is that if political leaders were to make immunization a priority, coverage rates would improve as a result” (Ibid. 2002:8).

The PAHO also recognized this issue in 2002. “The imbalance in the access to immunization continues undermining the principle of equity, on which national vaccination programs should be based on. Vaccination services in developing countries lack enough political commitment and investments, at the same time that vaccination programs are stopped by deficient health service provision systems” (PAHO.2002:8).

Therefore, alternative strategies for improving vaccination programs in developing countries need to be thought about. Instead of approaching only the demand of immunization services, it is important to acknowledge problems in the supply. Further more, as the case of Colombia has shown that this is not enough, “political commitment” of local authorities in a decentralized public sector can be a major determinant for the program’s improvement.

Stronger social participation can be the key for strengthening local authorities’ accountability and pressuring their commitment.

“The component of territorial performance (...) makes possible to turn health into a local political issue, to develop in the municipality and in the department measures that favor the efficiency and productivity of health services, and to make the municipality responsible -with citizen participation and departmental support- for collective activities of disease prevention and promotion of health” (ECLAC. 1998: 182).

3.4 Regular Immunization: the importance of the Routine Immunization Program (RIP)

Providing immunization services on a regular basis means that every municipality should offer to all its population free vaccines daily. This is done through the RIP, cornerstone of the EPI. The importance of this program relies on the fact that for immunization to be useful in stopping the spread of infectious diseases, 95% of the population under five years old must be vaccinated adequately, at the proper age and with all the vaccines and doses.

In order to have an effective RIP, it is important to guarantee the municipal supply on a daily basis. It is evident that the three problems presented earlier make this goal hard to achieve equally in the entire country. The program is still very weak in many regions, as evidenced by Graph 2.

There are two reasons that demand the strengthening of the RIP.

On one side, providing immunization services to the entire population is binded by international agreements and national legal documents: Colombia is committed with guaranteeing “Health for All” as signatory country of the Alma Ata Declaration in 1978; the Constitution of 1991 stated that health services are a right for every citizen; and finally, the Law 100 of 1993 created the SGSSS based on the principle of universality.

On the other side, as mentioned before, immunization efforts are not obtaining their objective to control certain diseases in the entire country if large sectors of the population don't have access to it.

Therefore, there is no excuse to continue with a program that does not cover all the population equally. Strengthening the RIP must be a priority and a responsibility at all levels: national, departmental and municipal.

3.5 What has been done?

The decline in coverage rates in the period between 1997 and 1999 raised the concern of national and international institutions to solve the problem.

In 1999, the national EPI organized its annual meeting to review the program's advances and the country's standing point in the goal of achieving high coverage rates. Many of the program's failures were highlighted, and an Intensifying Plan for the year 2000 was promoted in order to improve them.

This recovery of interest in immunization can be also related to external pressure. Support of international agencies (such as UNICEF and the PAHO) given to the EPI during the period from 1984 to 1996, was significantly reduced during the second half of the decade of the 90s especially due to the end of the Universal Child Immunization (UCI) program of UNICEF and due to the rise of AIDS as a health priority in the world. International agencies gave again priority to vaccination after the release of the Millennium Development Goals in 2000, as one of its goals is the reduction of child mortality¹⁰. Therefore, international donations and loans increased for the period of 2000-2003.

By 2001 national coverage rates for some of the vaccines increased nearly reaching the levels achieved in 1996 which were higher than 93% (IADB. 2005:5).

Although all these efforts contributed to the recovery of national coverage rates, it was only a partial effort to strengthen the performance of the program. The IADB found in 2005 that the program's failures continued to be present. The loans only helped to improve national coverage rates but didn't focus on improving regional inequalities.

¹⁰ Goal 4. "Millennium Development Goals" United Nations, 2000.

Communication strategies have played a central role in the EPI since its establishment, as is analyzed in the next chapter.

However, very few have addressed the issue of decentralization and the problems it has raised to the EPI. Further more, they promoted extraordinary strategies to increase coverage rates, but haven't been useful in helping to strengthen the RIP.

4. COMMUNICATION STRATEGIES IN THE EPI

4.1 Communication Strategies for Immunization

Behavior Change theories give the basis for communication strategies in immunization programs. There are two especial characteristics of this program that justify the need for communication strategies to promote population's behavior change:

On one side, due to its preventive feature, people don't demand this service in response to illness. Also, this program is relatively new if we consider that it was created in late 1970s. Before that, the coverage rates of vaccination were less than 20%. Therefore, there is a need to inform and educate people around vaccination and its benefits, in order to give them reasons to demand it as a way of preventing child morbidity and mortality; this is the desired "healthy" behavior.

On the other side, where as the effectiveness of immunization is a 95% coverage of the population (children under 5 years old), there is a need of mobilizing large masses of population to demand the service to achieve these coverage rates and stop the spread of contagious diseases.

This way, immunization programs can benefit from the three functions of communication and from any of the different existing approaches to communication for behavior change (Chapter 2). The choice of which one to use and on how to use it depends greatly on the country's context.

4.2 Communication strategies in Colombia's EPI

The aim of communication strategies in the EPI is to support the RIP. Since it is not enough to make available the supply of vaccines, it is necessary to mobilize people to demand vaccination and to inform and educate about vaccination. This is done through communication.

These strategies are totally controlled by the national government as a public health issue. They are designed and implemented by the MSP and the INS, with support from UNICEF and the PAHO. Funds are usually provided by all four institutions.

Since 1981, Colombia started to implement a communication strategies in order to support the strengthening of the RIP, which was very weak at the moment as it didn't cover the whole country.

However, by 1983 the coverage rates of immunization were still very low, reaching only 40% of the children (The Communication Initiative. 2005). This was not only in Colombia; the majority of the third world countries had very similar coverage rates by that time. This situation moved UNICEF, through its Universal Child Immunization (UCI) program, to promote a massive immunization drive in 1984 to accelerate the achievement of high coverage rates.

According to Fraser and Restrepo-Estrada (1998:69), at first the WHO was very reticent to follow this strategy under the argument that it was not recommended until the supply of immunization services was granted universally. However, UNICEF argued that this could take too long and that the population's mobilization to demand vaccination could pressure improvement in the supply in a shorter term. "Urgent action, based on provisional structures and temporary measures if necessary should begin" (Ibid. 1998:71), in order to immunize large numbers of the population and that way stop the transmission of infectious diseases that were vaccine-preventable.

Within this context, the National Immunization Days (NIDs) were launched through mass communication strategies with the support of UNICEF and the PAHO; Colombia was one of the countries that started implementing NIDs since 1984, with the Ministry of Health as the leader.

4.2.1 National Immunization Days (NIDs)¹¹

The NIDs, or “Crusades” as they are called in Colombia, are an extra-ordinary strategy aside of the RIP; they have a specific goal which was not or cannot be achieved by regular provision of vaccination. Their main objective is to increase immunization coverage rates in very short time. Therefore, they concentrate all the country’s supply and demand in one day (or in a few days) with special schedules, additional vaccination posts and availability of the necessary vaccines.

Communication strategies are highly important to support the NIDs as they inform and mobilize the population in order to increase demand of vaccination around that day. The use of mass media is the key and the most effective way to promote the NIDs throughout the entire country.

The NID of 1984, which intended to reach 50% of the country’s children, integrated Social Mobilization and Social Marketing, among others approaches (The Communication Initiative, 2005).

One of the greatest achievements of this NID was through Social Mobilization as it involved the President of the Republic and the First Lady, different public institutions including the majority of the Ministries, the Church, the most important mass media groups and other private enterprises, among others.

This was supported by a Social Marketing campaign which legitimized the NID in the public agenda as a national effort and invited publicly all the sectors and the population to participate for Colombian children’s benefit.

“In UNICEF’s work, social mobilization is the base for achieving large-scale delivery and acceptance of services that will benefit children and families. In practice, UNICEF’s objectives depend upon changing aspects of people’s behavior. These changes may include parents having their infants fully immunized...” (Fraser and Restrepo-Estrada.

¹¹ This section will analyze general aspects of the NIDs implemented in Colombia. For further information on each of them, see The Communication Initiative, 2005.

