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The guidelines described in this report call for increased attention to investment in health education. Health care systems in LDCs are often unable to provide better health for the majority of the people at an acceptable level of efficiency and at an affordable cost. Whether or not health services are available, a major barrier to reducing illness continues to be a lack of change in the health habits of the public. Therefore, education of the public in proper health practices is needed to change bad health patterns, to educate people to accept responsibility for their health, and to adopt a more active role in the provision of health services. Such education can take place in the home or the classroom, or through such means as communication between health personnel and patients, and through the mass media. Little knowledge is available on how to plan successful health education programs using the mass media; in the past, attention has been focused on the selection of available media rather than on efficient planning. This paper indicates that the use of the media in health education requires a multi-disciplinary approach to be effective, and it calls for the application of educational methods and techniques and organizational and promotional skills to health problems. The guidelines are based on a social approach, rather than a purely methodological or technological approach, and they examine when health education is needed and when

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and how mass media should be used for health education. The paper includes a discussion of evaluation needs research data requirements, and the role of test projects.

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EDUCATING THE PUBLIC ABOUT HEALTH
THROUGH THE MASS MEDIA

Guidelines for Project Planning
in Less Developed Countries

April 1976

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INTRODUCTION

These project planning guidelines have been developed on the basis of certain premises about health care in less developed countries which argue for increased attention to investment in health education.

1. Health care systems in less developed countries are often unable to provide better health for the majority of the people at an acceptable level of efficiency and a cost the countries can afford.
2. Those who are underserved in terms of health care are often the poorest elements of the rural population.
3. Whether health services are or are not available, a major barrier to substantial reduction of prevalence and duration of illness continues to be a lag in corresponding changes in health habits and practices of the public.

Effective education of information of the public is needed to change inappropriate patterns of health habits and practices, to educate people to accept a larger responsibility in maintaining and protecting their own health and those of the other members of their communities, and to adopt a more active role in the actual provision of health services.

Such education of the public can take place in several contexts and through a variety of different means such as the home, the classrooms of schools, in the health care situation between health personnel and patient, and the mass media.

Although the experience with mass media health education has been considerable, in the U.S. but also in less developed countries, it continues to be carried out in a haphazard way. Successes and failures occur, but we have not really understood why or how to plan for the former. Attention has usually been focused on selection between different media

assuming that the answer lies in one or a combination of these. This has been futile, costing billions of dollars, without advancing our knowledge in any significant way. The answer is more complex.

The present guidelines are for those who consider using the mass media for health education. But they do not make the assumption that the selection of a particular medium provides the key to success. To be effective, health education planning requires a multi-disciplinary approach. It calls for application of knowledge not only of relevant educational methods and techniques, and of certain organizational and promotional skills, but of health problems and the people who have the problems. It is in the latter aspect that it has usually been weakest. Both professional "health educators" and educational technology specialists have over-emphasized techniques, or techniques and health problems. Behavioral scientists, who tend to be oriented more to consideration of the human elements, have usually played a minor role in health education planning.

The present approach to mass media health education planning does not ignore the methodological or technological inputs, but it is an essentially social approach.

Because so few studies or field experiences in mass media health education have contributed to our knowledge, the field remains in its infancy. These "guidelines" must therefore be considered a preliminary attempt, subject to modification or improvement as our understanding increases.

The approach of the document is to ask and attempt to answer certain key questions involved in mass media health education planning in less developed countries. These are:

1. When is health education of the public needed?
2. When can the mass media be used for such health education?
3. How should mass media health education planning be carried out?
4. How can mass media projects add to our knowledge?

1. WHEN IS HEALTH EDUCATION OF THE PUBLIC NEEDED?

As a general rule, health education-information activities should take place whenever the public's health habits or practices need to be changed or modified in any way. This occurs when existing practices are not conducive to reduction of prevalence or duration of illness.

