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5. Author(s)

1. Anne Roberts
2. Reynaldo Pareja
3. Will Shaw
4. Barbara Boyd

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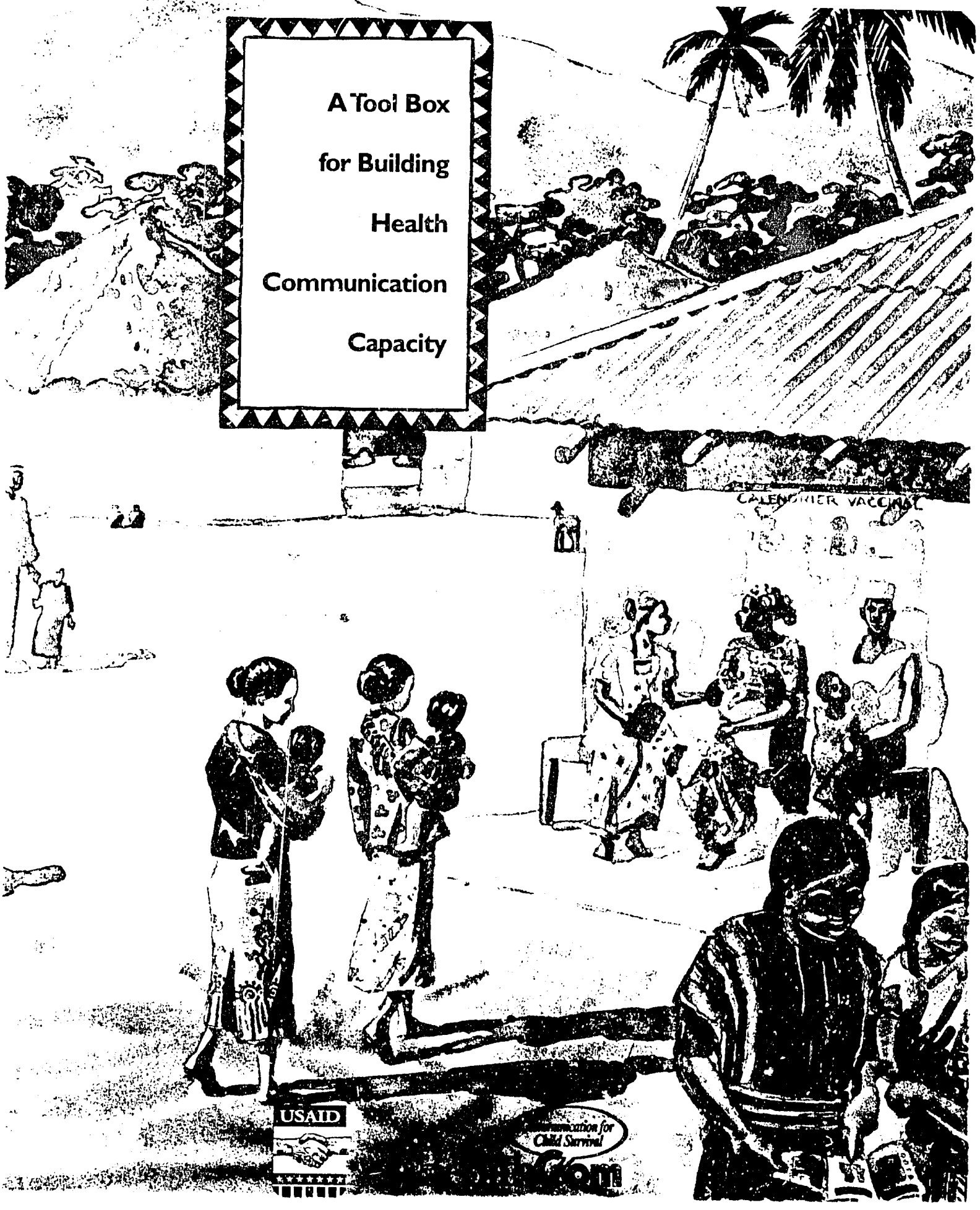
A Tool Box for Building Health Communication Capacity



PN-ABU-931

A Tool Box for Building Health Communication Capacity

USAID

Communication for Child Survival

HealthCom

The work described in this document was funded by the HEALTHCOM or Communication and Marketing for Child Survival Project which is a project of the Office of Health and Nutrition of the Bureau for Global Programs, Field Support, and Research of the US Agency for International Development (USAID). The project is being conducted by the Academy for Educational Development (contract no. DPE-5984-Z-00-9018-00) and its subcontractors: the Center for International Health and Development Communication of the Annenberg School for Communication at the University of Pennsylvania, Applied Communication Technology, Birch & Davis International, The Futures Group, The Johns Hopkins University, and Porter/Novelli. This document does not represent the views or opinions of USAID.

Academy for Educational Development
Social Development Division
1255 23rd Street, NW, Washington, DC 20037

April 1995

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INTRODUCTION

The past three decades have seen a quiet but dramatic revolution in health education programs. International health organizations, ministries of health and PVOs recognized not only the essential role that prevention and health promotion play within health care systems, but they also recognize the contribution that a modern health communication methodology offers to these programs and to the well-being of their people. The challenge now is how to carry out effective health communications programs.

This Tool Box was developed as a collection of practical, field-tested tools that can be used as needed by the many practitioners of modern health and social communication throughout the developing world. These materials include a wealth of ideas, models, concepts and strategies, crafted in the field under the pressures of real-life and real-time logistical barriers, cultural contexts, personalities differences, and funding problems. The methodology outlined in Section I of the Tool Box and presented in detail in Section II is the result of 17 years of experimentation and refinement by a series of three health communication projects in more than 40 countries, funded by the U.S. Agency for International Development (USAID) and implemented by the Academy for Educational Development (AED).

This collection of materials is designed to help managers of health communication programs meet the dual challenges of—

- improving their unit's organization and credibility; and
- strengthening their personnel's communication skills and confidence in their ability to apply the communication methodology described in the Tool Box.

Because the tools are drawn from field experience, they provide more detail and support in some technical areas than in others. Examples and materials have not been created where none existed. The Tool Box can be used for occasional support, choosing a tool that is needed at a given moment, or as a continuing staff training program for health communication personnel that need stronger skills, greater confidence, or examples and prototypes of successful programs. Above all, these materials provide a structure that can guide you through the process that is at the heart of health communica-

tion. In the same way that a surgeon will have all of the instruments he may need readily available, a given operation may only require several of them. In the Tool Box, HEALTHCOM has provided tools that meet the program needs that its staff and counterparts have identified in 17 years of implementing health communication projects worldwide.

These materials reflect the hard work, imagination, excitement, commitment, persistence and creativity of counterparts and resident advisors in programs in more than 40 countries. They can guide those new to health communication as well as those who wish to sharpen specific skills for more effective programs.

The History of These Materials

Historically, health education has relied upon the techniques of formal education under which most medical professionals had been educated. This model of education was basically a one way, teacher-dominated delivery system of information from the expert source to the uninformed learner. The assumption in health education was that people, once being told what they should do by doctors or nurses, would then proceed to follow those instructions. A failure to do so was seen as a failure on the part of the "learner" rather than the "teacher" or of the method of teaching.

Over the last decades, health professionals have begun to see that this traditional, one-way approach was not achieving great success, particularly in comparison with approaches being tried in other professions. Using principles of adult education, educators had responded to the fact that adults learn differently than children do and developed new approaches that build on the greater life experience of adults, their need to be respected as equals and given practical solutions to their problems. The value of involving learners in both the identification of their learning needs and the selection of learning activities became clear. Educators applying these principles of respect for the learner, participation, experiential learning, and practical objectives saw great gains in the impact of their educational programs.

Health professionals also saw that companies like Coca Cola and Nike were highly successful at using mass media and other communication channels to sell their products to a mass audience while health educators were hard pressed to get their clients to follow their exhortations to adopt healthier behaviors. Some marketing professionals and health educators joined together to try to use marketing methods to "sell" their socially valuable "products" such as immunizations and ORS to the public. They adopted the marketers' approach of placing the consumer at the center of all their planning, using market research to identify the segments of a population that would most likely be consumers of their products. These research methods were also applicable to the study of health attitudes and practices of these segments. In addition, the world-wide expan-

sion of communication technologies (e.g., radio, television, and offset printing) provided the communicator with a wider range of powerful tools. All of these developments led communicators and health professionals to move towards a new and more effective method of promoting more healthy behaviors through a merging of these disciplines and arts.

The Healthcom Projects

The HEALTHCOM (Health Communication for Child Survival) projects (1978-1995), applied a social marketing framework to achieving behavior change, drawing upon relevant knowledge from marketing, communication, behavior analysis, nonformal education, and medical anthropology. Long-term and short-term technical assistance was provided to more than 40 countries. Collaborative relationships were formed with ministries of health, departments of health education, international agencies (e.g., WHO, UNICEF), regional organizations (e.g., INCAP, SEAMEO, PAHO), international and national PVOs (e.g., Helen Keller, International and Save the Children), private sector (Johnson & Johnson) and numerous universities.

This sequence of projects began with the Mass Media and Health Practices Project (MMHP) in 1978 when USAID awarded a contract to the Academy for Educational Development (AED) to develop a systematic and multidisciplinary methodology for creating health behavior change among large populations. During this research and development phase, programs were carried out in The Gambia, Honduras, Ecuador, Indonesia, Peru, and Swaziland, which focused on the promotion of oral rehydration therapy and other key objectives of national efforts to combat diarrheal disease in young children. Results from the main sites showed major impact upon the use of sugar-salt-solution in The Gambia (rising from 2% usage to 80% usage after two years of communication efforts) and strong increases in the use of oral rehydration salts in Honduras. These successes led USAID to sponsor a follow-on project to test the methodology in other countries and apply it to more child survival interventions.

In 1985, HEALTHCOM began a new project with the mandate to test and refine the communication methodology developed by MMHP for a wider range of child survival technologies and cultures. The Annenberg School for Communication of the University of Pennsylvania was contracted to conduct quantitative baseline and impact studies in sites in eight countries. A team of behavioral researchers was also organized to look into specific issues regarding health behavior change.

HEALTHCOM conducted long-term programs in Africa (Lesotho, Malawi, Nigeria, Zaire); Asia (Indonesia, Papua New Guinea, the Philippines); Latin America (Ecuador, Honduras, Guatemala); and the Middle East (Jordan, North Yemen) expand-

ing child survival interventions to include control of diarrheal disease, an expanded program of immunizations, acute respiratory infections, vitamin A, breast-feeding, child spacing, and malaria.

In August 1989, USAID awarded a third contract to AED to implement the final phase in the HEALTHCOM project sequence. This project continued technical assistance to developing nations, but it emphasized the institutionalization of the methodology and the sustainability of behavior change. HEALTHCOM sought to refine and simplify the methodology to make it more easily used and maintained by host country governments, universities, and other private institutions. Long-term assistance was provided to Burkina Faso, Egypt, Mali, Senegal, Yemen, Honduras, Peru, Indonesia, and the Philippines. Health problems addressed included most child survival interventions plus programs affecting adults, such as river blindness, cholera prevention, and marketing skills for hospitals moving to a cost recovery policy.

The result of these projects was the creation and refinement of a systematic, multi-disciplinary communication methodology which could create behavior change among large segments of the population if applied correctly. Fortunately, USAID was farsighted enough to make the documentation of this experience a major priority of all three projects, thus leading to the production of numerous books and articles. A complete description of the methodology and its application in developing nations can be found in *Communication for Child Survival* while the lessons learned from the first decade of HEALTHCOM can be found in *Results and Realities.* The HEALTHCOM approach to behavior change is detailed in the book *Communication for Health and Behavior Change.* Field strategies and techniques that were used in country projects are found in *Notes from the Field in Communication for Child Survival* and *Unlocking Health Worker Potential.* These publications and twenty others are available free of charge to public health professionals from the developing world. With the close of HEALTHCOM in April 1995, distribution of these documents will be managed by the Dissemination Coordinator, BASICS Project, 1600 Wilson Boulevard, Suite 300, Arlington, VA 22209, USA.

Acknowledgements

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Lynne Cogswell contributed a sound organization and clear writing to the effort, Jane Vella provided clarity to the adult learning approach.

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Material was liberally drawn from *Communication for Health and Behavior, A Developing Country Perspective* by Graeff, Elder and Booth, and *Appropriate Research Technology for Planning Evaluation and Improving Child Survival Programs (A.R.T.)* by John Elder.

Although it is not possible to thank all of HEALTHCOM's resident advisors, counterparts, and colleagues in the field, we provide a partial list of these individuals. It is they who originated and tested the ideas, materials, concepts, and forms included in the Tool Box. We also provide a list of the technical officers from the U. S. Agency for International Development's Office of Health who oversaw the HEALTHCOM projects.