1998:69). To achieve behavior change in the population that supported Social Mobilization for the NID, an educational effort was also implemented. Messages about vaccination's importance were transmitted through mass media with a Social Marketing campaign and through interpersonal communications.

Aside from the achievements of this NID in Social Mobilization and massive education, its effects were seen also in the increase of coverage rates, which is finally the most important result. Please refer to Graph 1 and Table 1.

The positive outcomes of 1984's NID, encouraged the Ministry of Health to continue with this initiative in the following years, with the support of UNICEF and the PAHO.

The PAHO was especially interested in the continuation of the NIDs to promote new objectives such as global and regional campaigns for disease eradication. Consequently, NIDs started to be implemented either to increase coverage rates in general or to eradicate certain diseases, or both at the same time.

“Through the years it has been demonstrated that this strategy is fundamental to interrupt drastically the circulation of the virus and to complement the coverage of the RIP, offering unique opportunities for children living in marginal urban areas as well as in rural areas that are geographically inaccessible or due to the armed conflict that crosses the whole country” (EPI Colombia. 2001).

Some regions or remote communities of the country only received vaccination services when the NIDs were implemented as they had no possibility or infrastructure to provide regularly vaccination services during the rest of the year.

The NIDs implemented after 1984, remained with similar communication strategies: promoting Social Mobilization, using Social Marketing strategies, and educating through the mass media and through interpersonal communications in communitarian activities.

Some of the NIDs were¹²:

- ✓ 1985: Second National Immunization Crusade with the purpose of immunizing 80% of the population with the basic scheme.
- ✓ 1987–1990: Colombia committed with the PAHO for the regional (Latin America) campaign of Polio eradication. Each year, between one and two NIDs were implemented, focused on Polio vaccine and in completing the vaccination basic scheme of children. The reduction of Polio cases by 1990 was related directly to the increase in coverage rates due mainly to NIDs. However, it was not until 1994 when the region, including Colombia, was declared free of polio.
- ✓ 1991: Two new NIDs were implemented for Polio eradication and general increase of coverage rates.
- ✓ 1993: In this year, before polio was declared as eradicated, the PAHO promoted the goal of eradicating measles in the region by the year 2000. In Colombia, this was important as the disease had an outbreak in this year with 5.000 cases and 48 deaths. The NIDs after 1993 have the purpose of eradicating measles and sustaining the eradication of polio.
- ✓ 1997: “The last NID with Oral Polio Vaccine (OPV) took place. Since then, the vaccination coverage rates of the country have been lower than 95%. By mid 1999 it was registered at 53.3%” (PAHO. 2000). Apparently, during the crisis period of 1997-1999, there were no more NIDs¹³.

4.2.2 After the crisis... more NIDs

In 1999, after the crisis of 1997, the EPI’s national annual meeting reviewed the general status of the entire immunization scheme, disease by disease, and posed general recommendations for each. The recognition of the crisis in the health situation, evidenced

¹² Information taken from The Communication Initiative (2005).

¹³ There was no report found of NIDs for this period.

in the decrease of immunization coverage rates, led the EPI to propose the continuation of the NIDs as the most effective strategy to increase coverage rates. Therefore, they were intensified.

“Facing this situation, since 2000 the central level starts again with promotions, but that are not adjusted to what happens in the regions. The promotions stimulate people to go to vaccinate, but there are no extended schedules, neither more facilities are provided and there are no offers different from the regular ones. Evidently in the events that are implemented there is an increase in coverage rates, although not in the same proportion as before, and people start to perceive that it’s the same to attend with or without promotion” (Hernan Salamanca. Interview in The Communication Initiative. 2005).

In 2000 the country organized a NID against polio and measles. However, the outbreak of measles in 2002 showed that this disease was far from being eradicated. Thus, a new NID was organized during this year to increase its coverage.

Also in 2002, a new form of NID called the “V-Day: Day to update” was implemented twice in the year. Its purpose was to offer a possibility to all the country’s children to complete their vaccination schemes in order to end the year updated. The “V-Day” was a big success and the year ended with coverage rates between 67% and 93% for the different vaccines.

For 2003 the PAHO, supported with funds from UNICEF, promoted the organization of the “Vaccination Week of the Americas”. As stated by the PAHO, it “is an unprecedented show of Pan Americanism that should be seen not as ‘another campaign’ but rather as ‘another opportunity’ to promote the importance of routine vaccinations” (PAHO. 2004:2).

The MSP organized it in July, and additionally a new “V-Day” in November, with the purpose to again end up the year updated.

NIDs in the New Millennium have become routine, as there is at least one each year. The purpose currently is to continue with “Vaccination Week of the Americas” and with “V-Day” every year.

4.2.3 The negative effects of NIDs

The success of the NIDs in achieving an increase in national immunization coverage rates is unquestionable. But its positive effects are only sustainable in the short run due to its extraordinary nature, but not in the long run.

The following are problems that come with the NIDs in the long run:

- ✓ They are focused on increasing the demand of the population towards vaccination, as if that was the main problem. This distracts the attention from structural problems and leaves the RIP without strengthening.
- ✓ Immunization coverage rates increase only in the month when the NID is implemented. The rest of the year the coverage decreases until a new NID comes (Hernan Salamanca. Interview in The Communication Initiative. 2005)
- ✓ The utility of vaccines decreases as children are never vaccinated in the appropriate age, as the immunization scheme is different for every child and rarely matches with the NIDs. “A representative national survey reported that only 52% of the children are totally vaccinated at the right age in 2000” (IADB. 2005:4).
- ✓ The frequent implementation of NIDs has made the population get used to them and not be proactive daily. “By the end of the 80s there is a country used to have promotions all the time” (Hernan Salamanca. Interview in The Communication Initiative. 2005). Since there is an NID each year, parents tend to wait for that moment to immunize their children, and not do it accordingly to their individual scheme.

- ✓ Since NIDs place national coverage rates in the public agenda, local indicators have remained invisible. National rates shadow local rates leading to decrease the attention over inequalities in local performances and leaving local authorities free of accountability towards their population and the public in general.

- ✓ The concentration in one disease (eradication campaigns) fragments the RIP instead of strengthening it. Also mixing eradication objectives with general increases of coverage rates confuse on what is the final aim of the NIDs.

All these problems should increase the awareness of decision-makers when deciding interventions to increase immunization coverage rates. The extraordinary nature of the NIDs should lead to clearly differentiating them from the RIP, and by no means replace it.

However, there are two findings of this paper that make possible to conclude that exactly the opposite situation has taken place.

On one side, in Chapter 3 it is stated that the structural problems in the RIP are still present. This is also confirmed by the IADB (2005). On the other side, the present chapter has demonstrated that NIDs have been a recurrent strategy to increase coverage rates.

Therefore, the RIP hasn't been strengthened, and on the contrary it is the NIDs which have become routine.

If the EPI continues to be based only on NID strategies without really tackling all the problems that the RIP faces, it will make the EPI endlessly dependent on NIDs to sustain high and useful coverage rates.

This goes in contradiction with the country's objectives, as expressed by Marta Velandia, former director of the EPI in the INS: "There are NIDs generally three times a year. But the real objective of the EPI is to avoid them. We acknowledge their importance, but the idea is to let everybody know that everyday is a vaccination day, to allocate in the same

level of importance the regular days with the National Immunizations Days” (Interview in The Communication Initiative. 2005).

The strengthening of the RIP requires new communication approaches which discourage extraordinary solutions and start promoting vaccination supply and demand on a regular basis.

Within this context, the following chapters will analyze possibilities for alternative communication approaches. Chapter 5 reviews theoretical perspectives and Chapter 6 presents a practical perspective.

5. WHY HAVE THESE COMMUNICATION STRATEGIES FAILED? WHAT CAN BE DONE?

As mentioned in Chapter 4, communication strategies for immunization focused on promoting the NIDs are not adequate for the EPI in terms of strengthening the RIP. They have focused on extraordinary promotions instead of regular provision. In the long run, these communication strategies don't offer sustainable solutions for the EPI's structural problems.