Examples of such health-threatening habits or practices are:

- failure to adopt preventive and health-supporting practices
- disregard for the basic principles of sound nutrition
- failure to seek medical help or delay in doing so
- over-use of medical services
- failure to appropriately follow medical instructions
- use of health-threatening drugs, hallucinogens, or indulgence in other such practices which are directly threatening to health

Some of these listed practices are associated with under-utilization, over-utilization or inappropriate utilization of health services, others can exist when health services are limited or non-existent.

Adequate health services

- failure to seek medical help or delay in doing so
- over-use of health services when there is no need to do so
- failure to appropriately follow medical instructions
- failure to adopt preventive and health-supporting practices
- disregard for the basic principles of sound nutrition
- existence of practices which are directly threatening to health

Limited or absent health services

- failure to adopt preventive and health-supporting practices
- disregard for the basic principles of sound nutrition
- existence of practices which are directly threatening to health

The situation of limited or lacking health services is frequently the lot of the poorer sectors of the rural population in less developed

countries. Education or information may be all we can offer to them, at least in the short term, to improve their physical well-being.

These guidelines have consequently been designed to be especially relevant to the latter situation: that of limited or no health services

The above provide the general kinds of situations in which health education information activities can take place. However, such activities can only have an impact to the extent that one or more of the below is either the sole or only missing factor in such habits or practices:

- relative disinterest in health as compared to other benefits (e.g., economic, social, etc.)
- ignorance or misinformation as to the relationship between certain kinds of practices and bodily health
- existence of certain social or cultural barriers to change of health habits or practices
- general passivity or lack of motivation to change practices

The listed factors are not only often all involved to a greater or lesser degree, but may also be closely interlinked. In other words disinterest, ignorance, misinformation and/or passivity may be involved.

Whereas disinterest, ignorance, misinformation or passivity may be an identifiable causal factor of the inappropriate health habit or practice, it is important for project planners to remember that it may not be the only factor. Lack of access to certain facilitating materials or services may also be involved, even when not immediately apparent to the outsider.

Examples:

- People may be ignorant of the need to boil the river water, but they may also lack sufficient fuel or a second pot to do so.

- People may be unaware that they are suffering from fecally transmitted diseases and may also lack know-how for improving sewage disposal, but they may also lack materials.

In sum, it is important for non-formal education project planners to remember that even when ignorance, misinformation or passivity is a major cause of health-threatening practices, education-information activities are often not the entire answer.

While the barrier of medical services might be able to be circumvented, more often than not, other kinds of non-informational inputs are also required in order for information to do any good. Any such needed input must therefore either already be available and accessible or be able to be made available and accessible. Otherwise health education-information can only result in frustration or perhaps unplanned-for socially disruptive action.

THE RULE: Health education-information activities should take place when:

- health threatening habits or practices exist
- such habits are solely caused by disinterest, ignorance misinformation
- such habits are primarily caused by the above factors, with any non-informational requirements for change either already available and accessible or able to be made available and accessible

2. WHEN SHOULD MASS MEDIA BE USED FOR HEALTH EDUCATION?

Whereas certain education-information planning activities are often needed in the situation where people's health habits or practices need to change, such education-information activities are not always best carried out through the mass media.

Ideally, one should choose between various available alternatives or various combinations of alternative means, and be able to select according to both health problems and the public involved.

Experience in behavior change, including health, in less developed countries and laboratory experimentation, has still not fully resolved all the complexities involved, partly because there are so many health problem and audience factors to be considered. But while results tend to be confusing and our knowledge incomplete, general guidelines can be suggested:

THE RULE: Generally speaking mass media can be effectively used for health education or information if the below criteria apply:

- The problem health behaviors are easily identifiable, fairly similar, and shared among large numbers of people in the same area or areas
- Ignorance, misinformation, disinterest or passivity are major causes of problem health behaviors, with any needed non-information inputs available and able to be co-ordinated with the information plan.
- The mass media are available in terms of economic, political, technical and other considerations
- The mass media are suitable in terms of the nature of the intended audience

- The mass media are suitable in terms of the intended information to be conveyed
- The mass media use can be combined and co-ordinated with some kind of supportive more personal local activities, either interpersonal or group focused in nature, and ideally both

Exceptions to the latter point do exist, but it is generally safer to follow the rule.