Healthcom Resident Advisors and Counterparts

Countries	AED Advisors	Counterparts
Burkina Faso	Carolyn Elliot-Farino	Abdoulaye Traore
	Inge de Vries	Alassane Ouedraogo
	Wilnia Meeus	Nemat Kazemi
		Leonard Tapsoba
Ecuador	Reynaldo Pareja	Marco PoloTorees
		Ilka Andino
		Carmen Laspina
		Martita Marx
		Ligia Salvador
		Eduardo Salazar
Egypt	Dana Faulkner	Hassan El Kalla
		Nihal Hafez
		Mohammed Edrees
The Gambia	Mark Rasmuson	Sekou Dibba
		Saihou Ceesay
		Amie Joof-Cole
Guatemala	Jose Romero	
Haiti	Robert DeWolf	

Honduras	Reynaldo Pareja	Arturo Diaz
	Jose Ignacio Mata	Maria del Carmen Miranda
	Partricio Barriga	Luis Sarmiento
		Hector Valladores
		Luis Montoya
		Fanny Mejia
Indonesia	John Davies	I.B. Mantra
	Terry Louis	Victor Sartono
	Tom Reis	Neni Surani Sulaeiman
	Mark Rasmuson	Omaj Sutisnaputra
	Tjep Marku	Rahardju Sawandi
Jordon	Anne Roberts	Sima Bahous
		Ayman Abulaban
		Abee Hamdan
Lesotho	Edward Douglas	
Malawi	Deborah Helitzer-Allen	
Mali	Souliman Baro	Sekou Drame
Nigeria	Tony Agboola	Felicia Henshaw
Papua New Guinea	Andy Piller	
Paraguay	Jose Maria Espinola	
Peru	Luis Medrano	Maria Luz Perez
		Ruth Perez
		Duani Puertas
Philippines	Jose Rafael Hernandez	Manual Dayrit
		Mario Taguiwalo
Senegal	Elenora de Guzman	Bilal Fall
		Ibrahima Leye
		Nbaya Diop
		Animata Sene
Swaziland	Dale Huntington	
Yemen	Syed Jehangeer Haider	Mohammed Al Hamly
		Adel Barakat
		Ali Yeslam
Zaire	Joan Schubert	Tony Musinde
		Mongolo Molengi
		Musinde Sangwa

Academy for Educational Development

William A. Smith
Cecilia Verzosa
Anne Roberts
Elizabeth Mills Booth
Clarence Hall
Alan Andreasen
Carmen Falcon
Robert Letourneau
Mark Rasmuson
Renata Seidel
Sylvia Lopez-Gaona
Sandy Del Prado
Diana Urban
Julia Rosenbaum
Ann Bergin
Kristin Cooney
Willard D. Shaw
Judith Graeff
Joseph Diederich
Elayne Clift
John Elder
Ximena Sheehy-Downey
Diane Mason
Laura Shafuly

USAID/Cognizant Technical Officers

Anthony Meyer
Robert Clay
Holly Fluty
Melody Trott

SECTION I

MANAGERIAL TOOLS

MANAGER'S GUIDE TO BUILDING A COMMUNICATIONS CAPACITY

This guide is intended for managers of governmental, PVO, and NGO health education units who wish to strengthen their organization's capacity to do modern health communications. Whether you represent an large health education unit that is well-established or a smaller unit that is just getting started, this guide should be useful in helping you to assess the status of your unit, analyze the environment in which your unit is working, and help plan how your unit can increase its effectiveness. This guide presents a diagnostic process involving a series of basic questions—one set of questions for looking at the environment surrounding your unit and another set for looking internally at your unit. The chart on the following page provides an overview of this process. By answering these questions in relation to your own situation, you will collect the information required to make wise decisions on how your unit can grow into an effective instrument of health communications.

This planning process will identify areas of need for your unit. In some cases, there are "tools" in the Tool Box that will help you address these needs. Although this guide is intended for managers, the process of organizational development works best if other staff members are included in the discussions. By doing so, you get realistic ideas from the people doing much of the work, and you also begin to develop support for the changes that you may eventually make.

Assessing Your Environment

Before examining your own unit in detail, it is important to first complete an analysis of the environment in which your unit operates. This external assessment will provide you with an overall picture of who is active in the communications area, where you might find support for your activities , how you can avoid unnecessary duplication of efforts with other organizations, and what "niche" or market your organization should serve. In marketing terms, your health communication capacity is the "product" that you have to "sell." You need to understand the surrounding environment to be able to tap the resources available to you and to serve the different audiences that will benefit from your product. As you create this picture, you and your staff should ask yourselves the following questions and then map out the environment surrounding your organization.

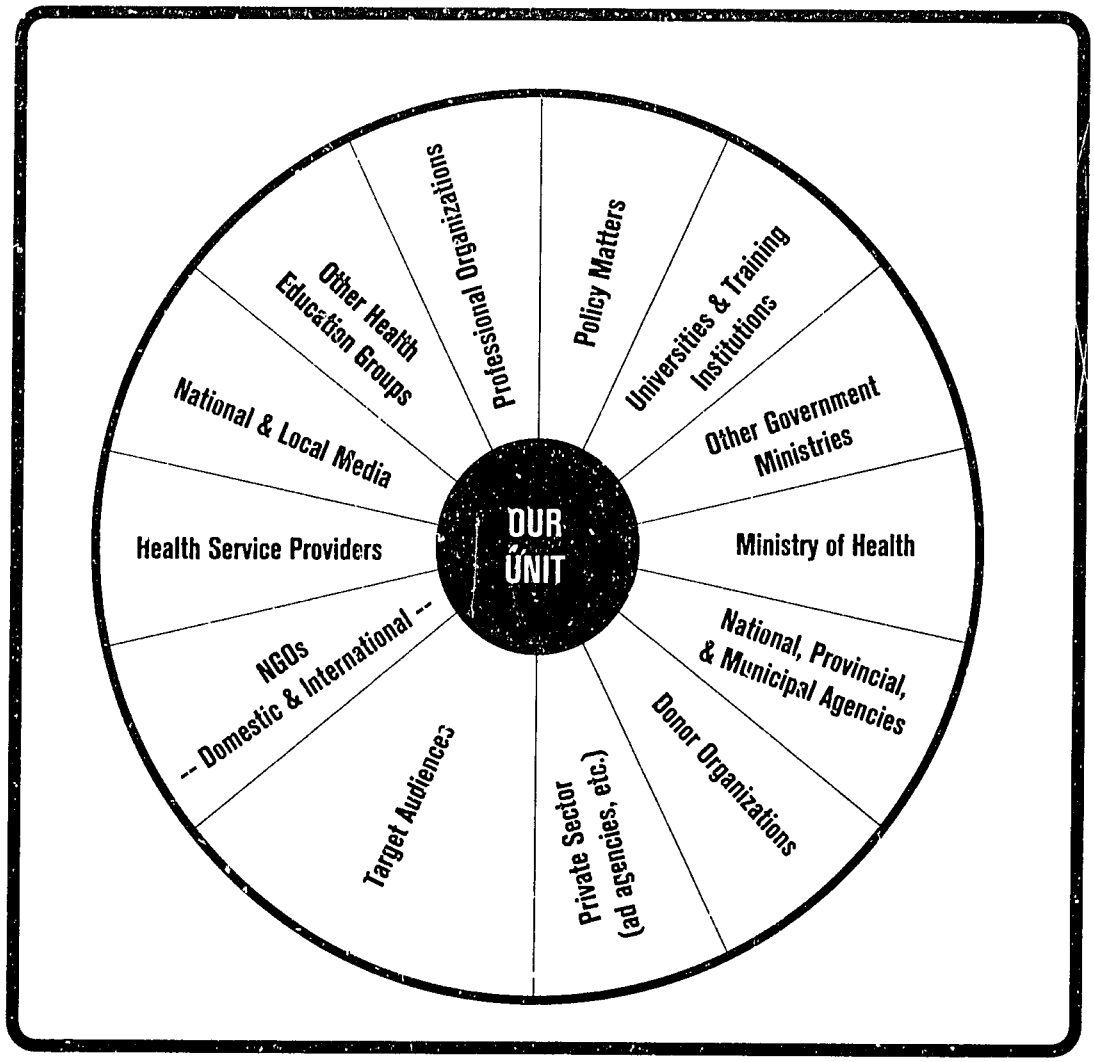
What are the groups that may interact with our organization?

You need to identify all the organizations, departments, and groups that will come in contact with your unit and perhaps have an impact on your work. This includes groups you are currently working with as well as other groups with whom you might work with in the future. All groups active in similar public health or communications activities should be identified. You should include groups at each geographical and bureaucratic level you operate: national, provincial, district, village.

What is the relationship of these groups to our organization?

Do they direct or supervise your work? Do they support your work or help finance it? Do they benefit from your work? Are there groups that are particularly skilled in an area of communications such as materials development or evaluation who may be hired to do some of your work, thus saving you the cost of creating your own capacity?

PARTNERS IN SUSTAINING HEALTH COMMUNICATION



Who are or should be the main clients for our current and future services?

Your clients include those in the community whom you wish to serve as well as those in positions of control and influence over what you do. The intended beneficiaries of your work might be the general public or a subset of the population, such as children or mothers. An NGO, for example, may be created to serve a specific group of clients in the community, such as sexually active adults who are at risk from AIDS. You probably have another set of clients who direct your work. If your unit is part of the government, there may be officials such as a minister of health or department directors who will largely determine what activities you do. Foreign donor agencies or private companies may also be influential in setting your objectives. You should consider the future outlook for continued support from each of these client groups. Do you need to broaden your client base, either in terms of upper level influential people or community groups that benefit from your health educatic services?

Who are the key decision makers affecting our daily work?

Who supervises or directs your unit's agenda? a government minister or director? a private board of directors or advisory council? What can you do to keep them informed of your unit's successes and needs? What can you do to build and sustain their support for your unit?

What are the health interventions that our unit plans to address?

A clear picture of the public health situation affecting the people your unit seeks to help is an important starting point for making decisions on your unit's goals and priorities. Data may be available from epidemiological studies which can identify the major health problems that are endangering your chosen clientele. You will need to understand the extent and severity of these problems so that you can allocate more of your resources to the problems seriously affecting the greatest number of people.

What are our key funding sources?

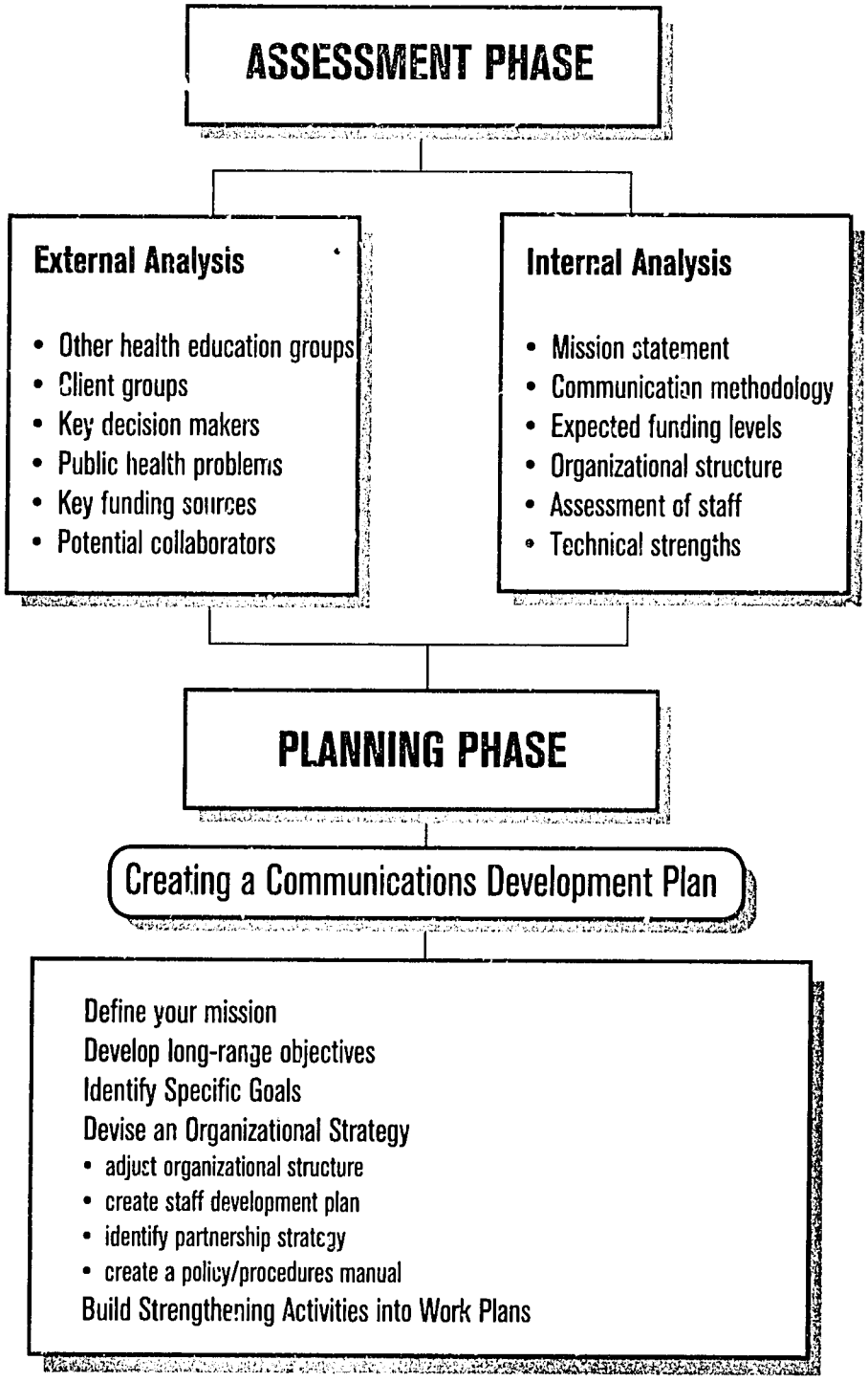
Do your funds come totally from the government? foreign donors? private companies? public contributions? other sources? Who determines the flow of funds into your unit? Are there other potential sources of direct or matching funds that you should explore, such as private companies, the Chamber of Commerce, etc. Is there a way of increasing the resources available to you by cost-sharing some activities with other organizations or by getting in-kind contributions from other groups?

What groups are the ultimate audiences for our health communication materials?

Although the ultimate beneficiaries of your activities may be a specific group of the population such as children, your unit will probably have to work with other groups of

people who are involved in providing health services to your clientele. You may find a need to develop communication materials for doctors, nurses, or other health workers. Perhaps your work may require the creation of point of purchase materials for pharmacies or "detail men" who promote pharmaceutical products to doctors.

Process for Building a Communications Capacity



What other organizations are currently involved in similar health interventions and working with same audiences?

What groups are active in health communication? Are they focused on a specific geographical region or specific health issues? Can you increase the impact of your unit by sharing information, materials, staff, or funds with these other groups? Do your planned activities greatly overlap with the activities of other organizations? If so, you should consider rethinking your unit's goals and target audience?

How can our organization's relationships with other groups be strengthened to increase political, financial, and community support for our unit?