If the RIP is so important to achieve high and sustainable coverage rates, it is then important to ask: how can communication strategies strengthen the RIP instead of weakening it?

This chapter analyzes the failures on certain theoretical approaches for communication in relation to the context of the EPI. Furthermore, it explores alternative communication theories in order to establish more pertinent communication strategies.

5.1 What happens with Behavior Change strategies?

The NIDs, focused on changing individual behaviors to increase coverage rates, never questioned the why they were low. And even if the causes were recognized, the majority of the communication strategies never tried to tackle them.

Waisbord raises important critics to Social Mobilization and Social Marketing strategies, the most common communication approaches applied to NIDs.

About Social Mobilization strategies, he states that they are "interventions often decided by past practices rather than on the basis of strategic goals" (2004:12). IN Colombia's case, this is confirmed with the return to Social Mobilization NIDs after the crisis of 1997 (Chapter 4).

About Social Marketing, Waisbord says that it “could be useful to address certain issues (for example, increase rates of immunization) but is inadequate to address deeper problems of community participation that are ultimately responsible for permanent changes. It also can result in the problem that interventions conclude when public information campaigns are terminated. One of the problems is that such interventions create dependency on media programs (...). Another problem is that even when Social Marketing strategies are successful at raising awareness, they do not last forever and, therefore, other support systems are necessary to maintain participation and communication” (2003:31).

Although individual behavior is recognized as a major determinant of health, other determinants deserve equal importance. According to Henrik Blum¹⁴, aside of individual behavior, well-being is also determined by genetics, environment and health services. The concept of Health Promotion (Chapter 2) also recognizes that social and environmental conditions are important for the population’s health.

It is not possible to foster a change in individual behaviors if health services are not enabling people to adopt healthy behaviors. In the context of Colombia’s EPI, this means that if immunization services are not provided on a regular basis and universally, how can we expect people to see everyday as a vaccination day?

“In any type of project in which communication processes intervene, it is necessary to look at the game between supply and demand. The providers or agents of social development, in poor or developing countries, are generally the governments and in many cases the services they offer are not of the best quality or have very demanding characteristics for the users. But this hasn’t received the attention it deserves, because generally it is believed that the action of communication can only affect demand” (Hernan Salamanca. Interview in The Communication Initiative. 2005).

¹⁴ Cited by Cotes & Salamanca (1997).

The focus of communication strategies for immunization in individual behavior ignores structural problems of supply. Furthermore, as Waisbord (2004:13) says, “expecting specific behaviors a few times a year is different from ‘changing the norm’ ”.

5.2 Communication for the EPI in a decentralized context

To define a different role for communication strategies in the EPI, the first step must be acknowledging the program’s problems. Since immunization services require so many technicalities (vaccines, cold-chain, infrastructure, etc.), it is difficult to understand the role of communication in solving their failures. Thus, it is important to recognize that we cannot pose on communication expectations that are beyond its capacity.

However, as mentioned in Chapter 3, there are more than only technical problems underlying the failures in immunization’s supply. “The limits to preventive medicine are not only technical and economic but also social and political (Holtzman 1979)” (Cited in Turshen. 1989:180). Taking into account the political and social dimensions of the EPI’s problems can certainly open a space for communication interventions.

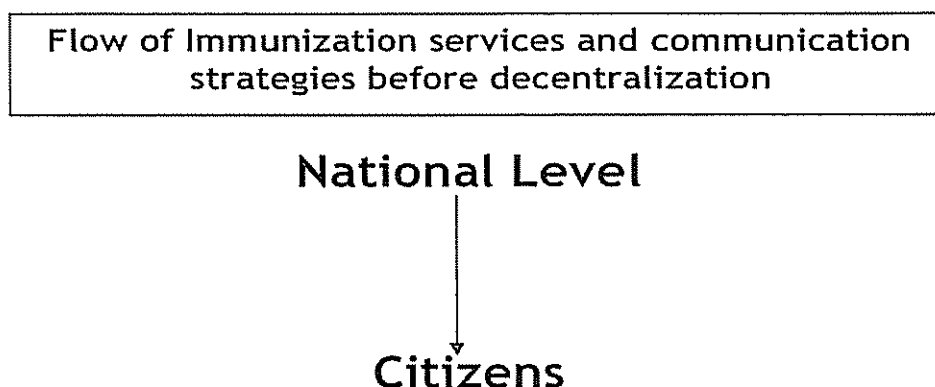
Whereas problems in the EPI are greatly related to the health sector’s decentralization, communication has to face them. As Meredith Turshen says, “immunization is only as good as the vaccine and the science behind the use of the vaccine, including epidemiologic studies; mass immunization campaigns are only as good as the analysis of the political situation in which they are mounted. Of the two, science and politics, the political analysis of the decision to mount a vaccination campaign is the less understood and in this sense the more important to public health workers” (1989:168).

This new political organization of the health system requires a different role for communication within it.

5.2.1 New flows of immunization services in decentralization

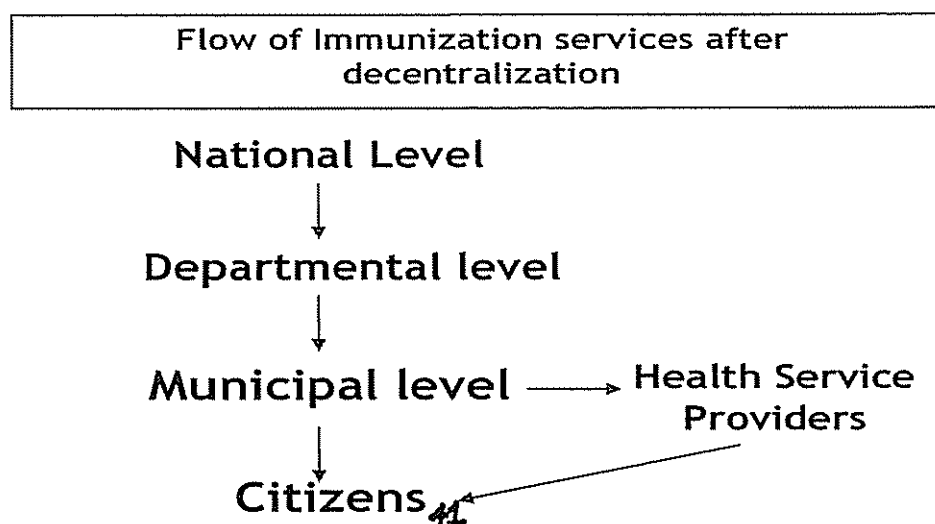
In a centralized system where health services were provided by the central government, communication followed the same process: from the national government to the citizens, as shown in the following graph.

GRAPH 3



But decentralization changed the way health services are provided. The inclusion of new actors in the system implies a change in the flow of immunization services. As expressed in Chapter 3, the national level provides to the municipalities, through the departments, the necessary means for the provision of immunization services to the population. Also service providers, private and public, enter into this flow controlled by the local government.

GRAPH 4



Reforms in the health system "...changed the relations between supply and demand, and changed, as well, the roles of its actors. It is important to precise them in order to determine the actual role of communication in reference to the organization of the new (...) system" (Cotes & Salamanca. 1997:28).

