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Development Communication Report

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To Our Readers:

After over a decade of innovation and evaluation in the field of health communication, this issue of the DCR focuses on Communication and Health: What's New, What's True? Research results, trends and case studies are represented to show the diversity of what has been learned, what remains good practice and future challenges for development communicators. Not just for those in health, this issue will inform practitioners from all fields who use communication.

-The Editor

Inside this Issue ...

HEALTHCOM:
Lessons from 14 Years in Health Communication

by Mark Rasmuson, Holly Fluty and Robert Clay

Once a misunderstood and mistrusted add-on to public health programs, health communication has now been widely embraced by governments and private voluntary organizations, by international donors and United Nations agencies, by universities, epidemiological research organizations, and non-governmental organizations throughout the world. Now after fourteen years of experience and some very convincing evaluations, one multi-million dollar health communication program reveals the lessons learned, lessons reconfirmed, and the insight gained about the future challenges of communication and development.

In 1978, the U.S. Agency for International

continued p.2

Mass Media Entertainment for AIDS Communication in Zaire

by Julie Convisser

The use of popular entertainment to convey messages of health and sexual responsibility is rapidly becoming one of the most innovative and effective behavior change approaches in health communication today. The methodology is not new; entertainment has been a forceful communication tool as long as people have sung and performed for each other. But now, health communicators are recognizing the power of entertainment and the mass media for health promotion. And the beat plays on...

Nowhere has AIDS hit harder than in east central Africa. In Zaire, the HIV or AIDS virus is officially estimated to be carried by 6% to 8% of those who live in major cities and over 3% of the rural population. Unofficial reports show the rates to be much higher. In the absence of a vaccine or cure, communication

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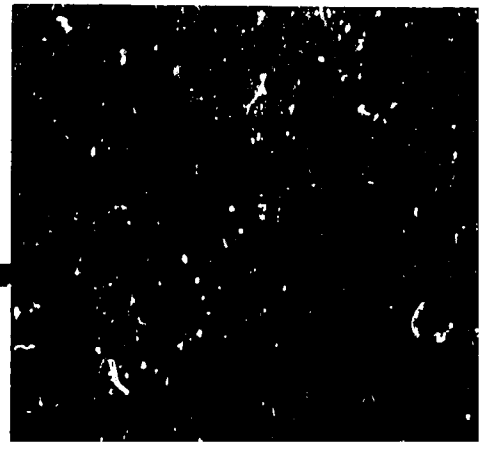

Development Communication Report

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Lessons Learned, cont'd from p. 1

Development launched an innovative research-and-development project in two countries, Honduras and The Gambia. Called the Mass Media and Health Practices Project, the purpose of this effort was to explore how a systematic communication approach could help teach rural villagers an emerging new health technology: oral rehydration therapy (ORT).

From this modest beginning, A.I.D.'s investment in health communication has grown into a sustained 14 year $50 million dollar program implemented by the Academy for Educational Development known as Communication and Marketing for Child Survival (HEALTHCOM). HEALTHCOM has provided technical assistance to the child survival programs of more than 35 countries, and played a global leadership role in health communication and social marketing. Over the years, two key research and development objectives have been maintained: (1) continued refinement of an effective communication methodology, and (2) rigorous evaluation of the methodology's application in specific countries.

The 5-step methodology pioneered by the initial project in Honduras and The Gambia—Assess, Plan, Pretest, Deliver, and Monitor—(Figure 1) has gone through many twists and turns through the years. While the process has been delineated variously by those working in different development technologies, at the heart of the process is one central concern — the consumer comes first. HEALTHCOM takes this priority seriously and program decision making systematically reflects the consumer's perspective in program planning through formative research, testing of communication materials, and monitoring of program effects.

Between 1985 and 1991, the Center for International Health and Development Communication (CIHDC) at the Annenberg School for Communication, University of Pennsylvania conducted 10 major pre- and post-intervention survey studies of HEALTHCOM programs in eight countries. The results of these studies afford a wealth of information about health communication. This article summarizes some of the most important of these lessons and challenges.

Lessons Learned

Lesson 1: Health communication works.

HEALTHCOM's programs have demonstrated definitively that health communication can work in the broadest sense — to increase immunization coverage, use of ORT, consumption of vitamin A capsules, and improve breastfeeding and other healthy practices.

- In four out of six sites where HEALTHCOM supported immunization programs relative coverage rates ranged from 25 to 85 percent.
- In Lesotho, the communication program helped boost ORT use from 39% to 60% and any treatment of a diarrhea case from 58% to 75%.
- HEALTHCOM's media campaign in Jordan contributed to an increase from 38% to 56% of mothers who initiated breastfeeding within six hours after their child's birth.
- In Central Java, Indonesia, vitamin A capsule consumption increased from 24% to 40% in districts with a health post following a one year communication effort.