Do the people overseeing your funding or staffing levels need to be better informed of the importance of your projected activities and record of achievement? Are there community groups that would be good collaborators for the implementation of programs? Would some groups make strong advocates for increased funding and political support of your activities?

Once you have answered these questions and mapped out the organizations and groups that relate to your unit, you will have a good picture of the environment in which you work. (An example of such a map is presented on the following page.) You should make a special effort to identify new groups that are potential collaborators, new relationships that can help you in your work, and strategies for utilizing old relationships in new ways. This external assessment may also lead you to reconsider the goals of your unit and your operational plans if you find your proposed activities overlap too greatly with other organizations.

Assessing Your Own Organization

Having completed the external assessment, you will have a better idea of the resources you may tap, the obstacles you face, the opportunities that exist for increased collaboration and support, and the role that your unit can successfully play. With a clear picture of this environment, you will be better able to assess the internal structure and capacity of your own organization by asking yourself the following questions:

1. What is the mission of our organization?

Your unit should have a mission statement clearly identifying the overall purpose for its existence and the goals of its proposed efforts. It answers the question: "Why was this organization created and what does it aspire to achieve." This mission statement serves as a compass to allow you and your staff to assess if you are going in the right direction and to make decisions on what programs to initiate. A good mission state-

ment also serves to motivate staff members by providing them with a higher goal than just their own job responsibilities and a clear idea of what the organization hopes to accomplish.

2. What is the communication methodology that will guide our work?

To be able to design and implement effective health communications programs that cause positive behavior change, your unit needs to have a rigorous technical methodology that governs the work of your staff. This methodology should provide your staff members with a standard process that they can follow in developing materials and programs. In this way, you can maintain the quality of your work. If all staff members are trained in this process, they will be able to work together well and produce communication materials and programs that are sound and effective. In organizations where there is a high turnover of staff, the guiding methodology can also be a tool for maintaining the continuity and quality of your work. New staff can be brought into the unit and trained in the methodology, ensuring that they will fit well into your system and work according to the common model.

The methodology you choose should have at least four characteristics. It should be:

Systematic - having clear steps to be followed to create a complete, functioning communication approach
Multidisciplinary - drawing from the fields of mass communication, social marketing, nonformal education, behavior analysis, medical anthropology, etc.
Behavior-Oriented - focusing on the creation of behavior change as the ultimate product of health communications, nor just awareness-raising or information-sharing
Flexible - able to be applied to a wide range of health communication problems

The health communication methodology developed by the HEALTHCOM projects has been effective in promoting behavior change in dozens of developing nations and merits your consideration. A summary of this methodology is provided in this section of the Tool Box. Details on how to implement this methodology and train others in its use can be found in Section II.

3. What are the current and future funding levels for our organization?

What you can accomplish and the extent to which you can build your communications capacity will largely depend upon the financial resources that you receive or are able to attract. If you are a government unit, you can usually rely on a basic budget each year to maintain a core staff and office, although the exact amount may fluctuate from year to year. A PVO may rely totally on donations which may also fluctuate significantly each year. If you are planning to expand your capacity, you need to look for ways to

maximize and stabilize your regular sources of income and to explore new sources of funds. International donors such as USAID or UNICEF may be a source of additional funds for program activities. Private sector groups like the Chamber of Commerce or Lion's Club may support specific public health programs through the provision of funds, equipment, or media time. Private companies may collaborate in a specific program by paying for the production of materials or providing pro bono services such as staff time for the design of an advertising campaign or evaluation plan.

Public sector and NGO managers need to learn to think like entrepreneurs. An energetic manager may be able to find innovative ways attracting additional funds for program activities. The assessment of the external environment should result in the identification of possible sources of such funds. The manager should also learn about the types of activities that other groups normally fund. Are they more likely to provide equipment, funds for materials production, technical assistance or in-kind contributions? Whatever their funding priorities, most donor agencies are much more likely to fund a well-designed plan that identifies specific inputs and outputs than a general request for money for equipment purchase or vague program ideas.

4. What is our current organizational structure?

In looking at the structure of your own unit, you should ask yourself the following questions:

- Does you unit have a hierarchical structure with clear lines of authority?
- Are there different sub-units within your organization?
- Are those sub-units arranged by functional areas (e.g., research, materials development), geographic responsibilities, type of intervention (e.g., immunization, nutrition) or some combination?
- How many staff are assigned to each sub-unit?
- Do they have detailed job descriptions for their positions?
- Is the size of each sub-unit appropriate to the level of work assigned to that unit?

After answering these questions, you should be able to create an organizational chart which displays most of this information.

5. What are the job responsibilities and skill levels of our staff members?

The most important components of any capacity-building effort are the human resources who will provide the creativity, dedication, and effort to create and deliver effective communication programs. One of the first steps towards strengthening capacity is to take an inventory of all staff members. This inventory should include the educational background, current responsibilities, and additional skills of current staff. You should also make your own assessment of each staff member's ability to per-

form their work well. Another consideration to make is the likelihood that a staff member will continue to work with your unit over a long period of time. A sample staff inventory form is illustrated below. Your form, of course, will have more detail about current tasks and skills.

Sample Staff Inventory Form

NAME	TITLE	EDUC.	TASKS	OTHER SKILLS
R. Gurung	Admin. Assistant	Dipl.	-type & distribute reports -handle correspondence	computer skills office machines
O. Kayode	Graphics Artist	M.A.	-illustrate materials -manage production	-speaks Japanese -desktop
M. Gonzalez	Accountant	B.A.	-manage petty cash -keep financial records	-photography -Lotus 1-2-3
T. Sudarsono	Chief Researcher	Ph.D.	-design KAP surveys -develop research proposals -analyze and write reports on data	-degree in social work & counselling

6. What are the special technical strengths of our organization?

You also need to have a clear idea of your unit's ability to provide a range of communication services. The international management expert Peter Drucker has noted that one of the major mistakes made by organizations is the failure to recognize what they do best. You should consider if you have the capacity to implement each component of a communications program or if your organization is best at carrying out activities in one area of communication. Among the questions you should consider are:

- What are the particular strengths of your unit?
- What type of activities can your organization perform as well or better than other comparable organizations?
- What health education activities are you weakest in performing?
- Do you have enough trained staff to be able to implement all the steps in a program development process?
- Or are you more highly specialized in one area, such as research or materials development?
- Are you able to maintain the staff that you have and also recruit new staff--either to fill vacancies that occur or to expand your organization's capacity?
- What type of facilities and equipment do you have?
- Are they sufficient for the role that your unit wants to play?

The answers to these questions will tell you how ambitious you can be in planning an expansion or refinement of your unit's mission, objectives, and goals.

Creating an Organizational Development Plan

Having conducted both an external analysis of the environment surrounding your unit and an internal analysis of your structure and resources, you now have the information necessary to develop a plan for strengthening your organization's capacity to do effective health communications.

Define your Mission

Your mission statement should identify the overall purpose of your organization, the primary beneficiaries of your efforts, and the products or services you will be providing. Based on your assessment of the external environment and the identification of other organizations involved in health education, what is the best role for your organization to play? Which audiences and health problems should you address? Are you focused on awareness-raising, information-sharing, or the ultimate goal of behavior change? Given your existing resources of staff and equipment, what can your organization reasonably hope to accomplish? Here is an example of a actual mission statement for a national health education unit.

The primary function of the Health Education team is to encourage and reinforce healthful behavior and to discourage unhealthful behavior among our citizens, thereby promoting general public health and well-being....To its special constituency, the citizens of (country's name), this Division will provide special information and education, advice, skills, and follow-up support....To other units of the Ministry of Health, to other ministries, and to nongovernmental organizations, the Health Education Team provides planning, educational materials, and professional services (including training) in support of public health programs....With respect to projects not concerned with the primary mission of the Health Education Team, the Health Education Division will attempt to help other units of government to the extent resources are available and will provide materials and services to such units at our cost.

This mission statement clearly summarizes the overall purpose of the unit. It also helped to solve some internal and external problems related to what unit personnel could not or should not do. The mission statement clearly lists the primary constituencies in order of priority—the general public, the ministry of health, and then other ministries and NGOs—provided the work is related to public health. This statement served as a basis for health education staff members to refuse requests to use their time and equipment to record public and private functions or perform other work that was extraneous to their primary function of improving the public health of their fellow

citizens. A good mission statement can be used to protect a unit from unwanted diversions. It also provides staff members with a standard for allocating resources and establishes a motivational theme that will guide all activities.

Develop Your Long-Range Objectives and Goals

Once you have clearly defined your mission, you can proceed with identifying your long-range objectives and specific goals. Your objectives will provide more detail on your unit's future direction and purpose. Given your stated mission, what can you expect to accomplish with your existing resources? What do you want to achieve and how? Strategically, you also need to think about the position of your organization or unit within the larger environment you have mapped. What can your organization do that is different from what other organizations are already doing? Will you be competing with similar organization or complementing them? Is there a way in which you can develop partnerships with other organizations that will help you achieve your goals?

The long-range objectives for your unit will identify what you hope to accomplish over a period of years—not just this year—and should be assigned some level of priority. Your goals, however, will be more specific about what you want to accomplish within a shorter time period. They will, of course, be directly related to one or more objectives. You should keep in mind that your objectives and goals may change over time in response to changes in the environment in which you work. They are dynamic--not static. An example of different types of long-range objectives and goals is provided in the following table. These include objectives that focus on the overall mission of the unit, such as improving nutritional status of children, as well as specific objectives and goals for developing your communications capacity.

Sample Long-Range Objectives and Goals

OBJECTIVES	GOALS
Improve the nutritional status of children aged 1-5	expand the consumption of vitamin A-rich foods among children (ages 1-5) by 20% over a two-year period
Develop the unit's capacity to carry out formative research in support of public health programs	recruit and hire two research specialists this year who have skills in both quantitative and qualitative research organize workshop for all technical personnel on use of formative research data
Strengthen the unit's capacity to develop health education materials that are effective in conveying public health information to a specific target audience	train all materials development staff in pre-testing procedures over the next year pretest all materials with a sample group of the target audience before production identify outside sources of research data on the target groups you seek to help

Goals should represent realistic results that are desired—not merely be activities that are planned. Goals should also be set in close collaboration with the people who will have the responsibility for achieving them. It is counterproductive to have supervisors set unreasonable goals that staff members know cannot be achieved. This undermines the credibility of the entire planning process.

Develop an Organizational Strategy

Having outlined your unit's mission, objectives, and goals, you can now move into developing an operational plan which may re-structure your unit and develop your human resources.

Evaluate your Organizational Structure

Based on your decisions regarding what your unit wants to accomplish, you can look at your current structure to determine if it is the most efficient way to achieve your objectives and goals. If your organization is just being formed, you will have the opportunity to plan without worrying about the disruptions that might be caused by a reorganization or by the resistance that might occur from current staff. Much of this resistance can be prevented by involving staff in the discussion of your unit's mission and the setting of objectives and goals.

Create a Staff Development Plan

The most crucial element in enabling your unit to perform its mission is having a motivated staff with the proper skills and support. Once you have created the struc-

ture that is conducive to the achievement of your mission and goals, you can better see how your current staff can fit into the specific positions within the subunits of your organization. You should take time to study the background of each staff member and interview them to decide how best to utilize and expand their skills. You should establish an annual process of reviewing the performance of each staff member and planning what they will do over the next year to contribute to the organization, develop their skills, and take on greater levels of responsibility.

Devise a Strategy and Goals for Developing Partnerships

Almost every organization welcomes outside help in reaching its goals, but few actually plan out how they can establish partnerships that will strengthen the impact of their efforts. The mapping exercise should have identified a wide range of organizations and groups that could be potential collaborators. Some groups may be able to provide you with additional human, financial, or material resources. Some may be able to provide you with help in a specific geographical or technical area. Partnerships are developed, not magically created. In your annual plan, you must include specific goals for investigating and building such partnerships.

Create a Procedures Manual

To make everyone in your organization aware of the mission and goals of your unit and the methodology that underlies your programs, you may consider creating a procedures manual which includes this information as well as the responsibilities of each subunit and position. In addition to uniting your team with a foundation of common knowledge about the organization, a procedures manual will be invaluable in helping to orient new employees to your unit. An example of a procedures manual is found in Section III of this document.

Incorporate Organizational-Strengthening Activities into your Work Plan

If you are already a functioning communications unit, you probably develop an annual work plan (or even a plan for multiple years). If you are to strengthen your communications capacity, your work plan has to include specific steps for developing that capacity. Your work plan cannot simply focus on the communication products that you will create. Many of the steps described in this guide need to be included in your actual work plan. If you want to develop the skills of your staff, specific steps need to be taken each year. If you want to create partnerships, time and resources have to be set aside to do so. Organizational development will not occur simply because you want it to happen. It will only occur if you plan and allocate resources to make it happen.

Conclusion

This guide outlines a basic process for analyzing your unit or organization and the environment in which it operates with the goal of developing a plan to improve your organizations capacity to do effective health communications. The guide has been kept simple to make it useful for managers of small PVOs and large ministry of health departments. Heads of large organizations may also consider hiring a organizational development consultant to help devise a plan, using this guide to help develop a scope of work for the consultant. One of the advantages of using an outside person is that he will be seen as a neutral party and be able to sclicit the frank opinions of staff members. Involving staff members in the restructuring of your unit will result in a wider range of good ideas and practical solutions to outstanding problems. The participation will also help develop support for the changes that will ultimately occur.

HEALTHCOM METHODOLOGY OVERVIEW: A PROCESS FOR HEALTH BEHAVIOR CHANGE

Importance of a Guiding Methodology

To enable your organization to design and implement effective health communications programs that can bring about positive behavior change, your unit needs to have a rigorous technical methodology that guides the work of your staff in creating and implementing such programs. Having such a methodology at the heart of your technical work is as important as having blueprints for the construction of a large building. While it may be possible for experienced builders to erect the building without such blueprints, the construction will proceed more efficiently and produce better results if professional blueprints are used. The blueprints also make it possible for others to replicate your work—and to make adaptations that can improve the original design. A governing methodology provides an organization with a standard process that can be taught to all of its members. Team work is easier when all members are working according to a common framework. Although some staff members may change, the methodology will remain to be applied by new people to new situations.