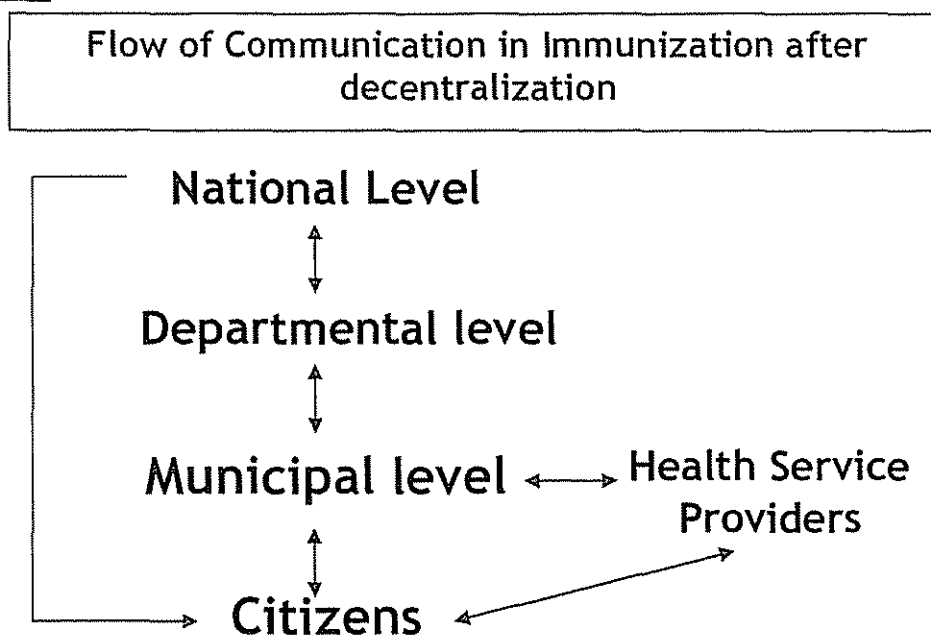
5.2.2 New communication flow in the EPI

Communication needs to take into account all the actors in the health system. In the case of the EPI this is especially important because the responsibility of strengthening the RIP and solving its problems must be present in all levels.

Active dialogue between all the actors generates recognition of problems and triggers debate about possible solutions. Communication can definitely contribute to this two-way process in order to democratize the program and to promote real negotiation among the different actors.

The following graph shows a new possible flow of communication in the decentralized immunization program.

GRAPH 5



Like the health sector, communication should be decentralized as well. The municipal RIP should design and implement their own communication strategies according to the programs' needs. Then, why is it important to include the national level in the new flow of communication in decentralization (Graph 5)?

Acknowledging the need of departmental and municipal communication strategies doesn't mean that national strategies lose their importance. The role of national strategies in the EPI continues to be meaningful due to two special issues: on one side, the problems in the supply of immunization involve also the national level (Chapter 3); on the other side, the lack of political commitment in the local level requires an active role of the national government in pressuring it. Without local political commitment towards the RIP, how can we expect the use of communication strategies in local programs?

However, communication strategies promoted by the national government, need to change their focus. The role of the national government is now to generate debate about the EPI's problems in order to trigger their solution.

Nonetheless, the debates over the problems that the EPI faces have happened inside the institutions and no public accountability has taken place. The low public recognition of the problems in the supply of immunization services has been one of the factors that have allowed their permanence after several years of acknowledgement by the authorities.

Therefore, the debate needs to be public and communication has the capacity of generating it. The Agenda Setting approach for communication can be the key for this.

5.3 Agenda Setting: An alternative communication approach for the EPI

The concept of Agenda Setting was first mentioned by McCombs and Shaw in 1972. They were concerned about analyzing why some issues were given more relevance in the public agenda, and some others were not. Their conclusion about this debate was related

to the power of media in setting the public agenda, which means their influence in defining what issues are relevant to be discussed publicly.

Without denying the importance of media in Agenda Setting, narrowing this approach only to mass media denies the possibility of other communication channels to promote public issues and debate. Communication is definitely much more than mass media.

Therefore, this study proposes the use of the Agenda Setting approach as a communication model, and not only as a media model.

In this regard, Cotes and Salamanca state: "Communication is capable of taking the public interest to certain issues and to promote the introduction of these issues in the agenda of the citizens. Today it is clear that beyond modifying the way people think, communication has the great capacity of orienting the public agenda towards issues that, in a determined moment, can be considered predominant" (1997:16).

But, why is this approach so important for new communication strategies in order to strengthen the EPI? As was mentioned previously, until the problems of immunization provision are considered a priority and a public issue, there will be no solution to them. "Every social system must have an agenda if it is to prioritize the problems facing it, so that it can decide where to start work. Such prioritization is necessary for a community and for a society" (Dearing & Rogers. 1996:1).

Communication has the capacity of making public the information previously controlled by the government. Further more, in a decentralized sector, communication has the capacity of breaking the monopoly of the central government over issues that are of interest of the entire nation, municipality by municipality.

And, what makes this approach different from previous approaches focused on individual behavior change? Agenda Setting strategies recognize that health issues are a matter of inequalities in the social level, rather than being a problem in the individual level. Therefore it intends to promote change of social and political conditions.

In this regard, Salmon et al (2003) talk about Public Will Campaigns which use the Agenda Setting approach, among other approaches.

“Public will campaigns can be defined as organized, strategic initiatives designed to legitimize and garner public support for social problems as a mechanism of achieving policy action or change (Henry and Rivera, 1998; Coffman, 2002). The goal of public will campaigns is to alter the policy potential of a social problem in such a way that it moves from having a relatively low profile on the unstructured and somewhat amorphous public agenda to a much higher profile on the more structured and concrete policy agenda” (Ibid. 2003:4).

Communication, through Agenda Setting, can foster social change by using the coverage and power of the media and other communication channels in raising issues that are important in society. It can foster change in policy-makers by exposing the need of political action towards an issue.

In relation to the use of this approach in health issues, Salmon et al state: “The growing use of public will campaigns in public health is in direct response to perceived shortcomings of individual-change-behavior approaches” (2003:5).

However, it is important to review the Behavior Change concept. Even though it is clear that changing citizen’s behaviors towards immunization is not possible until there is a process of social change in which immunization services are adequately provided, Fraser and Restrepo-Estrada (1998) have pointed out that the other actors in the health system should also change their behavior: policy-makers and service providers. Promoting the commitment of these actors in the provision of immunization services is important for the success of the EPI. Therefore, Behavior Change approaches cannot be narrowed only to the individual level since they can also affect the social level.

With all these possibilities for a new role of communication in a decentralized sector, the following section will analyze their use in strengthening the RIP.

5.4 Setting the public agenda to strengthen the RIP

Taking into account the three main problems that the RIP is facing (regional inequalities, supply problems and lack of political commitment), the following section shows how a national communication strategy based on Agenda Setting can address them.

However, as mentioned before, communication cannot solve the problems in the supply but can trigger their solution by introducing the issue in the public agenda. Therefore, communication strategies can focus on the issue of regional inequalities and lack of local political commitment, pressuring in that way policy-makers and local authorities to address problems in the regular provision of immunization services in the municipalities.

Further more, an important issue to address is related to Social Participation. Agenda Setting, although focused on achieving political action on immunization, takes the debate to the public arena informing and mobilizing citizens to participate in demanding and controlling that local authorities respond to their public commitment.

5.4.1 Acknowledging regional inequalities

Regional inequalities in the local provision of immunization services, which reflect in the disparities among regional coverage rates, is one of the issues that has been left out of public debate.

Even though decentralization opens the possibility for municipalities to design and implement their own strategies to improve local RIPs, national strategies such as the NIDs have lowered the importance of regional actions.

Since the objectives of immunization programs are set in the achievement of national indicators, municipalities that are not performing well have no public pressure to do so, and municipalities that have performed well have no incentive to continue doing so.

This situation also affects the population. Since the objectives of increasing coverage rates are set nationally, their individual action means very little in a country of 43 million

persons, and therefore they don't feel pressured to react. Also, as local coverage rates are not publicly known, the population does not feel that low rates can affect them directly.

“An initial step towards achieving this can be to translate macro-level information into the local context and circumstances. This is important because global and national problems, and plans for resolving them, may be meaningless to local authorities, groups and individuals” (Fraser and Restrepo-Estrada. 1998:274).

In a decentralized context, it is important to start raising the importance of local performances and strategies. National communication strategies can definitely help in this process by making public local information. Using Elder's (2001) concept of Reinforcement, announcing publicly those who are doing well supports their actions and exerts pressure on those that are not doing so yet.

5.4.2 Promoting political commitment

The commitment of local authorities with the EPI is key for strengthening the RIP (Chapter 3) and, therefore, increasing coverage rates in a sustainable way. Low public commitment of local authorities has lowered the political priority for immunization programs in the municipalities and departments.