Lesson 2: It doesn't work by itself.

Communication by itself is rarely enough to change health behavior. People must have the opportunity to perform a recommended behavior and the environment must be able to sustain the behavior change. Elements such as access to an immunization service, access to oral rehydration salts (ORS) or condoms, and/or physicians and nurses who support healthy practices must be considered. In HEALTHCOM's experience in Ecuador, for example, immunization rates were dramatically improved as a result of a combined service delivery/ communication approach, whereas the use of oral rehydration salts was improved only temporarily by communication in the absence of a continuous supply of ORS. In Jordan, increases in early initiation of breastfeeding following a communication campaign were much higher in public hospitals, where physicians and nurses supported early initiation, than in private hospitals where they often did not.

Lesson 3: It does more than create demand.

The creation of demand and motivation for higher use of health services have been important functions served by health communication programs. But they have not been the only functions served. Communication programs have had important positive "side effects" beyond their principal demand creation objectives. In the Philippines, for example, HEALTHCOM's communication campaign on measles did indeed significantly increase measles immunization coverage. Yet it also had a positive effect on the timeliness of measles immunization, and boosted coverage rates for other immunizations as well.

Lesson 4: It works differently for different interventions.

Different health interventions require different communication strategies — some inherently more difficult than others. Teaching how to mix an oral rehydration solution in the home is a thornier communication challenge than informing parents where and when to go for their child's next immunization. Even for the same intervention, the communication issues vary depending on the "maturity" of the program and the special problems it encounters. HEALTHCOM has found, for example, that increases in immunization coverage are easier to achieve through communication in programs with relatively low coverage rates at the start than in programs with higher rates. Moving a program from 70% to 90% coverage, which often means targeting hard to reach groups like the urban poor, is harder than boosting rates from 40% to 70% using a standardized informational campaign approach.

Channel	% Exposed (a)	Effect of Exposure (b)	Channel Effect (a) x (b)
Clinic	22%	18.1%	4.2%
Outreach	16%	20.1%	3.2%
Radio	60%	13.6%	8.2%

Lesson 5: It may not work as dramatically as public health officials expect.

Public health officials often have unrealistically high expectations of how communication can help a health program, setting short-term goals of 80 per cent immunization coverage or 60 percent adoption of a new health technology like ORT. Such goals can inadvertently set up communication planners for failure and disappointment.

Lesson 6: Interpersonal channels are important.

A longstanding tenet of development communication theory and practice is that interpersonal communication is vital in motivating behavior change. HEALTHCOM's research results confirm that tenet. In Swaziland, for example, CIHDC's research found that clinic staff and outreach workers were more effective channels in increasing knowledgeable use of ORT than radio. Each type of interpersonal contact was associated with a 20% greater likelihood of appropriate use of ORT, while heavy contact with the radio was associated with about a 13% greater likelihood of appropriate use.

Lesson 7: But so are the mass media!

In the Swaziland example cited above, health workers reached only 22% of the population and outreach workers only 16%, while radio reached nearly 60% of the population. Thus, even though it was less effective per contact, because radio could reach many more people, it was more effective overall. By one calculation (table), CIHDC concluded, 8.2%

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Lessons Learned, cont'd from p. 3

more of the entire population was using ORT appropriately as a result of exposure to radio, while only 3.2% resulted from contact with interpersonal sources. CIHDC's other evaluation studies supported this finding: in the 16 interventions they studied, exposure to mass media messages was sharply associated with the level of program success. Of the 6 programs operating in environments where only light exposure to mass media was achieved, only 2 were considered successful. Of the 9 programs which achieved high media exposure, 7 were associated with substantial change in behavior.

Lesson 8: It needs to be sustained.

HEALTHCOM's programs have consistently demonstrated a clear correlation between different levels of communication programming and rises and falls in the practice of new behaviors. The fact that some level of communication needs to be maintained in order to sustain new behaviors is old news in the world of commercial marketing and advertising — Coca Cola keeps on spending millions in advertising even though it is the market leader. Unfortunately, it is another fact not always well appreciated in the public health community where another mistaken expectation is that once a communication program has helped boost a new health product or practice, it is there to stay.

Lesson 9: It must be multi-disciplinary.

Effective health communication is a mix of science and art — a blend of solid consumer research and highly creative design. It continues to be influenced by many other disciplines. Marketing has been particularly important in providing an overall planning framework which includes supply elements as well as demand. Social and behavioral psychology, anthropology, and epidemiology have also been influential. In practice, health communication requires the collaboration of a team of program managers, researchers, and communication professionals — each contributing their special expertise.

Lesson 10: It is difficult to institutionalize in developing countries.