However, the real-world situation of development planning is not ideal, and one must differentiate.

The planner of mass media health education may come into a situation of greater or lesser pre-definition of the project on both the health side or the communication side.

Irrespective of the point at which the planner enters, and the degree of control he has as to mass media selection, he will plan better if he consciously acknowledges and keeps in mind the principal strengths and weaknesses of mass media use for change of health habits and practices.

At a minimum, the below must be kept in mind:

Advantages:

- The mass media are at times able to reach populations that are isolated from road communications and health services, but the media vary considerably in terms of outreach. Radio is generally acknowledged as the most "democratic" and newspapers and television generally reach mainly those that are more educated, urban, and more affluent.
- Mass media like radio and television, have the advantage of speed. of information transmission, with messages reaching large numbers of people simultaneously and over a short period of time. Thus mass media education is quicker than education through health promoters, teachers or extension workers.

- Mass media transmissions are relatively dependable. That is, with appropriate infrastructure and operational arrangements it can usually be ensured that messages will get out and be available to the audience-- if the audience receives them--whereas bad roads and personal limitations may stop people-access among disperse rural populations.
- Compared to other means of health education, such as those based on personal services, mass media education can be relatively low in cost per message when the population is disperse.
- Mass media often have the ability to give legitimacy or prestige to a practice which individuals sometimes do not possess.

Disadvantages:

- mass media reception in the open listening situation is not able to be forced on the audience. The person for whom the message is intended may either forget to attend, or simply choose not to, perhaps with a simple turn of a knob.
- The mass media itself, or its use for educational purposes, may be new to the traditional audience and thus require a change in behavior in and of itself. This may preclude or delay the media-transmitted message's effect on health practice.
- The mass media messages are "public" and health is often a very personal matter. This makes certain kinds of personal health information difficult to transmit effectively. It also leaves the message open to all kinds of censorship, including "censorship" by family and neighbours which can undermine effectiveness.
- The mass media messages, to a greater or lesser degree, have to be relatively homogenous and "mass" prepared or they will be too costly, meaning that it is difficult to adjust them to different health needs or socio-cultural differences of diverse populations.
- The mass media messages when rapid, as in the case of radio and TV messages, are often transitory. They exist for a limited period of time and are not able to be recaptured by an audience wanting review or reminding.

- The mass media are not able to select their audience as effectively as a personal educator can. They will almost always miss some who are meant to attend, and reach others who are not intended to form part of the audience.
- Unlike in the individual-to-individual situation, the mass media are not able to be immediately responsive to their audience. They can not reformulate, omit, or repeat information not understood or inappropriate.
- Normally the mass media audience does not know each other, which with the socially and culturally embedded health behavior means that people can not support each other to change, (but this can also act for the benefit of change.)
- The mass media in their traditional operation develop passive learning situations which are not in harmony with self-help health attitudes and behaviors.

The above are fairly general and usually well acknowledged but even the most experienced planner often tends to forget them in practice.

In the situation where change of traditional health practices are concerned, the lack of sensitivity of the mass media to individual differences (socio-cultural and health) and to immediate feedback, are particularly critical. This is because of the way health practices are so often very personal and "tied up" with a variety of values, beliefs, taboos, family relationships and so on, and as a result difficult to change.

An attempt must therefore be consciously made in mass media use for health education to counteract their disadvantages, and optimally exploit their advantages.

THE RULE: If the choice of educational means is up to the planner he should ask the below "media" question:

Is the use of mass media at all appropriate in this situation?

If mass media or a particular medium have already been identified as the means for health education the communications planner needs to ask:

How can I make the best use of media in this situation?

Many projects have failed because planners have not considered alternative media uses, but have blindly followed tradition.