“Information and communication about major issues are the means by which political will for change can be generated, either by direct intervention with policy-makers or by empowering people who can then exert pressure to force changes in national policies” (Fraser and Restrepo-Estrada. 1998:14).

NIDs have always focused on the issue that immunization is the responsibility of parents, and forget that it is a shared responsibility of local authorities in providing immunization services. As NIDs recreate the centralized provision of immunization, local authorities are not forged to assume publicly their responsibility towards this service. However, if the purpose of the national government is to promote vaccination daily, local RIPs have to be strengthened to be able to provide immunization on a regular basis.

If communication strategies are focused in making public the responsibility of local authorities in order to respond to the rights of the citizens to be immunized regularly and not only in NIDs, they can foster political priority given to RIPS in the municipalities. This can be done by setting local coverage rates as indicators of the performance of local governments.

Local Agenda Setting strategies are important for placing in the local agenda the importance of immunization. However, although it is mostly important to develop local communication strategies, setting the issue of local immunization performance in the national agenda can increase the awareness of local authorities. They are not only publicly committed with their populations, but also the eyes of the entire nation are set on them.

Mass media are a key component to increase political commitment. The use of media, either through mainstream, alternative or communitarian channels, must go beyond simple advertisement promoted by Social Marketing approaches. Introducing issues into the structure of the news and as contents of editorials, changes the perspective people have of them: it is not something that the central government is advertising, but instead it is an issue of interest for everyone that deserves public debate.

The media can also play a very important role fostering two-way communication, in promoting dialogue. Although a national strategy focused on setting in the public agenda the local immunization coverage rates poses on municipal authorities the majority of the responsibility, it can not be forgotten that national and departmental authorities share the responsibility of strengthening the RIP.

Therefore, communication strategies cannot be focused only in emitting messages to local authorities, but should also open public spaces in the media for them to pose their demands to other actors that are important in the process. Promoting the public debate, advocating to the concept of communication as a dialogue, can be the ultimate purpose of these strategies.

5.4.3 Promoting social participation¹⁵

Although a communication strategy based on Agenda Setting promotes per se political action by making public the responsibility of local authorities, citizen participation cannot be left aside.

Citizen demand and control over health services can be one the most effective ways to exert pressure over local authorities to commit with the regular provision of immunization in the municipalities. This is done through Social Participation.

As mentioned in Chapter 3, mechanisms for Social Participation are considered by law within the new health system. Strengthening these mechanisms and promoting participation in them is important in order to improve the RIP.

Communication strategies can foster these mechanisms by two types of strategies which are complementary:

- ✓ On one side, informing about these mechanisms, how they work and what are their importance and benefits, enable citizens to participate within them.

Further more, public promotion of Social Participation mechanisms also exerts pressure on local authorities and service providers to create these spaces and take them into account for the design of health policies and for the adequate provision of health service that are responsive to the demands of the population.

- ✓ On the other side, it is not only important that people participate in these spaces, but also that there is quality in their participation. This cannot happen when the population lacks the knowledge to participate from an informed point of view. Otherwise, participation will not accomplish its purpose or will be considered as irrelevant by local authorities and service providers.

For individual participation, it is important that the population understands the functioning of the health system and their individual rights within it; and for

¹⁵ Information for this part is taken from Cotes and Salamanca. 1997:41-44. Please refer also to Chapter 3 in which these mechanisms are explained.

communitarian participation, it is important that the population knows about the state of health in their community and the problems they are facing.

Communication strategies that promote social participation in the EPI in order to strengthen the RIP are more related to the second type of strategies.

On one side, informing people about their right to receive daily and free immunization services, so they can demand their individual rights through customer service offices or user associations.

And on the other side, raising awareness about the importance of immunization for the communities and making public the performance of their own municipalities and departments in immunization coverage rates, so communities can demand for their collective rights through the COPACOs or other collective mechanisms.

However, it is important that these communication strategies are complemented by those of the first type, because empowering the population to demand their rights in an informed way will be useless if there is no knowledge about the mechanisms (or even no open mechanisms) through which they can pose their demands.

All these aspects provide enough inputs for future design and implementation of communication strategies that strengthen the RIP in a decentralized context.

In Colombia, two communication strategies, very similar to each other, have already implemented the Agenda Setting approach for the EPI.

The following chapter presents one of them, in order to see the practical side of the theories presented in this chapter, and also to see its effects in comparison to the traditional NIDs. Therefore, the overall objective of presenting this campaign is not to assess it.

6. NEW APPROACHES, REAL STRATEGIES

Communication strategies specifically focused on strengthening the RIP have been implemented only twice in Colombia. In 1988, with the onset of political decentralization. And in 2003, after the outbreak of measles which raised the awareness about the crisis of coverage rates in late 1990s and the big regional inequalities that were behind it.

This study focuses on the second strategy, although the first one is presented briefly.

6.1 “Juanita” and “Posters” Campaigns¹⁶: introducing children’s issues in local political agendas

The campaign of 1988, called “Juanita”, took advantage of the new municipal elections to promote children’s issues in the local political agendas. Juanita is the name of an average Colombian girl who, in representation of the Colombian children, wrote a letter to the municipal candidates for mayors calling their attention around the situation of children in the country and the need to tackle them locally.

This campaign addressed publicly that the coming local authorities should promote projects for the well-being of the children in their municipalities; and also it raised awareness among the citizens inviting them to elect those candidates whose political programs included children’s issues. Immunization was among these issues.

The strategy, among others mechanisms, created debates through national and local media channels in which the candidates presented their programs and answered the questions Juanita was raising publicly to them.

In 1989, one year after the municipal elections, a second phase for this strategy focused on Immunization. The “Posters” campaign was designed and implemented with the

¹⁶ Information about these campaigns was taken from Fraser & Restrepo-Estrada (1994) and from The Communication Initiative (2005).

purpose of calling the attention of the citizens and the now elected mayors towards the situation of children's immunization in their municipalities. Posters with information of local coverage rates were delivered to each municipality in order to inform the local citizens and to question each mayor on their strategies to improve them.

This strategy was very effective in raising general awareness about the RIP's importance RIP and the responsibility of local authorities in strengthening it in each municipality.

However the new path that the "Juanita" campaign opened for communication strategies in immunization was not continued and the country went back to the implementation of NIDs. It was not until 2003 when the MSP, recognizing the weaknesses of the RIP and the incapacity of NIDs to strengthen it, proposed the revival of this strategy.

The "Puye" campaign of 2003 is mostly based on the "Posters" campaign.

6.2 "Puye" campaign¹⁷: a communication strategy for the RIP

In 2003, the MSP and the INS, supported by the PAHO and UNICEF, proposed to go beyond the NIDs and develop a strategy in order to strengthen the RIP. The communication campaign called "Puye" was designed and implemented in the second half of the year.

6.2.1 The starting point

This campaign took as starting point the acknowledgement of the problems in the EPI. It also acknowledged the failures of previous communication approaches which have been explained throughout chapter 4 and 5.

Therefore, this national communication strategy for immunization aimed to promote local responses to improve immunization's supply through pressuring local authorities to allocate political priority to the RIP.

¹⁷ Information about this campaign was provided directly from REP/GREY (2004a), advertising agency that designed and implemented it, and from The Communication Initiative (2005).

But if this campaign was directed to the decision-making level, why doing it through a mass communication strategy to inform the citizens? As stated in the document of the strategy, “we believe that the best mechanism, the most powerful and the most innovative to move the supply is through the demand of the citizens. If the citizens know that something is not working well and that for the first time it not only depends on them but that instead it must be also the commitment of their local government, they will be the first to demand to their authorities an immediate response” (REP/GREY.2004a).

6.2.2 The Rationale¹⁸ of the strategy

The communication campaign called “Puye” aimed to “push” regional response to strengthen the RIP and improve local coverage rates. From an Agenda Setting approach, its purpose was to place in the public agenda the municipal and departmental coverage rates.

For this, the strategy took advantage of the INS’s information system that disaggregated immunization coverage rates by municipalities and departments. This database was created in late 1980s when the “Posters” campaign was implemented, but has never been used publicly after, especially due to the continuous focus on national coverage rates in the NIDs.