Four Key Characteristics of a Methodology

The guiding methodology for any health communication unit should have at least four key characteristics. It should be:

- **Systematic** - having clear and logical steps to be followed to design and implement a complete and effective communication approach
- **Multidisciplinary** - drawing from state-of-the-art knowledge from the fields of mass communication, social marketing, nonformal education, behavior analysis, and medical anthropology to form a theoretically sound approach to communication for behavior change
- **Behavior-Oriented** - focusing on the promotion of behavior change as the ultimate product of health communications, not just awareness-raising or information-sharing
- **Flexible** - able to be applied to a variety of health interventions (e.g., immunizations, diarrheal disease control, AIDS, and nutrition), cultures, and programs both large and small

Five Steps to Successful Programming

The methodology adopted by a health communication unit should follow the five steps of successful program planning. The steps are simple and appropriate for all types of programs, not just health communication efforts.

1	**ASSESS**	the public health situation, target audience and their environment, current and proposed health behaviors, program resources and constraints
2	**PLAN**	the public health intervention based on data on the health issue, audience, communication channels, and available resources
3	**DRAFT, PRETEST & PRODUCE**	the appropriate print, audio, video, and counselling materials
4	**DELIVER**	the health communication program in tandem with service delivery groups
5	**MONITOR & EVALUATE**	to determine how well the program is being implemented, make mid-course corrections in strategy or materials, and assess the overall impact of the program and its constituent parts

Six Essential Elements

Worldwide experience over the last two decades has also identified six essential elements that should be at the center of the development of a health behavior change program. They are:

- Consumer-Centered Planning
- Research-Guided Decisions
- Specific Behavioral Goals
- Multi-Channel Communication
- Integrated Program Components
- Balanced Supply and Demand

Consumer-Centered Planning

The consumer or target audience is at the heart of any health communication effort. Reaching them and helping them learn to adopt more healthful behaviors is the main goal of any health education effort. No matter how wonderful your communication products look; no matter how impressed your colleagues and supervisors are with the programs you develop; if you do not succeed in changing the behaviors of the people you are trying to help—you have failed. Sustained behavior change is difficult to achieve. Awareness-raising and information sharing are much easier steps, but they are

only the initial stages in promoting behavior change. In health education, the ultimate goals always has to be behavior change.

The first step towards helping people is to gain an understanding of them and the social and physical environment in which they live. To begin this process you have to identify that segment of the general population that you wish to help. Most health problems do not affect all segments of the population equally. Age, location, nutritional status, and sexual activity are some of the categories that may be used to determine which portion of the population is likely to be affected to a particular health problem. Once you have defined your target audience, you need to learn how they view and describe the health problems affecting them; their knowledge, attitudes, and practices regarding the specific health behaviors you wish to change or promote; and the obstacles and anticipated benefits factors that might affect their adoption of new behaviors.

Research-Guided Decisions

Research can be an effective way of "listening" to people and bringing their views and opinions into the program planning process. Decisions on project design and implementation should be made based on reliable data drawn from existing research reports, new formative research, and current monitoring systems to make. One way to better target research is to utilize the "backwards decision-making model." As a program is being planned, program managers can look ahead to the decisions that they will have to make in the future—decisions about creative strategy, use of communication channels, types of needed materials, and key messages. Once the managers have identified those decisions, they can then move "backwards" to the present and determine what information they will need to gather in order to be able to make those future decisions. A combination of quantitative and qualitative research is more likely to provide the range of information and insight needed for accurate decisions. Surveys, in-depth and intercept interviews, behavioral observations, and focus groups are research methods that have proven their worth in many programs.

Specific Behavioral Goals

Program managers need to identify the precise behaviors that consumers need to adopt to ensure a healthier lifestyle and study the practicality of those behaviors in the consumers' environment before they begin to promote them among the general populace. A behavior such as handwashing, which is easily done in upper class homes where soap, water, and towels are readily available, are much more difficult to practice in poor villages. Asking people to do the impossible is not a recipe for success. The behaviors that are promoted must be practical, and the communication messages provided to the public must be actionable ones.

Multi-Channel Communication

Effective large-scale communication programs generally utilize a combination of mass media, print, and interpersonal channels. The communicator needs to understand the advantages and disadvantages of each channel in carrying certain messages to a given group of consumers. Some key criteria to apply to any channel for a given target audience is to assess its: REACH (the percentage of your target audience that will be exposed to that channel); FREQUENCY (how often your audience will be exposed to the messages that you convey on that channel); APPROPRIATENESS (how effective that channel will be in conveying the type of message you want delivered); and COST (usage of that channel). Although the interpersonal channel can be very effective in persuading people to adopt new behaviors, the mass media are likely to reach many more people.

A study conducted in Swaziland by HEALTHCOM revealed that the face-to-face contacts of health workers with clients resulted in a higher percentage of clients adopting the new behavior compared to mass media. Because the mass media reached a much higher percentage of the overall population, however, it had a greater overall affect in promoting behavior change. In a well-balanced program, however, each channel serves its own purposes and has a synergistic affect in raising the impact of other channels.

Mass media is particularly effective in awareness raising activities such as promoting the availability of a specific product such as ORS or conveying simple messages like the time and place for immunizations. Print materials can convey more detailed information and persuasive arguments as well as serving as reference materials for the future, such as the mixing of ORS, the treatment of dehydration, and the timing of childhood immunizations. Print materials such as counselling cards, flip charts, and treatment posters can be invaluable tools for health workers and volunteers. Interpersonal contacts are particularly important for counselling individuals, as long as the health staff are trained to provide such counselling in a sensitive and technically correct manner. It is incorrect to assume that everyone knows how to interact effectively with people without having had some training.

Whatever channel is used, the key to success lies in choosing the proper messages and pretesting the communication materials with a sample of the target audience before they are mass produced and distributed. Trying to save money and time by skipping the pre-testing phase is a false and dangerous "savings". Pretesting can mean the difference between success and failure. The relatively minor cost of pretesting ensures that the major cost of materials development, production, and distribution are not wasted.

Integrated Program Components

The impact of a communication program is heightened when all components of the program, including delivery systems, are coordinated. The communication channels must work in harmony, carrying consistent and mutually reinforcing messages to the intended audiences. What is said by the health worker is reinforced by the mass media and print materials and vice versa.

Balanced Supply and Demand

Demand creation is useless if the service delivery system is not prepared to provide the services that are being promoted via the health communication effort. Creating demand that cannot be fulfilled frustrated the people seeking services and the overwhelmed staff who are unable to provide those services. A health education unit must operate in close cooperation with the service delivery units. Unfortunately, in some countries the health education unit and service delivery units of a ministry of health do not collaborate well enough despite being parts of the same organization. NGOs and PVOs also have the responsibility to coordinate their efforts with public and private sector service deliverers.

Summary

This methodology uses a behavioral microscope to observe what people are presently doing, compares those practices with potentially more effective ones, and determines how to best motivate practical change. It is people-centered and alternates periods of listening (research), action (delivery), and reflection (monitoring and evaluation). By utilizing the science of modern communication to teach parents, health service providers, and policy makers new skills and concepts in ways that are appropriate to their individual cultures, young children are helped to survive and grow up healthy. This innovative integration of mass media, print, and interpersonal channels of communication holds perhaps the greatest potential for reducing preventable infant and child morbidity and mortality in developing countries.

This methodology is more complex and demanding than the traditional form of health education; but it is also more effective in producing specific and sustained behavior change in large target populations. It requires the application of many different sets of skills including research, planning, and materials development. It may not be possible for many organizations to immediately adopt and apply the complete methodology as outlined above and set forth in detail in the Tool Box. It is possible, however, for all organizations to adopt a process of "incremental change" and begin to immediately apply one or more elements of the methodology. An early first step could be to inculcate the idea of consumer-centered planning with staff members accepting the operating philosophy that all programs and materials must be developed with a clear under-

standing of the needs, beliefs, attitudes, and practices of the consumer. Once this philosophy is adopted, planning should become more effective.

Although the development of the research skills needed to learn about the consumer will take more time, the acceptance of the basic belief in the primacy of the consumer will lead planners to think in different ways and search for available information on the people they are trying to influence. Another step that can be taken immediately is to decide that no materials will be mass-produced without first pretesting them with the target audience. It may take time to develop an ability to do sophisticated pretesting, however, doing even rudimentary pre-testing of materials and concepts will improve your current system. The crucial step, however, is selecting a standard methodology that will provide your unit with a common framework to guide the development of effective health education materials and programs. Such a methodology is described in Section II of the Tool Box.

SECTION II

METHODOLOGICAL TOOLS

INTRODUCTION

Welcome colleagues to the adventure of defining your health communication strategy and putting together your health communication plan! Your work will not be easy. We know this because we on the HEALTHCOM team have assisted health education units in many countries with this work and we know the difficulties ahead for you. But in spite of these difficulties, we are confident that you can succeed.

Putting a Health Communication Methodology To Work for You

Please keep in mind that the material in this section of the Tool Box is intended to show you how to manage the process of defining your health communication strategy and organizing your health communication plan. It provides you with an overview of all the components needed. The section deals with the application of the methodology, outlined in Section I of the Tool Box, to a specific health problem—one that you select. The methodology with its five steps—(1) assess, (2) plan, (3) draft, pretest, produce, (4) deliver, and (5) monitor, evaluate—is presented in the form of 25 questions.

This format was chosen after HEALTHCOM field staff provided lists to HEALTHCOM/Washington of the most common questions personnel within health ministries and private voluntary organizations had regarding the application of the methodology to specific health interventions. Because the questions are field-based, they address the most common obstacles encountered in undertaking health education activities. Providing you with a solid, theoretical foundation, they use information from real work situations to demonstrate how to get the results you want to achieve.

25 Questions To Help You Manage Your Work

The questions that follow will assist you and/or members of your health team in applying the methodology to any health problem for which you are designing a communication plan. As stated above, the questions are organized to correspond to the five steps on the health communication methodology.

• Step 1: Assess	Questions 1 - 12
• Step 2: Plan	Questions 13 - 17
• Step 3: Draft, Pretest, Produce	Questions 18 - 21
• Step 4: Deliver	Questions 22 - 23
• Step 5: Monitor/Evaluate	Questions 24 - 25

How the Questions Are Organized

Each question starts with an introduction to the subject under consideration and includes background information, examples from the field to study and discuss, a synthesis, and worksheets for your team to use in applying the learning to your own situation. When the material covered in a question is highly technical, an appendix is included at the end of the question to provide additional information on the subject. A complete set of worksheets for all the questions is included at the end of this section of the Tool Box.

Examples used within the questions are based on child survival interventions. They were selected to illustrate key principles of the health communication methodology. They are primarily based on HEALTHCOM field activities in the Americas, Asia, Africa, and the Middle East.

The first two questions deal with the obvious but seldom asked question, "What is the health problem our communication strategy will address?" Without a clear answer to this question, no sequence of actions will be effective or permit your team to focus clearly on specific issues. Question 3 explains how to identify the audience for your plan.

One of the biggest problems in health communication planning is clearly defining the feasible behavior the audience will be asked to perform. Questions 4 and 5 will help your team define that behavior and identify the causes impeding its adoption by your target audience.

Question 6 focuses on defining research needs and how to meet those needs. All research efforts are futile and remain academic exercises if the actions taken from the research cannot be evaluated in terms of the impact, change, or adoption of new behaviors. Question 7 demonstrates how to plan for the evaluation of your work by establishing evaluation indicators as part of the research plan.

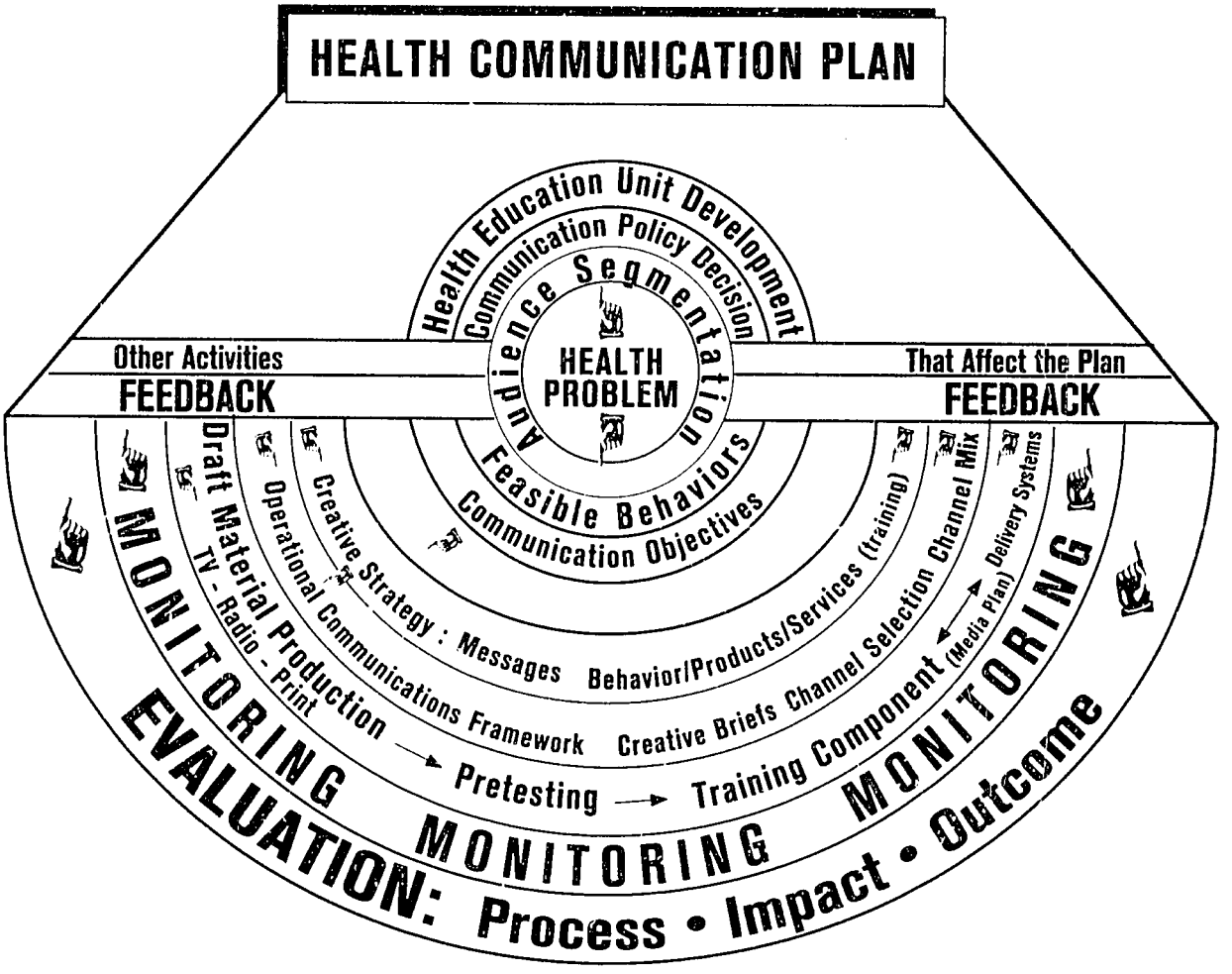
The subsequent five questions are devoted to details of undertaking formative research, including doing it yourself, selecting an outside firm to do it, analyzing the information obtained, and preparing a research report.