3. HOW SHOULD THE MASS MEDIA BE USED FOR HEALTH EDUCATION?

There is no magic in radio or any other mass medium. They are only tools. Like any other tools they can be very effective in getting the job done, or can be completely useless: it depends entirely on whether they are used in the right place and in the right way.

As emphasized in the previous section, the planner of health communications may have limited control over whether the place of a media use is the right one. He usually has more control over whether it is used in an appropriate way.

If mass media are to maximize their potential for changing health habits and practices of the public, not only the content and channel of media use have to be well planned, but the entire process of use, taking into account the audience and the situation in which they operate, and the complexities of the health problem(s) to be addressed.

In this more "social" and process-oriented approach to health education-communication, behavioral scientists must play an important role, as do behaviorally oriented communication specialists.

Thus, health communications planning "walks on two legs" -- it must on one side constantly either seek to define or keep in mind the health problems and audience to be addressed and on the other, the communication processes to be set in motion and the means employed to do so. These are closely connected and one affects the other.

As a consequence:

- The premature choice of a medium may limit the nature of the audience to be reached, or the degree of effectiveness with which an audience can be reached and influenced.
- The earlier definition of a health problem to be addressed will limit the range of possible media means than can be effectively used because it will usually select a certain primary audience, which will direct media choice.

The key decision points in mass media health education are outlined in question form. These are especially relevant to the limited health service situation where outreach to poor rural masses is often the goal.

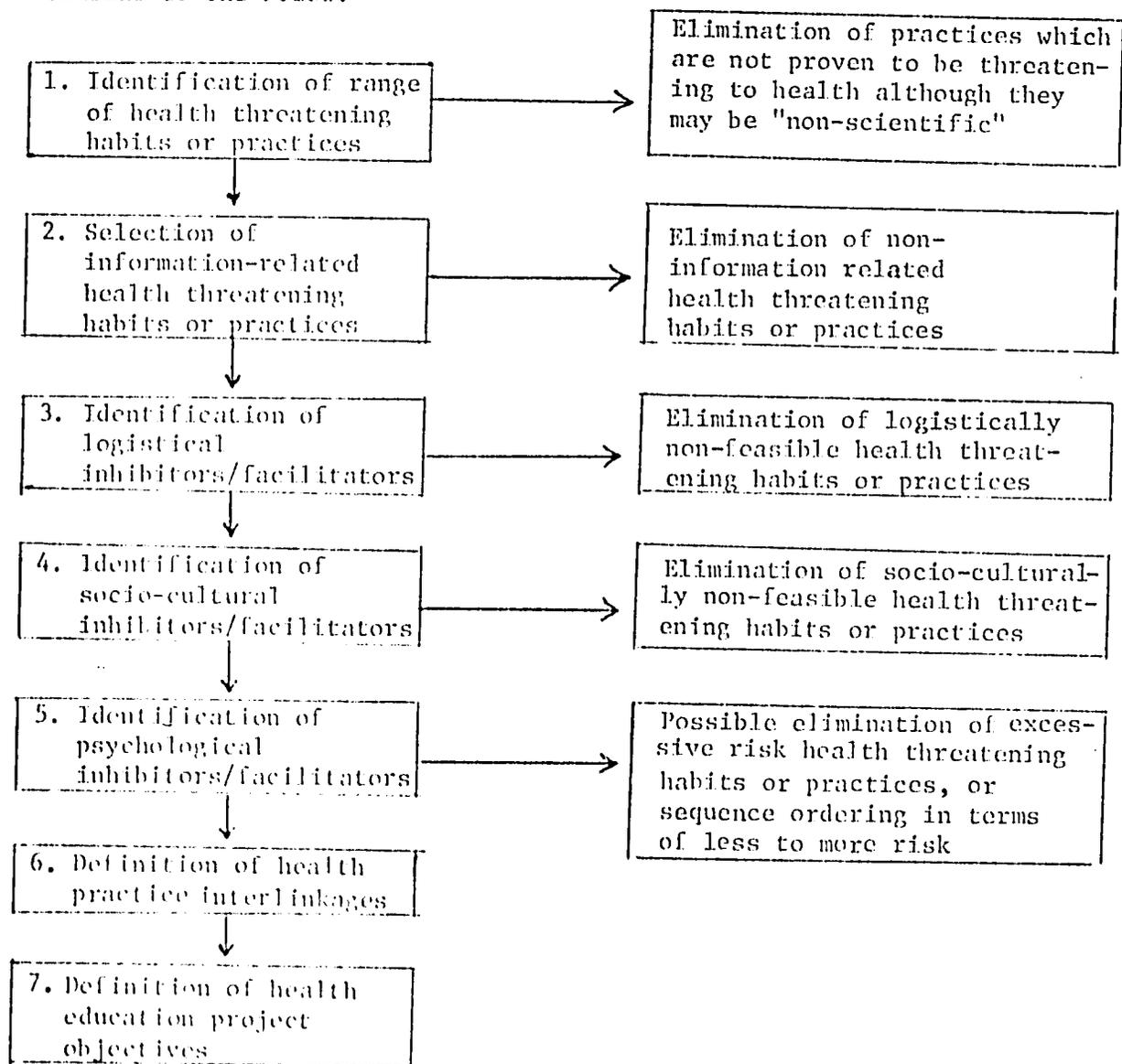
A caution: the order of decision-making is not rigid, nor are all the steps the same in every situation, but there are obvious dependencies.