By informing publicly the municipal and departmental coverage rates, communication achieved two goals. It not only increased the demand for immunization as the population acknowledged their children’s risk, but also promoted citizen action in demanding local authorities the adequate provision of immunization services on a regular basis and not anymore as an extraordinary event (REP/GREY 2004a).

“The strategy, more than being limited to stimulate the demand, tried to stimulate the mechanisms of supply (according to the possibilities and characteristics of every municipality) through making visible the situation of vaccination in the municipalities and ‘denouncing’ low coverage rates” (REP/GREY. 2004a).

¹⁸ Rationale in advertisement jargon refers to the fundamental reasons of a campaign.

The positive effects of this approach, as already analyzed in chapter 5, are that informing publicly the local rates exerts pressure over political authorities to take action and improve this situation.

“Information about the local state of immunization, linked to the local responsibility of achieving better coverage rates, turns vaccination into a political fact and into an administrative challenge. Even more, it becomes an indicator of bad or good performance of local governments. In general terms, taking to the public an issue that is usually forbidden to the citizens, democratizes the program and introduces it in the local agenda turning the immunization coverage rates into an objective to achieve, controlled by the citizens” (REP/GREY. 2004a).

6.2.3 Mixing NIDs and RIP

Instead of denying the NIDs and their value in increasing coverage rates, REP/GREY integrated them into a major strategy that supported the RIP.

The strategy was clearly focused on this program and used the NIDs only as extraordinary opportunities for those municipalities that were behind in the achievement of useful coverage rates. The campaign was done in between the NIDs implemented during the year: the “Vaccination Week of the Americas” in July, and two “V-Day” implemented in August and November.

When there were no NIDs, the communication strategy sustained the issue of immunization in the public agenda by questioning what was being done locally on a daily basis and doing follow-ups to the municipalities.

This closes the division between the NIDs and the RIP.

“During the NIDs, mass communication was used as the final point in the chain that would guarantee that people were informed of the event and their assistance. This time communication was the central axis of the campaign because it was used since the beginning as the leading motor of the immunization strategy” (REP/GREY. 2004a).

6.2.4 “Puye”: a game of words

“Puye” means “Push” in English. It is a game of words which refers to “push” injectable vaccines, and to the popular expression of “pushing” which means demanding or exerting pressure.

As explained by REP/GREY (2004a), it was an invitation for the population to ‘push’ in all the possible ways: to themselves in order to take their children to be immunized; to others, family and neighbors, so everyone in the municipality would do the same; and, the most important one, to the authorities and service providers to provide immunization adequately and on a regular basis.

6.2.5 The strategy

The strategy had three phases. It focused its main actions in 443 municipalities which the lowest coverage rates. This counted for almost half of the municipalities in the country, giving the campaign important proportions.

A. The first phase was initiated with the “Vaccination Week of the Americas” which gave the perfect scenario to talk about immunization and to inform publicly about local coverage rates. The objective was to call the attention of those who had low performance and congratulate those who were an example for their high coverage rates. “But beyond this, what we were looking finally was to make an invitation to improve or sustain coverage rates. This way, the municipalities that were making daily efforts to achieve useful coverage rates, out of the big NIDs, had a new incentive: the opportunity to improve their public image” (REP/GREY. 2004a).

During 2 months after the NID, the following actions were implemented:

- ✓ Municipal Posters: Repeating the strategy of 1989, 443 municipalities received a personalized poster which informed their total number of children, how many were immunized and how many were not. Such technical information became a message easy to understand in order to feed the public opinion. Even more, the

coverage rates of the municipalities were qualified according to three categories to facilitate comprehension: bad, acceptable and good.

These posters as communication channels offered two perfect conditions: first, personalize the information for every municipality at low cost; and second, reach the majority of the population as possible in the places where their lives occur (schools, supermarkets, streets, church, etc).

GRAPH 6 – MUNICIPAL POSTERS



Source: REP/GREY

Note: 3 different examples, each one from one category. Left poster: BAD; center poster: ACCEPTABLE; right poster: GOOD.

- ✓ Supporting the mayors: “The campaign didn’t intend only to denounce the weakness of the supply; this was the mean to pressure its strengthening. And in this strengthening, the State also should assume a proactive position to support local authorities” (REP/GREY. 2004a). For this reason, several materials were provided to the mayors based on the idea that the majority was not informed about how to strengthening the RIP.
- ✓ Involving the Church: The Church has been a great ally for immunization strategies in many of the NIDs. However, this time the message for the Church was not to promote that their parishioners take their children for immunization; instead it was invited to “push” local authorities for the improvement of the RIP.
- ✓ Mass Media: The role of the mass media is key for an Agenda Setting campaign as this one.

The mainstream media like Caracol (Radio&TV), RCN (Radio&TV) and El Tiempo (print media) have recently created Social Marketing Departments that opened a new space for public interest campaigns with priority rates and spaces for emission. Also, they offer the possibility of using the media not only as advertisement, but also from an Agenda Setting approach in which the contents of the campaigns are introduced in the editorial and news agendas.

The media, which were used to promoting NIDs, were now invited to promote the RIP. The challenge was to turn a regular event in news. But they accepted the challenge and became great allies for the “Puye” campaign.

The following actions were taken:

- 1 TV commercial emitted in 14 national and regional channels through the five months of the campaign.
- Radio spots in 11 national stations and in 48 regional stations.
- Ads in the main national newspaper (El Tiempo) and in 4 regional newspapers

- Editorials and news coverage: this was the most important part of the mass media campaign. Newspapers released an editorial. Radio stations did a follow-up of the strategy in the news sections informing the municipal and departmental coverage rates, and a follow-up of the coverage rates calling the mayors to discuss on air the situation of their municipalities in immunization and questioning the actions they were taking.
- B. The second phase linked the ‘V-Day’ of the 31th of August to the strategy. This NID was an opportunity for those municipalities that were not performing very well to improve their coverage rates.
- C. The third and last phase was a final review of the departmental and municipal coverage rates before ending the year, in order to congratulate those who had achieved to improve and questioning those that didn’t. During this phase was implemented the second “V-Day” in November 22nd, as a final effort to end the year with high coverage rates.

6.3 Evaluation of the “Puye” campaign¹⁹

REP/GREY evaluated the campaign in terms by looking at the improvement in coverage rates. As expressed by their Final Report (REP/GREY. 2004c), this is the best way to measure the success of the campaign as it looks for its effects in its final objective: the improvement of the state of immunization in the country.

Immunization strategies are the most easy to evaluate in these terms due to the immediate change they cause in coverage rates, which are reported periodically by every municipality and department. Without this type of data it would have been a difficult task to evaluate the strategy’s outcomes.

¹⁹ Information about this evaluation was provided directly by REP/GREY (2004b-c).

6.3.1 Methodology

The evaluation²⁰ was done over the 931 municipalities who reported their complete coverage rates to the EPI, giving information about 21 departments out of 32 that the country has. It was a comparison between the 2003, year in which this campaign was implemented, with 2002 when there was no strategy for the RIP. Therefore, the only difference in the EPI of each municipality between these two years was the “Puye” strategy, as in both years there were NIDs. The months evaluated were from August until December, during which the strategy was implemented.

From the total number of municipalities evaluated, 526 were not covered by the strategy and 405 were.

The objective of the evaluation was to find how many municipalities improved their coverage rates in 2003, compared to 2002. “With this analysis we want to show how a communication strategy based in local information to support the RIP can offer much better results in the increase of coverage rates, compared to what is achieved in sporadic NIDs” (REP/GREY. 2004b).

The evaluation month by month allowed seeing the effects of the strategy’s phases, which also allowed comparing the NIDs’ achievements with the regular strategy’s achievements. Additionally, the inclusion of municipalities covered by the strategy and those that were not, allowed to compare the differences that the strategy generated.

6.3.2 Results and conclusions

The following Table shows the percentage of municipalities that improved their coverage rates in 2003 compared to their coverage rates in 2002.

²⁰ REP/GREY based this evaluation on official data provided by the INS.