Questions 13 through 17 focus on the planning step for your intervention. They will help your team identify its necessary components and position your intervention with-

in the ministry's overall efforts. These questions also will show them how to link the feasible behaviors defined earlier with communication messages and turn these messages into products, services, and training curriculum. Questions 18 through 21 focus on pretesting the communication messages.

The last four questions are devoted to your intervention's training needs, how to execute planned activities and monitor their delivery, and, finally, how to evaluate your team's efforts.

If you were to visualize this process, it might look something like this:



Starting with Question 13, this diagram will be included in most questions to help you visualize how your health communication intervention will come together.

How this Section of the Tool Box Can Be Used

In preparing this section of the Tool Box, HEALTHCOM staff members envisioned that these questions would be used in a variety ways. Perhaps you will be able to sys-

tematically proceed through the section, question by question and worksheet by worksheet. If so, when you finish Question 25, you will have a full communication plan for an intervention. You also will have communication materials that can be monitored and evaluated to measure the impact of your intervention.

It may be that you and your team members already are experienced in applying the health communication methodology to your work and just need to review information on some aspect of the methodology to refresh your memories on how it is done. You may, for example, lack experience in pretesting radio spots. If this is the case, you will use the Table of Contents to refer to Question 20, and information in this question will provide you with the help you need.

There also may be moments when you want concrete information on a particular step within the methodology. You might want to know, for example, what type of formative research to undertake for a proposed intervention. Again, the Table of Contents will tell you where to find this information.

Finally, you may want to use this section for training purposes. The 25 Questions can serve as a self-teaching guide for a course in health communication methodology. If you plan to use the material in this way, you may require additional information or expertise in such areas as identifying your research techniques, creating materials, or evaluating your plan. In Section III of the Tool Box, there is a list of additional resources.

How the Questions Are Specifically Used

The internal structure of each question suggests the way to use it. You will note that the question is introduced by a paragraph right underneath the title that tells you briefly how the question is linked to the previous question and what it contains. Starting with Question 13, the graphic will help you see where the question fits in an overall communication plan.

The Skills/Knowledge section at the beginning of the question should be studied carefully. It gives you a summary of the intended learning objectives. When you finish studying the question, this section should be reviewed to see how it is related to the Synthesis at the end of the question.

The exercises are self-explanatory. They will hep you process the information contained in the question. The Background Information section will provide you with the theoretical material to understand the exercises. It should be read carefully, either individually or aloud as a group. The examples provide you with an opportunity to seer how the methodology was applied to a particular health intervention.

The worksheets may be the most helpful part of this section of the Tool Box. They will enable you to use the methodology format to design your own communication plan, implementation strategy, communication objectives, and messages. This, in turn, will help you develop effective communication materials. Finally, the worksheets will assist you in monitoring and evaluating your work.

Let's Begin With an Open Mind and a Fresh Learning Attitude!

Step 1

Assess

Questions 1 - 12

Question 1

How Do We Start Planning For Our Health Communication Intervention?

In health communication, as in taking a trip, you have to know where you are going before you can plan your route. This question will get you started on planning your intervention by helping you see the big picture and the methodological steps you will need to take to reach your destination. Some of what you need for your intervention will be readily available to you, but obtaining other things will require considerable effort and creativity on your part.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Reviewed the process for planning a health communication intervention
2. Listed the major methodological steps for carrying out the intervention and put them in sequential order

Introductory Note

A communication intervention is not based on a hurried decision to make posters or prepare some brochures about a health problem, its causes, and its remedies. It is based on methodological steps that need to be carried out in a very systematic and careful way to achieve success.

The components of the intervention follow a sequence that begins with formative research on a specific health problem as lived with, experienced, and dealt with by those burdened with the health problem the target audience. The research results yield the audience's beliefs and current behaviors regarding the health problem, which serve to define the feasible behaviors the intervention will ask the target audience to perform. Those behaviors are turned into specific communication messages with specific objectives.

These messages are translated into communication materials by creative briefs that enable the producers to pretest messages in the field. Professional production of the communication materials is based on the pretest results.

After communication materials are ready, the delivery system assures the distribution of the materials and broadcast of the messages. A monitoring system tracks what is happening in the execution of the intervention and if activities are proceeding according to the plan and strategy.

Exercise 1. Reviewing a Communication Plan Outline

Materials

Copies of the example, Communication Plan Outline for a Vaccination Project for team members
Paper and pens

Instructions

Carefully review the example of a communication plan outline. Pay particular attention to the sequence of activities.
Discuss details with the team.
Conclude by making a list of the major steps that you will include for your intervention. Compare your list with the synthesis at the end of the question.

Example. Communication Plan Outline for a Vaccination Project

I. Identifying formative research needs
   A. Defining the health problem: *Low completed vaccination rates for children under one year of age who are most at risk for not surviving communicable diseases, particularly measles*
      1. Why this health problem and not others?
         Serious childhood diseases, some of which can be fatal
         Potential epidemics if levels of vaccination not high enough
      2. Whom does it effect?
         Children, especially under one year of age and of low and medium socioeconomic status
      3. What are the causes of the health problem?
         Irregular and unpredictable vaccination services in villages
         Nonuse of health centers for vaccinations
         Fear of side effects
      4. What beliefs, attitudes, and current practices contribute to the problem or possible solutions?
         Parents do not know -
            Ages for vaccinations.

Which immunizations already received.
When/if vaccinations completed.
Health workers do not communicate information about vaccination dates and side effects.

B. Defining the target audiences
   1. Who suffers most from the problem?
      Children under age one
   2. Who can be most responsive to the intervention (primary audience)?
      Mothers and fathers of children under one who already had their children vaccinated at least once
   3. Who can support the primary audience in its new practices?
      Allies such as health workers and community leaders

C. Defining feasible behavior(s) for each audience
   1. What is the desired ideal behavior?
      Parents take their children to be vaccinated according to the vaccination calendar: at birth, two months, three months, four months, and nine months.
   2. What is the current behavior(s)?
      Parents wait for the vaccination team to come to the village and generally do not complete their children's vaccination series. Those that have their children vaccinated once or twice do so much later than they should.
   3. What are the feasible behaviors to be promoted?
      Parents have their children vaccinated five times at some point before they turn one year of age.

D. Developing the research plan
   1. What do you need to know?
      Why parents do not completely vaccinate their infants and what would motivate them to do so
   2. Who will do it?
      Epidemiology (EPI) team and temporary hires by EPI team with technical assistance by research specialists
   3. What type of research/timing?
      Quantitative Vaccination Coverage Survey conducted simultaneously with a Knowledge, Attitudes, Practices (KAP)
      Study—first phase
         Mothers of children between 12 and 23 months of age
         436 selected based on random cluster sampling in two pilot provinces
      Observations/interviews at vaccination sessions—second phase
         168 observations of vaccinations given
         179 exit interviews with mothers after sessions

8 interviews with health center supervisors
7 advanced and 1 fixed site (4 vaccination sessions per province)

Focus group discussions—final phase
Mothers and fathers of children between 9 and 18 months of age
Vaccination status—vaccinated no times or one time versus vaccinated two or more times
11 groups in the two provinces

II. Designing the communication strategy

A. Defining the communication objectives

Increase nonliterate parents' understanding of ages/number of contacts and to gain their active participation
Increase use of fixed facilities to vaccinate their children five times before one year of age

B. Developing the messages

Feasible behaviors(s)
Mothers should have their children vaccinated as soon after birth as possible
If mothers are worried about vaccination reactions such as fever, diarrhea, or scars, they should ask the health worker for help
Health workers should tell each mother when to come back and what to do in case of potential side effects

Products
Vaccines, vaccination cards, illustrated vaccination sheets, stickers, posters

Services
Vaccinations, counseling, one-on-one advice

Price
Purchase of vaccination card, travel time, and waiting time versus better health/likelihood of children's survival

Place (where to get it)
Health centers, if the health workers do not visit villages when it is time for the next vaccination

C. Developing a creative strategy

If your child is completely vaccinated, he or she will survive to help you in your later years.

D. Selecting the communication channel (most effective)

Interpersonal communication (health workers)
Training (with behavior modeling video) and supervising of health workers to improve services/communication

Radio—series and song—and illustrated materials—illustrated vaccination sheet, "completed" sticker, and flip chart

E. Preparing the creative brief for radio drama series
The communication strategy is the basis for the conception and production of the radio series and supporting materials. The content of these materials will be based on the same key messages in the radio series to reinforce their impact.

F. Selecting the channel mix
All media will support the interpersonal messages. Because few members of the target audience have access to television, this medium will not be used. The messages for the flip chart and the radio series are very similar. All materials will tell or show the story of Awa as an example of a mother who, despite many hurdles, successfully preserves her child's health by completely vaccinating him before he turns one year of age.

III. Designing draft materials
A. Print material (example)
1. What kind
Flip chart/poster/illustrated vaccination sheet/sticker
2. Objective
Help health workers explain the important elements of vaccination to mothers so mothers know when they should vaccinate children and when the children have been completely vaccinated
3. Content
Covers vaccination process for Awa and her child—ages for vaccination, number of times to vaccinate, number of times left/vaccination series completed
4. Number
100 flip charts (one per health center in the two pilot provinces, plus additional 40 percent), 1,000 posters (one per village in pilot provinces, plus 30 percent additional), 10,000 vaccination sheets and stickers (to cover estimated population of children under one year of age in pilot provinces)

B. Radio

C. Additional channels of communication
Training of health workers
D. Pretest plan[1]

E. Final production of materials

IV. Implementing the delivery system

A. Products

Vaccines, vaccination cards, illustrated vaccination sheets, stickers, posters

B. Services

Vaccinations, counseling, individual messages

C. Media plan

Radio, print

V. Monitoring and evaluating

A. Monitoring mechanisms

1. Mass media broadcast
2. Delivery systems
3. Training

B. Evaluation

1. Who will conduct the evaluation?
   The EPI team will conduct, with technical assistance on methodology, instrument development, and analysis.
2. Who will define evaluation variables
3. Who will define methods to be used
4. Who will conduct project evaluation, using same methodologies as in the baseline research

Synthesis

A health communication intervention plan is made up of the following major components:

1. Formative research for defining the target audience and feasible behaviors
2. A communication strategy for developing communication objectives, messages, and creative strategy briefs
3. Communication channels (print, television, radio) and their accompanying materials for disseminating messages
4. Delivery systems for distributing the materials
5. Monitoring/evaluation for assuring execution of the plan

[1]The rest of the outline does not include illustration examples because it does not relate to the first 12 questions of the manual

Question 2

How Do We Define the Health Problem?

A health education unit faces many problems and must set priorities among them. In this question, you will start to select your priorities to determine the one health problem your intervention will address. You will begin to define this problem precisely by asking: What is happening? Who is suffering? What are the effects? The answers to these questions will provide you with the information you need to write your health problem statement.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Identified the elements of a problem statement
2. Examined the value of focusing on a single health problem
3. Prepared the first draft of your problem statement (Worksheet 2-1)
4. Listed existing resources and literature to provide you with information for your problem statement (Worksheet 2-2)

Introductory Note

Generally the ministry of health will let you know which health problems they want you to address, but if your team has the opportunity to select the health problem itself, excellent! Select one that you think you can handle well and for which you have epidemiological research data to support your choice.

Even when your team is assigned a health issue, you will need to choose what part of the problem you will address with your communication plan. If the ministry wants you to take part in their malaria campaign, for example, you will need to use research to decide whether the critical problem in your country is bed-net use or acceptance of chloroquine medication by pregnant women.

In the first example, the health education team in Jordan was asked to promote breast-feeding to decrease nutritional problems among infants. Their first step was to identify problems with breast-feeding practices.

Reflecting on Field Experience

Exercise 1. Defining the Problem

Materials

Copies Example 1, Problem Statement, First Draft
Paper and pens

Instructions

Read the example in small groups. Discuss it and determine if the problem definition is adequate.

Example 1. Problem Statement, First Draft

Jordan, a country in the Middle East, faced a problem of high morbidity and mortality rates for infants and children under two years of age. To address this problem, health education team members wrote the following problem statement in their first draft of a health communication plan:

> *There is a concern that mothers are increasing their use of formula instead of using breast milk. This situation is attributed to a loss of confidence in breast-feeding due to the changing role of women and the idea that breast-feeding is not a modern method.*

After analyzing this first draft of the health problem statement, suggest additional information that you think the health team could include to state the problem more effectively. Compare your statement with the following more comprehensive draft made by the health team with additional information:

> *After examining the demographic health study, the health education team realized that 94 percent of women initiate breast-feeding and 84 percent breast-feed for at least six months. Using a more detailed nutritional survey carried out by researchers at the state university, they found that mothers said they stopped breast-feeding because of pregnancy, lack of milk, and thin milk. The team now presumed that mothers accept the value of breast-feeding but are having difficulties in continuing successfully.*

Ask your team members to think about and respond to these questions:

- How may this additional information influence the way health team members address the problem?
- What sources of information do you think the health team members have used so far to design their problem statement?
- What additional sources could they have used? (Examples could include studies done by local and international private voluntary organizations, universities, and religious groups, or projects and studies supported and funded by international donors such as the World Health Organization, World Bank, U.S. Agency for International Development, and United Nations organizations. Such studies and reports often provide useful information on audiences, behavior, community support systems, and/or service provision.)