3.1 On the Health Side: Definition of Objectives

- 1) Identification of range.....▶ What are the priority identifiable and widely shared health threatening practices among which kinds of people?
- 2) Selection of▶ Which are the priority health threatening practices which are caused primarily by factors such as disinterest, misinformation or passivity?
- 3) Identification.....▶ What other non-informational inputs (materials, services, etc.) if any, in addition to education-information are needed, available and accessible, to change the identified health threatening information-related practices?
- 4) Identification of.....▶ What are the social and cultural socio-cultural inhibitors/facilitators that are closely connected to and determinants of existing health threatening practices?*
- 5) Identification of.....▶ What are the absolute, psychological relative and perceived inhibitors/facilitators risks and benefits that are involved in changing health practices?
- 6) Definition of▶ What are any biologically, culturally, or health practice economically determined interlinkages among various health habits or practices interlinkages themselves that might determine the order of their change?
- 7) Identification of.....▶ From the above (1-6) what are the health education habits/practices which should become project objectives the objectives for the health education project?

*It is a mistake to think that there are only social and cultural "inhibitors" or "barriers" to change: the same kinds of factors can also be used to facilitate change. For example, the fact that the villagers only believe they should clean the village area when the important visitor arrives, and never at other times, can be turned around to become an important motivator in the communication strategy for change. Again, the fact that the mother-in-law or the sister of the household head is the one who decides health practices, can serve to assist in planning the information diffusion strategy.

In the situation where the health education planner has a considerable amount of freedom in selection of the health problem focus, his diagnosis of the health problems and relevant audience factors involved proceeds step by step to eliminate those which are not suitable for educational intervention at that particular stage, and identifying those which are. This process might be similar to the below:



3.2 On the Media Side: Definition of Methods and Procedures

The education plan should, as emphasized earlier, ideally be adapted to both health problems and the people with the problems. Its immediate objective is always the sustained change of certain health threatening habits or practices, with the ultimate objective being improvement of health status.

Relevant questions are suggested below. The dependencies with health questions should be obvious.

- 1) Identification of range.....▶ Which range of mass media of mass media available are available or potentially available for use in the situation? (e.g., in terms of economic and policy considerations)
- 2) Consideration of.....▶ Which of the media are audience constraints suitable for the audience with the health-threatening behaviors? (e.g., in terms of such factors as outreach, credibility, comprehension, cost, etc.)
- 3) Consideration of health.....▶ Which media are able to problem constraints best transmit the kinds of information to be focused on?*
- 4) Consideration of.....▶ Which media are appropriate technical constraints for the physical and social setting?
- 5) Consideration of.....▶ Which media are feasible in manpower constraints terms of manpower requirements for design, production and distribution.
- 6) Consideration of.....▶ Which media are likely to financial constraints be financially sustainable in the project?