Table 2 – Quantity and Percentage of Municipalities that improved coverage rates in 2003 compared to 2002 – Differences between municipalities covered and not covered by the campaign

Improvement by month	Total	AUG		SEP		OCT		NOV		DEC		Average
	#	#	%	#	%	#	%	#	%	#	%	%
Municipalities Covered	405	309	76.3	319	78.8	307	75.8	319	78.8	316	78	77.5
Municipalities not covered	526	263	50	277	52.7	234	44.5	268	51	243	46.2	48.9

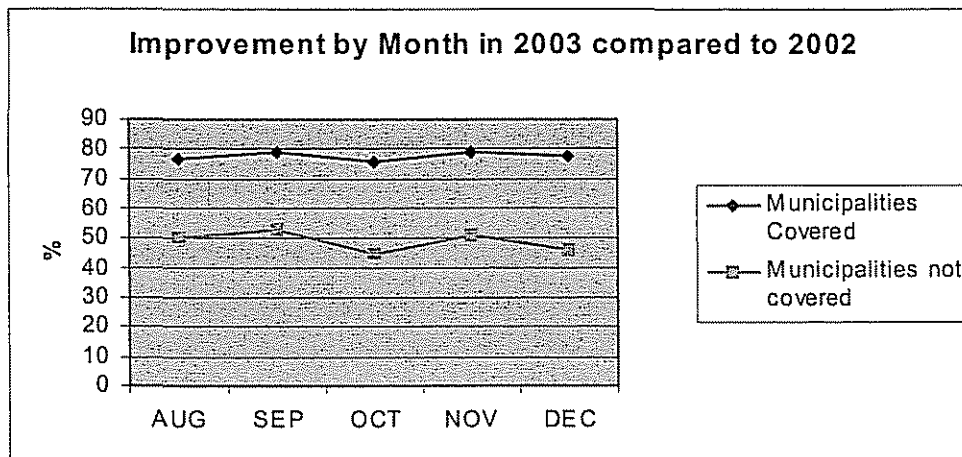
Source: REP/GREY (2004c).

Table 2 presents the quantity and percentage of municipalities that improved their coverage in 2003 from August until December, compared to the coverage rates they reported in the same months of 2002. In general, coverage rates in 2003 improved compared to those of the previous year.

However, according to REP/GREY (2004c), “in 19 of the 21 departments, the percentage of municipalities that improved was more in those covered by the strategy than in the not covered. While in average 77% of the municipalities covered improved during the 5 months, an average of only 48% of the municipalities not covered achieved to improve. Even more, the tendency is sustained from August to December”.

The data presented month by month shows the incidence of every stage of the strategy., in order to compare the effects of the strategy for the RIP with the effects of NIDs. The following graph, a visual representation of Table 2, helps to see more clearly this aspect.

Graph 9 - Percentage of Municipalities that improved coverage rates in 2003 compared to 2002 – Differences between municipalities covered and not covered by the campaign



Source: REP/GREY (2004c)

In this graph we can clearly see the peaks in September and November due to the two “V-Day” implemented around this months²¹. As these NIDs were implemented nationally, this explains why we can see those peaks both in the municipalities covered by the strategy and in the not covered.

However, the interesting thing to see is that the municipalities not covered by the strategy show more visible decreases in the months when there were no extraordinary actions taking place, especially in October and December. These decreases in the percentage of municipalities that improved their coverage rates is less evident in those that were covered by the strategy. This is supported by Table 2, which shows that the variation in the percentages is much lower in the municipalities covered by the campaign than in those not covered.

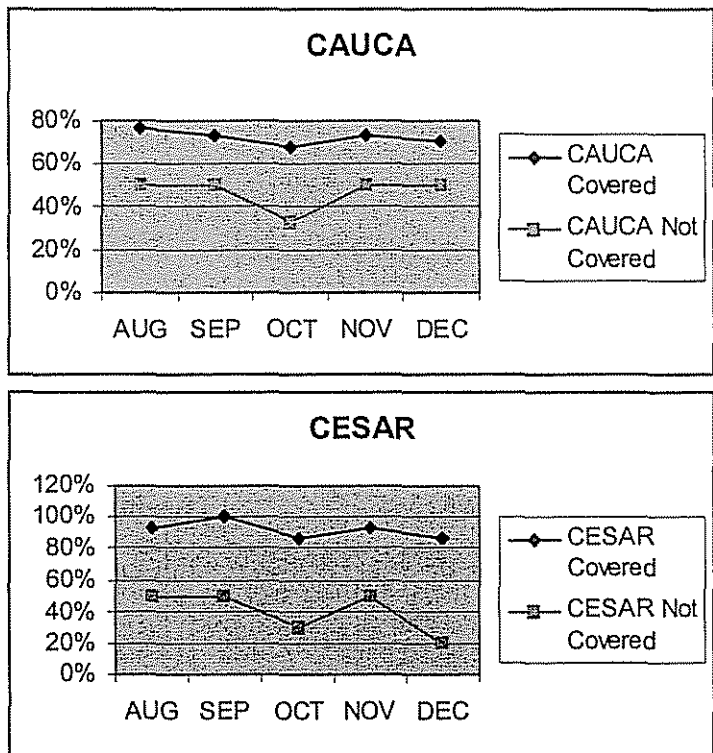
“The municipalities covered by the strategy are also affected by the presence or absence of NIDs. But the coverage rates don’t decrease so radically in the months without NIDs. This allows seeing a presence of the RIP in many municipalities that sustains the coverage rates without extraordinary actions” (REP/GREY. 2004c).

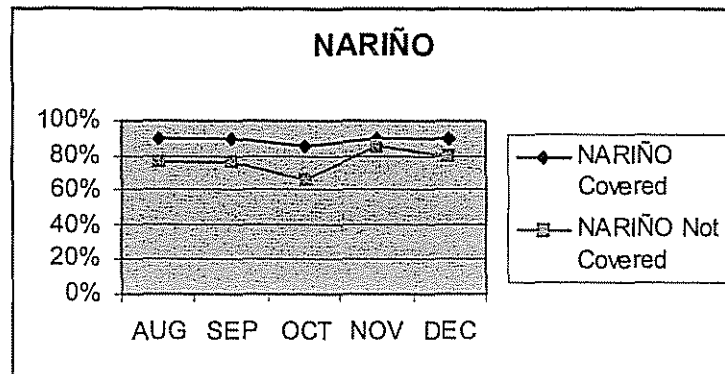
²¹ Although the first “V’Day was in August 31st, it is registered in the coverage rates of September.

This analysis led REP/GREY to find that the “Puye” strategy, which was supporting the RIP and was continuous throughout the five months, has more influence in the sustainability of coverage rates than the NIDs. This confirms the statement made in Chapter 4 in which it is recognized the immediate positive effect of the NIDs in increasing coverage rates, but their sustainability in the long run is highly questioned. Graph 9 allowed REP/GREY to confirm that the NIDs generate a cycle of highs and lows in the coverage rates which creates a dependency of the EPI on them.

When looking at the data of each department, REP/GREY found that the same trend is clearly present in 14 of the 21 departments analyzed. This can be seen specifically in the departments of Cesar, Cauca and Nariño, as shown in the following graphs.

Graphs 10, 11 and 12 - Percentage of Municipalities that improved coverage rates in 2003 compared to 2002 – Departments of Cesar, Cauca and Nariño.





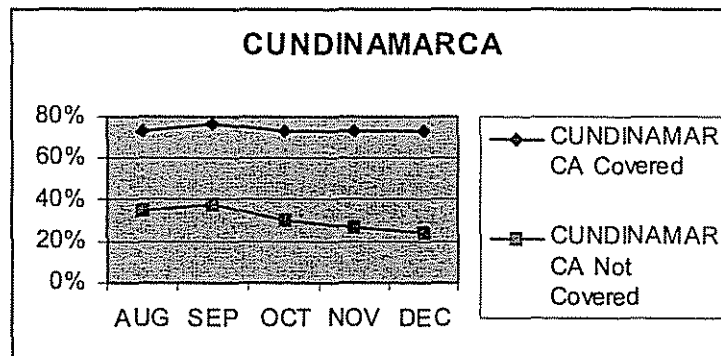
Source: REP/GREY (2004c)

In these departments, the peaks of September and November show the clear incidence of NIDs. The drop in the percentage of municipalities that improved coverage rates in October and December is less radical in the municipalities covered by the strategy, than those not covered.