Exercise 2. Refining the Problem Statement

Materials

Copies of Example 2, Problem Statement, Third Draft

Instructions

Distribute the second draft of the problem statement, prepared by Jordanian health team members. It is preceded by the questions team members asked themselves to focus their attention on including the most essential information.
Discuss the differences between the first draft and this draft of the health problem statement.

Example 2. Problem Statement, Third Draft

What is happening?

Although it appears that mothers accept the value of breast-feeding, they are not breast-feeding their infants frequently enough or for a long enough period to ensure stable growth.

Where and when?

University research shows that most mothers nationwide do attempt breast-feeding within the first three days following birth, but that they have problems continuing breast-feeding for as long as they would like.

Whom does it affect?

The small number of mothers (seven percent) who do not initiate breast-feeding are primarily urban, more affluent, and educated. Their children are not malnourished and, therefore, are not a priority audience for the intervention. Refugee mothers tend to breast-feed longer than other mothers, so they are not considered part of the target audience. Mothers with less access to health care are more likely to breast-feed.

Primary effects?

A higher incidence of diarrhea and malnutrition exists among children of low-income, less-educated, rural mothers.

Possible causes?

1. *Insufficient motivation to continue breast-feeding*
2. *Lack of family support*
3. *Belief that formula is better than breast milk*
4. *Poor breast-feeding practices, such as late initiation and early supplementation*
5. *Lack of confidence in the ability to breast-feed*

After discussing the information related to these questions, health team members added the following information to the problem statement:

Children of low-income, less-educated rural mothers are at the greatest risk. They have high incidences of diarrhea and malnutrition, which are reflected in poor growth when they are not breast-fed adequately. Their mothers do attempt breast-feeding shortly after birth and are confident of its value. Their breast-feeding practices, however, do not enable them to continue long enough to provide children with adequate nutrition.

Risk factors include a lack of confidence in the amount and quality of milk and possibly poor advice from health professionals.

Service/supply. Both health care services and pharmacies encourage the use of formula. There are no support groups for encouraging breast-feeding mothers.
Economic. Some mothers work in the fields, and it is difficult for them to take infants with them.
Social. Loss of confidence in experienced, successful breast-feeding older women.
Cultural. Culture and religion support breast-feeding.
Other. Short intervals between pregnancies. Belief that breast-feeding while pregnant is dangerous to infant.

Background Information

To ensure having a well-defined problem statement, ask the following five questions prior to drafting the statement:

1. What is happening that is a problem?
2. Where and when does it usually take place?
3. Whom does it affect?
4. What are the primary effects?
5. What are the possible causes?

Focusing your problem statement can save time and money and ensure that your communication plan addresses the important causes of the problem that will make the difference in your health education team's efforts.

Exercise 3. Analyzing a Problem Statement

Materials

Copies of the example, Malnutrition Problem Statement

Instructions

Read Example 3, Malnutrition Problem Statement.
Make a chart with the following headings: what is happening, where and when, to whom, with what effect, and as a result of what causes.

Example 3. Malnutrition Problem Statement

In a West African country, the Ministry of Health recognized that malnutrition was a serious national problem. He asked the staff in the information, education, and communication (IEC) unit to develop a community education activity. Team members reviewed existing clinic records and relevant literature, such as public health, demographic, anthropological, economic, and social science studies. They found that the group suffering the highest mortality and morbidity were infants from 6 to 18 months of age.

Team members contacted the nutrition department at the national university and found several studies showing that the problems of this age group were correlated with infant feeding practices and possibly with the kinds of infant foods commonly used. A demographic health study gave them information about mothers' breast-feeding and weaning practices. Such information helped them state their problem as follows:

> *The highest infant mortality and morbidity rates are found in infants from 6 to 18 months of age. More than 35 percent of the deaths of infants in this age range are nutrition-related as are almost 40 percent of the illnesses reported at local clinics. Often these deaths occur following an episode of acute illness such as measles or diarrhea. While mortality rates are higher in rural areas, urban areas also show high rates for this age group. Infants from low-income families are at highest risk. Possible causes for poor nutrition problems include current feeding practices that rely on thin, cereal-based gruels or soups with low-calorie or low-protein content and on abrupt weaning practices.*

Now that the team has focused on infant feeding, they can collect more data on causes (risk factors, services/supplies, and obstacles) to complete this problem statement.

Background Information

The value of stating a problem clearly before starting a communication activity can be seen by contrasting the actions of the health team in West Africa with the typical action of many health directors who receive assignments for an educational activity, such as a nutrition campaign, from their ministry of health and respond by designing a beautiful nutrition poster with the three major food groups. When this occurs, these directors do not develop a clear idea of the specific problem that needs to be addressed. With a clear problem statement, you will have a simpler task as you plan research, choose audiences for the communication intervention, determine desired behavior changes, and identify program objectives.

Synthesis

Asking the questions—what is happening, where and when does it take place, whom does it affect, what are the primary effects, and what are the possible causes—is essential for formulating a clear, focused health problem statement.

Congratulations! You Have Already Defined An Accurate, Precise, and Manageable Health Problem!

Application

1. Go to Worksheet 2-1, Health Problem Statement.
   As a team, use the four questions on Worksheet 2-1, Health Problem Statement to start developing the problem statement for the health issue you are addressing in your health communication intervention.
2. Go to Worksheet 2-2, Possible Sources of Problem Statement Information.
   Use this worksheet to help answer what information needs to be collected and where it can be found.

Worksheet 2-1

Health Problem Statement

1. Epidemiology of health problem (mortality, morbidity, prevalence, geographic location, including what is happening, where and when, to whom, with what effects, and as a result of what possible causes)

2. What are the risk factors related to this problem?

3. What service/supply problems are part of the problem?

4. What are the anticipated obstacles?
   a. Economic
   b. Social
   c. Cultural
   d. Other

Worksheet 2-2

Possible Sources of Problem Statement Information

Sources	Needed Information
1. Ministry of Health (Central)	
2. Ministry of Health (Provincial)	
3. Other groups (media, religious, university, nongovernmental)	
4. Other	

Question 3

How Do We Identify Our Research Audience(s) Based on the Health Problem that We Want to Address?

Effective health communication interventions reach audiences who have the greatest potential for being responsive to the intervention, as well as those for whom the need is most pressing. In this question, you will learn ways to identify these audiences.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Determined how to focus and segment your potential research audiences
2. Examined the importance of using all existing resources to focus and segment your research audiences
3. Identified the primary and secondary audiences with whom to conduct your research (Worksheet 3)

Introductory Note

A primary research audience is defined as (1) those people who are most affected by the problem, (2) those who are most responsive to behavior change, and (3) those who are most reachable. Because these groups of people often are not the same, you may want to conduct research with more than one group. Secondary research audiences include (1) others who can help identify ways to influence the primary audience and (2) allies such as decision-makers, community leaders, and health authorities.

Reflecting on Field Experience

Exercise 1. Narrowing the Research Audience

Materials

Copies of Example 1, Immunizing Children (Primary Audience)

Instructions

Give a copy of the example to each team member to read. Discuss it together. Conclude the session by discussing the advantages for your team in applying the same segmentation criteria listed at the end of Exercise 2 to the process of identifying research needs.

Example 1. Immunizing Children (Primary Audience)

The health ministry of an African country undertook an intervention to increase the number of fully immunized children. The original research audience for the intervention was the following:

Mothers with children under five years of age

When the team asked themselves who was *most affected* by the problem of nonvaccination, they realized that infants under age one were most vulnerable. In particular, the danger of measlesthe most fatal of the diseases for which vaccine existsis greatest in the first year, between the time the maternal protection wears off and the time in which child is old enough to survive a bout of the disease. The team therefore decided that the age group in which completion of the series would have the most impact on public health was children under age one. Their narrowed target audience became the following:

Mothers with children under one year of age

Team members then asked who was likely to be most responsive to the intervention they were planning. Coverage data showed that about 80 percent of children had received at least one vaccination from the health system, yet only 17 percent of infants completed the series by age one and only 30 percent of children ever completed the series. Furthermore, a qualitative study carried out by researchers at a local university reported that the mothers of these children were aware of the value of vaccination, knew where and when to come for service, and were confident enough of the outcome to have tried the behavior once. This information helped them to decide to focus on the following:

Mothers with children under age one who had received at least one vaccination

If they succeeded in encouraging just half the mothers who had already begun the series to complete the series, they could double their coverage. With the research audience more narrowly focused and limited in size, the following research questions became simpler for the team to formulate:

- Why do mothers who take their children to the health center for one vaccination not return to complete the series?
- What barriers prevent them from returning to the health center?
- What benefits would influence them to return to the health center?
- What would be the best way to pass along information about benefits to those mothers?

Team members further examined available information to segment their audience for research regarding immunization of children under age one. They were able to identify the following four major groups of mothers:

- **Unaware Nonusers.** Mothers who are not aware of vaccinations and who never had their children immunized
- **Aware Nonusers.** Mothers who are aware of vaccinations, but who never had their children immunized
- **Trial Users.** Mothers who had their children vaccinated once before age one, but who did not complete the first-year vaccination series
- **Continuing Users.** Mothers who had their children vaccinated before age one and who completed the entire vaccination series

Team members thought they needed to understand more clearly the differences between continuing users and the other users and nonusers. To accomplish this, they further clarified their research questions as follows:

- What influences the women in the continuing users group to complete the vaccination series?
- What information do those mothers have or think they need? How do they get the information?
- What exists for those mothers that does not exist for mothers who have their children vaccinated only once before age one?

Note: Such research on differences among groups is key to understanding which factors influence your audience's behavior to adopt a new practice. You may find, for example, that people who use condoms to prevent sexually transmittable diseases are more confident and also talk to their sex partners about protection more often than those who do not use condoms. You may find that mothers who use oral rehydration therapy (ORT) regularly are those who attend health center sessions or are more likely

to know the dangers of dehydration. Mothers who complete the vaccination series may be more likely to know about side effects and how to treat them than other mothers do. Identifying these "differences that make a difference" in behavior will help you direct your intervention. For example, you may want to encourage sex partners to talk to each other and show them ways to do so without self-consciousness, or you may want to encourage mothers to attend health centers as a step toward influencing them to use ORT.

Exercise 2. Identifying Secondary Audiences

Materials

Copies of the example, Immunizing Children (Secondary Audiences)
Paper and pens

Instructions

Have team members read the information in this example on research audience segmentation and write a summary of the ideas presented.
Conclude the exercise with a discussion of the steps your team needs to take to define the research audiences for your health problem.

Example 2. Immunizing Children (Secondary Audiences)

Team members who wanted to increase the number of children immunized thought they also should examine possible allies in solving their health problem. An anthropological study on women and health practices conducted by researchers at a local university reported that although women are the primary caretakers, they generally do not take health actions, unless it is an emergency, without first consulting with their husbands. Additionally, the study showed that women would consider trying a new health practice if it was recommended by someone they trusted and respected. It identified health workers and respected mothers as the most trusted sources of information on health concerns.

Using this information, team members added the following two secondary research audiences:

- Fathers/husbands who influence decision-making within the family
- Health workers who recommend vaccinations
- Mothers who have completed their children's series

The following additional research questions took shape:

- Do fathers support vaccination? Why? Why not?
- What can be done to encourage them to support vaccinations?

- What is the best way to get the messages to them?
- Do health workers inspire trust and respect? Why? Why not?
- What can health workers do to motivate mothers to continue the vaccination series?
- How do mothers who complete the series differ from those who do not?

After examining relevant literature, reports, studies, and surveys, team members identified the following audiences for their research efforts:

Primary:
Mothers who had their children vaccinated once before age one but who did not complete the first-year vaccination series

Secondary:
Mothers who had their children vaccinated before age one and who completed the entire vaccination series
Fathers and husbands who influence decision-making within the family
Health workers who vaccinate children

Background Information

Research Audience Segmentation

In the example above, team members used previously conducted research to narrow the focus of their research to smaller, more-specific behaviors and more-specific audiences. Narrowing the audience even before conducting the research helped team members make better use of their resources and focus their research questions more clearly.

The three major functions of research audience segmentation are as follows:

- Decide resource allocation
- Devise communication strategies
- Develop targeted messages

To make research and programs more effective, think carefully about the feasibility of segments you choose. This approach has several advantages, as follows:

- Choosing feasible interventions and audiences, which helps focus your activities on behaviors that can be done
- Increasing the confidence and credibility of your health education staff
- Helping to demonstrate the effectiveness of a research-based communication methodology

It is not always possible or desirable, however, to focus all of your efforts on one or two segments of the population. Reasons of politics or equality of service may suggest you pay attention to audiences who are less likely to respond to your intervention. In such situations, you can use the following criteria to decide what portion of your resources should be spent on different segments. In the beginning, you may decide to spend more money on the segment that is most at risk from the health problem and will respond most easily and quickly. You could plan to provide programs for the hard-to-reach populations later, after you have had an impact on the first segment. When it is seen that a portion of the population has adopted the new behavior, it often makes it easier to reach the more difficult audience.

Segmentation Criteria

Useful criteria for choosing audience segments on which the intervention will focus include the following:

Segments *most affected* by the health problem

- Size of the segment
- Frequency with which the problem occurs in this segment
- Seriousness of the problem among this segment
- Resources the segment has to deal with the problem
- Ability of the segment to cope with the problem without outside help

Those most likely to respond to behavior change

- Accessibility, availability, and approachability of the research audience

Other Possible Sources of Information

- Key informants can provide insight into the audience. Such individuals are those within a particular community or population who can help researchers design and implement health interventions by supplying information about the community and its members. Those sources include village leaders or anthropologists.