*For example, if disease awareness is essential information and such awareness is best produced through viewing the way a person moves, television or film might be the ideal media, whereas if it is best obtained from the sound of a cough, radio is quite adequate.

- 7) Preliminary media..... selection  Given the above (1-6) which of the media choices are indicated in the present situation?
- 8) Definition of local..... support system  What organized activities exist or can be mobilized at the local level which can be effectively co-ordinated with mass media health education activities to lend them support?
- 9) Final definition of..... media-local support combination  Given the above (1-8) which is the best media-local support combination to be used for the health education project?

The decision points outlined result in selection and elimination of possibilities, as it also did in the case of health objectives.

It should be emphasized however that such decisions are not irreversible, and to some extent decision making is interdependent.

The correct asking of these preliminary questions about health problems, the problems and educational methods will establish:

1. The health goals of the health education information project in behavioral terms.
2. The primary audience to be reached.
3. The appropriate mass media to be used in their solution.
4. The general subject matter to be focused on in the education-information activities.
5. The other kinds of support activities which will have to be co-ordinated with the information plan.
6. The approximate ease or difficulty that will be involved in effecting change of behavior.

The implementation plan will have to put together the pieces of the puzzle into a workable and effective whole. Subsequent

questions such as listed below will usually have to be asked in most situations..

3.3 The Combined Approach: Definition of the Implementation Strategy

3.3.1 General questions about project design:

- How can any necessary support materials (communication or otherwise) or necessary services, be co-ordinated with the education activities so that decision to change can be effectively carried through to action?
- How can the primary local level support system be effectively mobilized and co-ordinated with mass media activities?
- How can the audience be brought together in an information-education situation which is more controllable than the unorganized "open" mass media use situation, in order to more effectively reach, monitor and affect events?
- Which individuals or groups (other than those whose habits/practices need to change) will have to be included in the primary audience or the secondary audience of communications, and perhaps given special consideration because of their influence on the key group's health practices?
- How can people themselves participate most actively in both the communication design and implementation and in associated other activities?
- If the change in habits/practices needs to be maintained either permanently or over a considerable period of time, how can it be ensured that it becomes institutionalized?
- How can actual, relative and perceived risk of the habit/practice change be minimized for the people, and the actual, relative and perceived benefits maximized, both through information and other associated activities?

- How can any locally existing development activities in other sectors be enlisted to support the health communication plan?
- How can education activities ensure that change spreads from those who have changed to those who are slow or reluctant to change?

3.3.2 Specific questions about the information design

- What is the best communications format in which to present messages?
- What frequency and degree of repetition is required for message effectiveness?
- What is the best season, day and hour to implement educational activities/
- How can all information be simplified so that traditional people with a low level of education will understand it?*
- How can the information-education design ensure that it supplies all information required to facilitate appropriate action, without overtaxing the informational capacities of the public?
- What kinds of motivations of health, social, cultural economic, political or other such nature can best be used to incentivate people to change their habits or practices?*
- How can the information transmitted be made sensitive to the local and regional economic, social, cultural, ecological and health status differences of the people to be affected?
- How can the information transmitted be made "personal" and "familiar" to the people by incorporation of known and familiar ideas, images, voices, concepts, and linguistic nuances, linking all new material to the familiar and accepted.

*It is necessary quite often to forego absolute scientific accuracy in order to simplify messages and/or put them in terms of existing knowledge and ideas of the people -- a fact which is difficult for the medical-scientific community to accept.

**Too often health education only uses health-related motivations, whereas social motivations can be much more effective. There are times when change for the "wrong" reasons is better than no change at all.

- How can the information transmitted reinforce its psychological impact through use of suitable "symbols" or "slogans" or provision of an overall "mystique" for emotional focus?
- How can two-way flow of information be set up which will allow the public to both formulate messages and respond to messages?
- How can the mass media design and the support activities be made flexible enough to respond to feedback from the audience?
- How can the total information plan not only to promote decision and action but also reward such action once it has taken place?