“Even more, there are cases in which the NIDs don’t mark a difference anymore. In 7 departments (Arauca, Caldas, Caquetá, Córdoba, Cundinamarca, Magdalena and Norte de Santander) the number of municipalities covered by the strategy is almost the same during the 5 months, while the municipalities not covered in those same departments have notorious ups and downs” (REP/GREY. 2004c).

As example we can see the data for the department of Cundinamarca in the following graph.

Graph 13 - Percentage of Municipalities that improved coverage rates in 2003 compared to 2002 – Department of Cundinamarca.



Source: REP/GREY (2004c)

In Cundinamarca it is clear that the percentage of municipalities covered by the strategy was almost equal during the 5 months, with exception of September in which the number of municipalities increases a little probably due to the “V-Day”. Mean while, the municipalities not covered have the same peak in September, but decrease notoriously in the following months when there were no extraordinary actions.

Additionally, REP/GREY (2004c) highlights that, during the 5 months, “in 9 of the 21 departments, more than 80% of the municipalities covered by the strategy improved their coverage rates”: Casanare, Cesar, Córdoba, Huila, Magdalena, Meta, Nariño, Norte de Santander and Risaralda. Even more, in four of them more than 90% of the municipalities covered improved their coverage rates.

Finally, this evaluation has given enough arguments to believe that communication strategies in support of the RIP, based on Agenda Setting and local information, can be a determining factor in generating better and more sustainable results in the long-run than the NIDs.

The final assumption, which can not be confirmed through this evaluation, is that the national strategy triggered local actions in each municipality in order to strengthen their own RIP and to increase local immunization coverage rates.

6.3.3 Some considerations over the strategy and its evaluation

Even though this evaluation has made very interesting and valid points in relation to the role of communication strategies in strengthening the RIP, there are various aspects that are worth to consider for further strategies and evaluations like these.

- ✓ The inclusion of NIDs as part of a major strategy has shown to be very positive. Especially because it took a step further from the discussion of what determines the increase of coverage rates: strategies that support the RIP or NIDs. The implementation of NIDs in the “Puye” campaign made a clear point that they were extraordinary measures to support the increase of coverage rates, but that they must

never replace regular immunization's provision which is highly important for the sustainability of high and useful coverage rates.

However, as we have seen in Martha Velandia's statement (Chapter 3), the final objective is to avoid NIDs in the future. It is important to consider then if the EPI is prepared for this, or if it should wait until the municipal RIPs are strengthened enough to achieve high coverage rates without extraordinary strategies. What would have happened with the results of the "Puye" strategy without the complement of NIDs? This evaluation cannot show this. Further and more specific evaluation is needed on how much the RIP and the NIDs determine the achievement of high coverage rates.

- ✓ The problems in the official data of coverage rates mentioned in Chapter 3, lead to question the accuracy of the strategy and its evaluation.

With respect to the strategy, REP/GREY expresses that the use of local coverage rates based on an outdated census was a limitation for the strategy. Many municipalities refused to accept the posters and the information that was emitted through mass media with the argument that they were inaccurate. However, the campaign successfully triggered this debate that was present for many years, but was never discussed publicly or approached as an urgent situation that needed to be solved.

With respect to the evaluation, it is a fact that its accuracy can be questioned if all these problems in the data exist. For evaluations like this in the future, the data needs to be more accurate.

However, there are two positive circumstances for the solution to this problem. First, the national government is currently implementing a new census. And second, the "Puye" campaign and the evaluation raised consciousness in the municipalities about the importance of reporting on time and accurately their data to the national government, solving the problem of lack of interest of many municipalities to frequently and systematically report the data of their population and their immunization coverage rates.

- ✓ Finally, REP/GREY's evaluation does not refer to other factors involved in the improvement of coverage rates. Although the way in which the evaluation was made, comparing the years 2002 and 2003 based on the assumption that the only difference between the two years was the strategy of "Puye" has facts in its favor, it is important to clarify that it doesn't talk about other factors that could have determined the increase in coverage rates.

However, it is important to recognize that the strategies' final objective was to trigger local actions in the RIP in order to improve municipal and departmental coverage rates. And the evaluation as such cannot determine what were the actions implemented in each municipality to achieve it. Therefore, complementary evaluations will be needed on a municipal basis to determine this. This can be a step further which was not the purpose of the "Puye" campaign and its evaluation.

- ✓ "Juanita" and "Puye" campaigns were implemented close to municipal elections in the country. In the former it was specifically designed to be as such, but in the latter it was more a casualty which was taken advantage of.

Both campaigns demonstrated that elections can be an important factor for their success, as it guarantees the inclusion of the issue of immunization in the local political agendas.

However, political elections are not a requirement for this type of strategies. Strengthening the RIP needs to be in the public and political agendas every year, and not every 3 years when elections occur.

7. CONCLUSIONS

This paper was focused on analyzing the role of communication strategies in decentralized health programs.

The most important conclusion we can derive is that the definition of a communication strategy must recognize the context in which it will be applied, and then decide on the theoretical approach that best responds to the needs of reality.

An analysis of communication based only on theories can mislead communication's role. But also, different theoretical approaches for communication broaden its role by acknowledging all the capacity communication has of promoting social change, whether in the micro or the macro level.

Therefore, the design of communication strategies must be a confluence of reality and theories. Different theories serve to different realities and needs. Different communication approaches serve to different health programs.

The lessons that can be learned from the role of communication strategies in Colombia's EPI are the following:

- ✓ Communication strategies for health programs should be designed and implemented according to its characteristics and needs. In the EPI, decentralization and the need of strengthening the RIP challenged the role of communication to go beyond its traditional approach of NIDs.
- ✓ Communication strategies based on changing individual behavior, as were the NIDs, are not appropriate when there is inadequate supply of health services. If the population cannot have access to immunization, how can we expect them to change behaviors?

- ✓ Communication strategies focused on promoting extraordinary measures to solve the supply's problems in health services, will lead to unsustainable solutions and won't generate real and long-run improvement in health provisioning. Therefore, it will create a dependency of programs on extraordinary measures as their absence immediately affects population's health.
- ✓ Structural problems in the supply of health services challenge the traditional approach for communication in health programs. Communication cannot be seen anymore as "the solution" as it goes beyond its capacity, but it can be definitely be a trigger for solving problems.
- ✓ A decentralized health sector requires communication strategies that recognize regional differences, involve new local actors of the health system, promote political action in the local level and promote Social Participation.

These lessons have led to review possibilities for an alternative role of communication in a decentralized health sector:

- ✓ Communication's role in triggering the solution of problems in health programs can be done through introducing these issues in the agenda and generating public debate about them. As long as problems are not publicly recognized, political action to solve them won't be pressured. Communication strategies based on Agenda Setting can be the most adequate approach for placing these issues in public and political agendas.
- ✓ Introducing local performances in health in the national agenda can be the key to stop thinking only in national terms, and to start recognizing differences among the different regions in the country and therefore promote the need to implement strategies according to the needs of each department or municipality. This is highly important whereas a decentralized sector requires decentralized actions.

- ✓ Further more, setting in the agenda the responsibility of local authorities in strengthening the regular provision of health services, exerts pressure over them and promotes their political commitment with health programs.

- ✓ Finally, setting these issues in the public agenda empowers the population to demand the response from their local authorities in providing adequate and regular services. Communication can promote Social Participation in health, based on the recognition of the population more than just as “users” but as citizens with an active role in demanding and controlling health services.

Although this conclusion opens the discussion about new approaches for communication in health, the purpose of this paper is not to propose them as the necessary “blue print” for communication in a decentralized health sector.

Fixed communication strategies applied equally to different health programs are not adequate for strengthening them and triggering solutions for their problems. Each health program needs to analyze its own characteristics, problems and needs, and therefore plan communication strategies accordingly.

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