- Allies can help solve the problem and provide support to the primary audience. They might include fathers, other family members, and health workers.

Exercise 3. Applying Research Criteria to a Problem Statement

Materials

Copies of the Example 3, Identifying the Audience

Instructions

Distribute copies of the example.
Have the team re-examine the problem statement used as an example in Question 2 and discuss whether they think the Jordanian health team identified the most appropriate research audiences for their intervention.

Example 3. Identifying the Audience

The health team in Jordan developed the following problem statement:

Although it appears that mothers accept the value of breast-feeding, they are not breast-feeding their infants frequently enough or for a long enough period to ensure stable growth. Existing university research shows that most mothers nationwide do attempt breast-feeding within the first three days following birth, but that they have problems continuing breast-feeding for as long as they would like. The small number of mothers (seven percent) who do not initiate breast-feeding are primarily urban, more affluent, and educated. Their children are not malnourished and, therefore, are not priority audience for the intervention. Refugee mothers tend to breast-feed longer than other mothers, so they are not considered part of the target audience. Mothers with less access to health care are more likely to breast-feed.

A higher incidence of diarrhea and malnutrition exists among children of low-income, less-educated, rural mothers. Possible causes of reduced breast-feeding could include the following:

1. Insufficient motivation to continue breast-feeding
2. Lack of family support
3. Belief that formula is better than breast milk
4. Poor breast-feeding practices, such as late initiation and early supplementation
5. Lack of confidence in the ability to breast-feed

The health team identified the following audiences for their research:

Primary:
Lower-income, less-educated, rural mothers with children under age two

Secondary:
Fully breast-feeding rural mothers with children under age two, fathers, and health workers

Synthesis

Research shows that when the initial research audience is carefully identified at the start of a program, the end result is much more cost-effective and the intervention is more successful. After the initial problem has been described, it is necessary to identify the primary and secondary audiences involved in the problem and consider how to learn more about their behavior through research. Such identification and selection are necessary to gather the most useful information from the right audiences to plan for the intervention.

The following five questions will help you identify your research audiences:

Primary Research Audience

1. Who is most affected by the identified problem?
2. Who might be most responsive to behavior change?
3. Who can be reached?

Secondary Research Audiences

4. Who might provide some idea of what might influence your primary audience to change behavior?
5. Who are the allies who can help solve the problem?

Good! You Are Ready To Make Your Research Audience Segmentation!

Application

1. Go to Worksheet 3, Research Audience Identification. Distribute copies of the worksheet. Review the problem statement you developed for your intervention in Question 2, Worksheet 2-1. Keeping in mind the five research audience segmentation questions, determine the audiences with which you should conduct your research and state why you selected them.

Worksheet 3 - 1

Research Audience Identification

Carefully review your problem statement before segmenting your audiences for research.

Primary Audience for Your Research

1. Who is most affected by the identified problem?

2. Who might be most responsive to behavior change?

3. Who can be reached?

Secondary Audience for Your Research

4. Who might provide some idea of what might influence your primary audience to adopt behavior?

5. Who are the allies who can help solve the problem?

Question 4.

What Behaviors Do We Want the Target Audience to Perform Regarding the Health Problem?

You have identified the health problem you will address in your intervention. You also identified those most affected (primary audience) by the proble , others involved in the problem. In this question, you will identify the behaviors you want your audience to perform so they will benefit from the intervention.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Reviewed the differences among ideal behavior, current behavior, and feasible behavior (Worksheets 4-1; 4-3)
2. Discussed guidelines for determining the steps needed to carry out a behavior (Worksheet 4-2)
3. Selected ideal behaviors for different audiences and determined the barriers and benefits of adopting the behavior (Worksheet 4-4)
4. Analyzed factors that could determine your audiences' feasible behaviors

Exercise 1. Hand Washing

Materials

A copy of the hand washing exercise for each team member
Paper and pens

Instructions

To understand (1) the differences between an ideal behavior and a feasible behavior and (2) the many steps involved in a relatively simple behavior, do this exercise with members of your team.

You have been asked to ensure that all team members of your health unit maintain clean hands by washing them daily as specified below.

Ideal Behavior

To wash your hands:

Before and after preparing or helping with meals (approximate number of times—10)
Before and after every meal (approximate number of times—6)
At work or home after using things that may be dirty (approximate number of times—2)
After urinating and defecating (approximate number of times—10)
Total number of times, approximately, you should wash your hands daily—28

Current Behavior

Step 1. Look at your own hands and analyze how clean or dirty they are. On a scale of 1-10 (1=cleanest, 10=dirtiest), record the number you think represents the cleanliness of your own hands: _____

Step 2. Wash your hands. Note how long it takes. Record:_____ minutes per hand wash.

- Determine your *current behavior* regarding hand washing
- How many times daily do you usually wash your hands? How does this compare to the recommended or ideal behavior?

Breaking the Behavior into Steps

Step 3. Write down all the things you did as you washed your hands; for example:

- Removed your watch
- Rolled up your sleeves
- Got water
- Wet your hands
- Picked up the soap
- Rubbed your hands with the soap

How many of these things did you do? What else did you do?

Step 4. List everything you need to wash your hands. Your list might include the following:

- Recognizing that your hands are dirty and need washing
- Knowing how to wash your hands
- Water
- Soap
- Credible information that washing your hands is important

Did your list include these points? What else did you list?

Step 5. Complete this calculation: Multiply the number of times (frequency) you have been asked to wash your hands (ideal behavior) during the day times how long it takes to wash your hands as estimated in Step 2. The result will give you the amount of time that is required daily to carry out the *ideal behavior.*

_____	x	_____		_____
frequency		(times)	=	(total washing time)

Determining the Feasible Behavior

Step 6. Ask yourself if you consider your answer to be a reasonable amount of time to spend each day washing your hands? If not, what would you consider a reasonable hand washing practice; i.e., number of times/situations (*feasible behavior*)?

This exercise demonstrates what may be involved in carrying out an ideal behavior in terms of time, supplies, attitude, and beliefs. You may think this is too much (too high a cost) given your current behavior. You may recognize that a more *feasible behavior* would be to wash your hands only before handling food. The exercise also demonstrates that a particular behavior can be made up of a number of essential steps. To research a behavior, you must take the time to understand each separate step that is required to carry out the behavior.

Background Information

The following brief summaries of the three categories of behavior can be used to plan your research:

1. Ideal Behavior

Ideal behavior usually corresponds to the first behavior thought of by health education team members as the "best" or the medically "optimal." For example, physicians may think that all low-income mothers should breast-feed their infants without additional liquid or solid supplements for the first six months. An ideal behavior, however, can be difficult to put into practice, as the hand-washing exercise demonstrates. Mothers who work in factories or the fields may not be able to take their infants with them. The intervention will have to find ways to help them find the best alternatives (expressing milk or assuring nutritious supplements are added). Before beginning your research, you can identify only some technically possible ideal behaviors what you think would be the model or perfect way to address the health problem.

2. Current Behavior

Current behavior corresponds to what the audience is actually doing. You can determine such behavior through appropriate research, such as observation. Observing current behavior can be helpful in determining what your audience considers the barriers to and benefits of a particular behavior. (See Appendix 8, Section II, for observation techniques.)

3. Feasible Behavior

Feasible behavior is the most realistic behavioral goal that you can expect your intervention to promote. After careful analysis of the current behavior, you can propose specific changes that will improve the health situation and that are in accordance with what the audience finds acceptable and believes they are capable of doing. Although it often times bears little or no similarity to the original ideal behavior, it will result in the desired feasible behavior change, which in turn will have a health impact.

Reflecting on Field Experience

Exercise 2. Determining Ideal Behaviors

Materials

Copies of Example 1, Determining Ideal Behaviors

Instructions

Read and discuss the example. Answer the following questions:

- What other ideal behaviors might the African team consider?
- What are the challenges to determining ideal behaviors in this manner?
- What are the advantages?

Example 1. Determining Ideal Behaviors

Team members of the Ministry of Health (MOH) in an African country who were working on their vaccination program were ready to determine ideal behaviors to help further focus their research efforts. They started with their four research audiences and listed them on a flip chart. After consulting with health specialists regarding ideal behaviors, they developed the following list of ideal behaviors for each audience:

Possible Criteria for Segmenting Your Audience	
Objective Measures	
General	**Behavior Specific**
Age of Adult	Contact with health system
Approximate income	Past behaviors (user/nonuser)
Sex of adult	Access to products
Place of residence	Distance to health center
Race, ethnic group	
Language	Behavior of relatives
Size of home	Behavior of community

Primary Audience:

Mothers with children under age one who have received one vaccination

Ideal Behavior:

Have their children complete the entire vaccination series before their first birthday

A mother in the primary audience needs to complete the following components to carry out the ideal behavior effectively:

- Purchase vaccination card
- Mark a calendar with all immunization dates
- Obtain father's approval to go to the health center and have the child immunized
- Take time from her work to go to the health center
- Travel to the health center for each vaccination
- Wait hours for the vaccination
- Have transportation money
- Locate the child's vaccination card
- Deal with possible side effects of vaccinations

Secondary Audience:

Mothers who had their children vaccinated before age one and completed the entire vaccination series

Ideal Behavior:

Provide testimonials and act as role models to other mothers in their communities

A mother in the secondary audience needs to complete the following components to carry out the ideal behavior effectively:

- Obtain father's approval
- Organize meetings/talks
- Prepare something to say
- Take time from other work to conduct talks
- Travel to sites to conduct talks
- Obtain transportation money
- Be available to answer questions from neighbors, friends, family, and peers

Team members continued to list the components of the ideal behaviors they had identified for both fathers and husbands who influence decision-making and for health workers who recommend vaccinations.

Exercise 3. Understanding Determinants of Current Behavior

Materials

Copies of Example 2, Understanding Current Behavior Example and the chart which follows the example

Instructions

Have team members analyze the example and chart. Ask them to comment on how this information complements the earlier exercise of breaking the behavior into component steps.

Example 2. Understanding Current Behavior

After the African team wrote the additional research questions that would help define the mothers' current immunization behaviors, they wanted to define the factors influencing the current behavior. They wanted to see if that because of these factors, important questions still needed to be added to the research questionnaire. To gain a better idea of these current behaviors, they asked the following questions:

- Is the ideal behavior not practiced due to lack of skills?
- If so, which skills?
- Are they practicing similar behaviors? What are they?
- Are they performing competing behaviors? What are they?

The team tabulated the answers in the following chart form:

Audience:

Mothers who had their children vaccinated once before age one, but who did not complete the first-year vaccination series

Ideal Behavior:

Have their children complete the entire vaccination series before their first birthday

Factors Influencing Current Behavior

Factors	Yes/No	Unknown/Need Further Research
Is the ideal behavior not practicable due to lack of skills?	Yes	
If yes, list specific skills: · Unable to use/read vaccination card		
Is the failure to perform due to other reasons?	Yes	
If yes, list reasons: · Fear of side effects · Cannot see results of vaccination		
Does the audience perform similar behaviors?		X
If yes, list the specific similar behaviors:		
Does the audience perform competing behaviors?	Yes	
If yes, list specific competing behaviors that act as barriers: · Use of local herbal teas, which they believe will cure disease if it arrives · Reliance on local healers		

After completing this chart, the team knew they needed to expand their research to answer the following additional questions:

- What competing behaviors do the individuals in the audience have?
- Do they practice any other similar behaviors? What? How?
- What other steps are involved in the current behavior?

Barriers and Benefits for Behaviors

Why should they adopt this behavior?	What are the barriers to adopting this behavior?	What are the benefits of adopting this behavior?
To protect their children from disease	• Time to go to the clinic • Cost of transport • Difficulty with husband/friends • Child's possible side effects • Unpleasant experience with health worker	• Reduce the cost of medical bills • Reduce the time to take care of sick child • Potential support from healthy adult children

Synthesis

Who decides what an ideal behavior is and what is a feasible behavior for any given group of people? The people themselves the audience for your intervention will make that decision. In the hand-washing exercise, you considered the quality and cost of ideal behavior, examined your current behavior, and decided on a more realistic behavior goal. Research will enable you to conduct the same analysis of your audiences' current behaviors, how the audiences would feel about your proposed ideal behaviors, and what the audiences would consider reasonable or feasible behaviors.

Without research on what people currently do and why they do it, it can be difficult to assess how an audience might perceive the adoption of a new behavior. Before beginning your research, you can identify only some technically "ideal" behaviors and what you think would be the model or perfect way to address the problem.

Ideal behaviors are determined by (1) selecting an ideal behavior for each research audience (assuming that later they might be part of the intervention); (2) listing the steps involved in each ideal behavior, and developing an ideal behavior profile to determine why the audience will adopt the behavior; and (3) assessing, to the extent possible, what is known about the audience's current practices in relationship to the ideal behavior.

Application

1. Go to Worksheet 4-1, Specifying Ideal Behaviors, and complete it for each of your target audiences. In the light of the health problem your intervention is addressing, ask team members to complete Worksheet 4-2 to break up in steps each ideal behavior.
2. Fill out Worksheet 4-3, Understanding Current Behavior, to find out what you already know and need to know to understand the factors influencing the current behavior.
3. Complete Worksheet 4-4, Barriers and Benefits for Behavior, for each audience.

Congratulations! You are on your way to defining with research the behavior your intervention will promote.

Worksheet 4-1

Specifying Ideal Behaviors

I. Audiences and Ideal Behaviors

Audience	Ideal Behavior
Primary	
Secondary	

Worksheet 4-2

Breaking the Behavior Into Steps

Audience:

Ideal Behavior:

Steps:

1.

2.

3.

4.

5.

6.

7.

8.

9.