THE RULE: Effective mass media use for health education is planned in terms of human as well as economic, technical and health factors, which requires a profound understanding of human habits and practices.

4. HOW CAN MASS MEDIA PROJECTS ADD TO OUR KNOWLEDGE?

Feedback and evaluation research must be built into the mass media projects from the beginning to both ensure success, and to learn from success or failure.

4.1 The Need for Evaluation

The idealized situation assumes that the plans that are developed are the best of all possible plans. In the real-world situation, even the best designed and pre-tested plans usually go wrong either because of defective initial design or because of change in the conditions of operation. There are several ways in which mass media health communications projects can run into difficulty. Among the commonly encountered are:

- There are failures in transmission or distribution of information (e.g., radio stations failing to regularly broadcast spots or there being a bottleneck in the poster-distribution system)
- There can be a failure in the logistical back-up so that materials or services necessary to implement actions do not arrive at the precise moment that they are needed (e.g., vaccines)
- There can be distracting occurrences in the general environment which relegate the kinds of benefits offered by the change of health habits or practices to a very low order of priority (e.g., major agricultural disasters or the incidence of another "distracting" illness)
- There can be unexpected reactions to information in the environment (e.g., negative rumours which threaten the project success)
- There can be unexpected opposition from a certain group or groups to the information or to the behaviors proposed (e.g., by traditional health practitioners, politicians)
- There can be use of inappropriate language or terms in spite of careful design, which threatens their communications effectiveness. (e.g., misnaming of a disease)

Certain information-gathering activities can be undertaken at times to avoid, and at other times to recognize and locate problems as they arise, thus providing opportunity for corrective action. Such data can also add to our knowledge about the actual accomplishments of health education carried out this way and what such accomplishments cost.

4.2 Key Points in Evaluation of Health Education Projects

Evaluation of health education programs or projects have tended to focus on the effort involved, describing of radio broadcasts, pamphlets distributed, and so on. This does not get at practices changed or health status changed, not the costs involved. Not only effort, but also performance, adequacy and efficiency must ideally be considered in the evaluation design.

The planner should remember the below points in evaluation of health education projects:

- 4.2.1 Goals of the project need to be clearly defined, and definition of goals and methods and definition of evaluation procedures need to be planned simultaneously.
- 4.2.2 Evaluation procedures should focus on observable behaviors, with evaluation of changes in knowledge or attitudes only serving as intermediate steps.
- 4.2.3 Evaluation activities have to be built into the project from the beginning with adequate benchmark data gathering conducted prior to the information interventions; during the project, at its termination. Quite often data should also be gathered a considerable period after all other interventions have terminated to measure maintenance of change in habits or practices and long term effects, such as change in health status.
- 4.2.4 Evaluation should be considered not just a measure of success of the project's activities, but a method for making sure that the project is a success. Consequently not only mechanisms for gathering various kinds of information should be built into the project, but also mechanism for using the information gathered.

4.3 Research Data Requirements

A mass media health education project should consider the below kinds of research:

- Certain kinds of background data gathering activities: at a minimum, demographic data, data about people's health problems, and behaviors, causes of behaviors, and about people's communications attitudes and behaviors
- Pre-testing of all communications messages and related data gathering about comprehension, acceptability and effectiveness of messages
- Monitoring of all mass media messages to ensure that information gets out
- Monitoring of the intended audience's reception, comprehension, decision and action on messages

4.4 The Role of Test Versions of Projects

A national or regional health communications project at this stage of our knowledge of the field, should ideally begin with a "test-version," conducted under equivalent conditions to those of the planned larger version and already linked into the country's decision-making structure. The purpose of the test version is simply to iron out rough spots and to test any unknowns before more major investment of resources is made. The research component in this small version is proportionally larger, and cost-effectiveness research should be done. However, the larger project will still need monitoring for effectiveness, as increase in size often changes conditions.