Good health communication requires capable well-trained professionals and resources for critical activities like formative research, media production, and program monitoring. While policy makers in many developing countries are now embracing the potential of health communication to improve public health programming, Ministries of Health, often strapped financially, are still lagging behind in committing the resources necessary to enable trained health communicators to effectively practice their profession.

Challenges for the Future

The final three lessons underscore two of the major challenges which face health communicators in the future: (1) How can health communication programs best be designed for developing countries to support multiple interventions over the long term at an affordable price, encompass strategies and resources for both sustaining behavior changes achieved in the past, and target new behavioral challenges as required? (2) What more can be done to enhance the prospects for institutionalizing an effective health communication capacity in developing countries? Three strategies currently being followed by the HEALTHCOM Project are:

- to strengthen health communication curricula in developing country training institutions;
- to develop streamlined methods of research and planning which can be more easily adopted in developing world settings; and
- to conduct communication cost studies which will demonstrate to policymakers the cost-effectiveness of health communication.

Another challenge is posed by shifting epidemiological patterns in much of the developing world. As patterns of morbidity

and mortality shift more in the direction of the "lifestyle diseases" characteristic of industrialized countries (e.g. heart disease), health communication, as a key influence on health behavior, becomes ever more important. But it also becomes more difficult: motivating a prevention behavior which has no immediate positive consequence is inherently harder than motivating a treatment behavior which cures an illness. This challenge calls on health communicators to sharpen communication strategies. In environments which are cluttered with thousands of competing messages, effective health communication programs will need to develop strategies which:

·Target specific audience **segments.**

·Account for where people are on the **behavior change** spectrum, from awareness through intention, trial, and adoption.

·Offer people a genuine **opportunity to behave** in a new way.

·Promote **benefits** people want.

·Mitigate **barriers** to new behaviors.

·Appeal to the **emotions** as well as the intellect.

Mark Rasmuson is the Vice-President for Health Programs, Asia Region, for the Academy for Educational Development (AED) and a senior advisor for the HEALTHCOM Project. He was Director of HEALTHCOM from 1985-92. Holly Fluty is the Cognizant Technical Officer for HEALTHCOM and Robert Clay is the Chief of the Health Services Division, in the Office of Health, Agency for International Development. For more information about HEALTHCOM, contact AED at 1255 23rd St., NW, Washington D.C. 20037. tel: (202) 862-1900, fax: (202) 833-6617; or the Office of Health, Bureau for Research and Development, USAID, Washington D.C. 20523-1817, tel: (703) 875-4526, fax: (703) 875-4686. For additional information about the evaluation results, contact Robert Hornik, CIHDC, Annenberg School for Communication, University of Pennsylvania, 3620 Walnut Street, Philadelphia, PA 19104-6220 USA (215) 898-7057, fax: (215) 898-2024.

How to Conduct Focus Groups:
Researching Group Priorities Through Discussion

How many times have health projects failed because project designers did not understand the priorities and beliefs of a community? Conducting focus groups is one way to open up dialogue with community members and uncover hidden beliefs and agendas.

Focus group discussions enhance the project process for several reasons. They give diverse community sub-groups the opportunity to express concerns and have a voice before the project begins. They stimulate ideas and conversation which may not emerge during a one-on-one interview. And they allow project monitors to have a baseline of information to which they can later refer to see if group attitudes or priorities have evolved.

Beliefs are not always consistent across a community. Mothers of small children may have a different interpretation of oral rehydration therapy than women who do not have children. Factory workers may appreciate the implications of urban pollutants differently than religious leaders. The focus group gives an outsider the ability to understand important differences and come to some conclusions about overall attitudes.

In order to ensure that the data collected is meaningful, it is important to have a discussion outline and to focus the groups upon particular areas of concern. Here are other guidelines on how to make focus groups effective and keep sessions consistent across distinct sub-groups:

- Each session should last between 60-90 minutes
- Groups should consist of 8-10 participants
- Sub-groups should represent the diversity within the community.
- Sessions should inspire a sense of openness and comfort (for example, beginning with songs or stories)
- Topics of discussion should be consistent across groups.
- Groups should be designed so that individuals are minimally inhibited (for example, if farmers are dependent on middlemen, they may not be as candid if middlemen are present)
- Questions should be carefully designed to not reveal a facilitator's bias
- Discussions should be focused and facilitated, but should not direct the group to "right" or "wrong" conclusions
- Information shared within the groups should be kept confidential. Members should discuss this point.

While they may not provide all the data needed to make qualitative comparisons, focus groups can be an excellent mechanism to learn about a community and the positions of its sub-groups. Quick, easy and informative, they may reap unexpected results.

HEALTHCOM

This focus group in Malawi begins with songs.