Worksheet 4-3

Understanding Current Behavior

Audience:

Ideal Behavior:

Factors	Yes/No	Unknown/ Need Further Research
Is the ideal behavior not practicable due to lack of skills?		
If yes, list specific skills:		
Is the failure to perform due to other reasons?		
If yes, list reasons:		
Does the audience perform similar behaviors?		
If yes, list the specific similar behaviors:		
Does the audience perform competing behaviors?		
If yes, list specific competing behaviors that act as barriers:		

Worksheet 4-4

Barriers and Benefits for Behavior

Why should the audience adopt this behavior?	What are the possible barriers to adopting this behavior?	What are the possible benefits of adopting this behavior?
To protect their children from disease		

Question 5

What Will Influence Our Audience to Adopt a New Behavior?

This question discusses other factors that you will want to consider in determining the barriers and benefits that influence your target audience in their decisions about behavior. Such an examination will enable you to ask the right research questions about behaviors affecting the health problem you have chosen.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Reviewed common factors that can influence behavior and examined how to use those factors to design your research
2. Described the importance of identifying the stage your target audience has reached in the behavior change process
3. Determined, to the extent possible, the stages that the audience might reach in the behavior change process based on your existing data (Worksheet 5-1)
4. Listed the factors that might influence the adoption of the new behavior (Worksheet 5-2)

Introductory Note

Behavior change is difficult! If a person told you to stop smoking or to use a condom, would you do so simply because the person told you to do so? Consider a time in your own life when you changed a behavior. Did you change because someone asked you to? Or did you change only after you considered (1) what barriers and benefits you would face in adopting the behavior, (2) whether you had the skills and confidence to change, (3) what kind of impact such a change would have on you and those around you, and (4) what you would have to do or need to have, such as access to services or supplies, before you could change the behavior?

Even as you examine factors that support behavior change and determine the stages of behavior adoption in which an audience might be, you must remember and respect how hard it is for all of us to change our behavior.

Exercise 1. Factors Influencing Behavior Change

Materials

Copies of Example 1, Factors that Influence Behavior Change

Instructions

Read this list with team members and discuss it thoroughly.

Factors That Influence Behavior Change

Fortunately for health education team members who attempt to base their strategies on sound behavioral and social scientific theory, the major theories (see Appendix 11) agree on several common factors that influence behavior change.

1. **Expected Outcomes**
   When considering adopting the new behavior, do members of the audience expect a positive or negative outcome for themselves?
2. **Intention**
   Has the audience formed a strong positive intention or is it committed to perform the behavior?
3. **Self-Image**
   Is the behavior compatible with the audience's self-image?
4. **Skills**
   Does the audience possess the necessary skills to practice the new behavior?
5. **Self-Efficacy**
   Is the audience confident that it can perform the new behavior?
6. **Emotions**
   If the audience chooses to perform the behavior, does it anticipate a positive feeling in doing so (pleasure, excitement, fun) rather than a negative gut feeling?
7. **Perceived Social Norms**
   Does the audience perceive greater social pressure (from all of society or its subgroup) to perform the behavior than not to perform it? How does the audience perceive that the community around it would feel or react if it adopted the new behavior? Does the audience perceive that the new behavior would contradict an existing social norm?

In addition to representing the points of consensus among theorists, those common factors have been shown empirically to account for much of the variation in any given behavior within a particular population.

Several other factors that influence health behaviors include the following:

8. Health Service
   What kind of service does the health center provide? Is it a barrier or a benefit (such as a rewarding experience) for members of the target audience who use the services?
9. Knowledge
   What and how much does the target audience know about the health problem? How much does it know about the correct behavior for dealing with the problem?
10. Behavioral Compatibility
    Does the audience believe that the new behavior is consistent with how it normally acts? Does it practice similar behaviors, or does it practice competing behaviors?

Background Information

All the factors you discussed may affect a given behavior, or possibly only some of them will affect the behavior. All factors usually do not influence any one behavior. You will find that different factors influence the same behavior in different audiences; for example, rural and periurban. Using your research will help you discover which factors may be influencing the behaviors you are trying to change with your audience. You can see how these factors affect behavior if you look at how each factor is linked to barriers and benefits.

Reflecting on Field Experience

Exercise 2. How Factors Determine Barriers and Benefits

Materials

A copy of Example 2, Factors Influencing Immunization Behavior, for each team member

Instructions

After reading this example carefully, determine what research questions you need to draft to obtain the full picture of the current behavior for your intervention.

Example 2. Factors Influencing Immunization Behavior

The team working on the immunization intervention determined their ideal behavior as: "Have the children complete the entire vaccination series before age one." In the following chart, team members listed factors that could influence the adoption of this ideal behavior.

Factors Influencing Behavior

Ideal Behavior:	Take children under age one to a health center for the vaccination series		
Factors	**Barriers**	**Benefits**	**Research Status**
Expected outcomes	Children will get sick (fevers, sores)	Not known	Insufficient
Intention	Not committed to vaccinate	Not known	Insufficient
Self-image	Good wife stays at home	Good mother protects children	Sufficient
Skills	Doesn't know what to do about side effects	Not known	Insufficient
Self-efficacy	Feels confused by card and schedule	Has taken child before	Insufficient
Emotions	Pain when child cries from vaccination	Not known; sense of safety?	Insufficient
Perceived social norms	Some older community leaders argue against use of vaccinations	Some influential villagers want mothers to comply	Sufficient
Other factors:			
Health service	Too far to walk Too long to wait Impatient, uncaring health workers	Not known	Insufficient
Knowledge	Cannot remember immunization dates; too far apart	Not known	Sufficient
Behavioral compatibility	Not known	Goes to health center for other services; tradition of amulets to protect child	Sufficient

Team members then drafted the following research questions to provide information they needed on specific aspects of the current behaviors.

Knowledge

What do mothers know about immunizations as a protection for their children against disease?

Do they know that they need five trips to the health center to complete their children's immunization schedule?

Do they know the place, date, day, and time they are to return for follow-up immunizations?

Expected Outcomes

Do they know what side effect might occur from the immunization and what they should do about those side effects?

Do mothers believe that immunizations are effective?

Do they know a child who was immunized but still developed the disease?

Do they believe that the disease the immunization prevents is a normal part of childhood?

Do they believe that the disease is a realistic danger to their children?

Perceived Social Norms

Are mothers expected to stay home to take care of their other children and, therefore, are unable to take the youngest to the health center to be immunized?

Do their husbands scold them for situations related to going to the health center? For example, do they scold their wives for having dinner late because they were at the health center?

Do husbands or other family members discourage mothers in other ways from taking children to the health center?

Do friends and other family members support or praise mothers for taking their children to the health center for immunizations?

Are mothers acquainted with others who are practicing the desired behavior by completing the vaccination series?

Health Service

Where is the health center located? Is it nearby? Or is it far away?

When is the health center open? Is it open at convenient times? Or is it open only when mothers need to do other things such as work in the fields or sell at the market?

Do health workers thank and praise mothers for bringing their children to the health center to be immunized?

How do health workers treat mothers? Do they treat them courteously and sympathetically? Do they treat them in ways that the mothers perceive to be discourteous?

Do they advise mothers about when and where to return for future immunizations? Or do they forget to advise them?

Do health workers advise mothers about the possible side effects of immunizations? Or do they forget to advise them?

Do they determine that mothers actually understand their advice?

Do they encourage mothers to ask questions if they do not understand what health workers are saying?

Do mothers have to wait a long time before their children receive their immunizations?

Are health workers in a hurry?

Do mothers say that their children have ever been denied immunizations because they had a cold or diarrhea?

Did health workers tell mothers to return at a later date for the mothers' tetanus toxoid immunization rather than immunizing her immediately?

Do mothers say they are uncomfortable coming to the health center because health workers are of another ethnic group or speak another language?

Experience shows that how you use your understanding of the benefits and barriers can determine your success in attaining your behavioral objectives. Some behaviors may be influenced by several factors; other behaviors by only one or two of the factors. You will need to address the barriers and benefits that most influence your audience, and which you can most influence. For example, you cannot eliminate side effects for some treatments. You can prepare individuals in your audience for such an occurrence, however, and help them manage the side effects.

Background Information

Stages of Behavior Adoption

The Stages of Behavior Adoption model assumes that individuals initially may be in a stage in which they are not even thinking about changing their behavior because they lack awareness of the problem or its relevance to their lives. They may accept the problem but not be aware of possible solutions. They become aware that the problem exists (awareness), then recognize a solution (knowledge), but make no decision about taking action. They decide they want to change their behavior (intention), try the new behavior (action), and finally accept the new practice over a long period of time (maintenance).

This model assumes that people may form weak intentions, strengthen these intentions, try the behavior inconsistently at first, and then finally adopt the new behavior as a routine part of their lives.

Movement through these stages can vary greatly from population to population and from individual to individual. Some people may remain in the same stage for months or years, while others may cycle back and forth among the stages. They may skip stages or find some unnecessary. Everyone, however, is vulnerable to reverting back to an earlier stage.

Understanding the Stages of Behavioral Adoption model can help health education team members focus their efforts. Often team members will decide on an objective of "sensitizing" the audience or building their awareness or knowledge when, in fact, the audience has already reached the stage of wanting to adopt the practice, but lacks the skills or self-confidence to move from intention to action. An effective health communication plan must allow for finding out where in the behavior change process the audience is and must target the interventions to that point.

Health professionals often feel that the audience needs the kind of understanding that is important to professionals, such as the concepts of germ theory, how immunization works, or the life cycle of a parasite. The audience may need to understand these concepts to change their practices, but more often it is found that they have more practical concerns. For example, mothers may feel they need to know what to do about side effects and the appropriate ages for each vaccination for their children, but they do not need to know about each specific disease for which their children are being vaccinated or how vaccinations work.

Stages of Behavior Adoption

Awareness (Recognizing the problem)	Knowledge (Recognizing a solution)	Contemplation (Seriously considering the problem)	Intention (Making a commitment to action)	Action (Trying the new behavior)	Maintenance (Assessing the action, reinforcing the action)

Effective interventions first determine where the majority of a population is in terms of the stages of behavior adoption and then address that specific "teaching moment"; that is, they attempt to move people to a subsequent stage of behavior and, eventually, to the maintenance of that new behavior. Careful research is essential to such efforts.

Exercise 3. Stages of Behavior Adoption

Materials

A copy of Example 3, The Stages of Behavior Adoption, for each team member
A large copy of the stages of behavior adoption chart on a flip chart.

Instructions

Read this material individually and then discuss it in a group.

Example 2. Stages of Behavior Adoption

In Kenya, the Ministry of Health/Epidemiology (EPI) initiated a program to introduce Hepatitis B vaccinations into the immunization schedule. Before conducting any research, the team devised a plan to develop radio spots announcing that Hepatitis B immunizations were now available at local health centers. Their objective was to increase coverage significantly for Hepatitis B vaccinations after one year.

The research they conducted before developing their radio spots showed that mothers of children aged under two years were unaware that Hepatitis B existed. They did not know the problems the disease could cause, nor what they could do to prevent it. In the Stages of Behavior Adoption model, the mothers were at the beginning; they had no awareness that the Hepatitis B problem existed. They had no intention of getting a new immunization for their children, especially since they were not fully convinced of the usefulness of the vaccinations their children currently were receiving.

In examining the data, researchers concluded that (1) even though some mothers were having their children immunized, they were not fully convinced of the value of immunizations, and (2) since they had no awareness of Hepatitis B, they were not willing to get additional immunizations.

Based on this research, the team decided that the most effective way to proceed would be to have a model Hepatitis B program in one district. They were accurate in placing the mothers in the awareness stage of the Stages of Behavior Adoption because they found that mothers see the relevance of the problem. Health team members wanted to move the mothers through the stages to action. By creating a model program in one district, they were able to work with a smaller population of mothers and identify which specific interventions moved them through the stages.

Those interventions, which could then be adapted to other districts, included the following:

- Increasing awareness and knowledge by arranging for people who were respected in the communities to talk about what the illness is, the dangerous consequences it could have on their children, and the vaccine that could prevent it
- Encouraging mothers by scheduling home visits by health aides to mothers of young children
- Reducing waiting times for vaccination sessions at the health center by setting up special Hepatitis B days
- Reinforcing positive behavior in the community by distributing congratulatory flyers to mothers who had their children vaccinated

The team not only immunized 25 percent of the children but successfully replicated the program in other districts.

Synthesis

Effective health communication program interventions must be sensitively matched to the specific factors and influencing behavior and behavioral adoption stages of the audience identified for the intervention.

The advantages of this research approach are that it enables you to accomplish the following:

1. Identify the factors that most influence the audience that is targeted for adopting the desired behavior
2. Discover where the audience is in the stages of behavior adoption
3. Use an understanding of the factors to design a research questionnaire to obtainthe best possible picture of the current behavior
4. Permit comparison of the current behavior with the ideal behavior to determine later what will be the feasible behavior that the target audience will be asked to perform in the communication plan

Application

1. Go to Worksheet 5-1, Factors Influencing Behavior, and apply the listed factors to each ideal behavior defined in Worksheet 4-1, Specifying Ideal Behaviors. Note if you need more research data.
2. Then go to Worksheet 5-2, Factors Influencing Behavior, and based on your existing information, determine where you believe your audiences are in the stages of behavior adoption. Use rough percentage estimates to determine portion of target audience in each behavior stage.

Congratulations!
You are ready to design your research questions!

Worksheet 5 - 1

Factors Influencing Behaviors

Behavioral Focus	Benefits	Barriors	Research Status
1. Expected outcomes			
2. Intention			
3. Self-Image			
4. Skills			
5. Self-Efficacay			
6. Emotions			
7. Perceived Social Norms			
OTHER FACTORS			
8. Health Service			
9. Knowledge			
10. Behavioral Compatability			

Worksheet 5-2

Stages of Behavior Adoption

Primary Audience	%	Secondary Audience	%
1. Awareness		1. Awareness	
2. Knowledge		2. Knowledge	
3. Contemplation		3. Contemplation	
4. Intention		4. Intention	
5. Action		5. Action	
6. Maintenance		6. Maintenance	

Question 6

How Do We Define Additional Research Needs and Objectives?

You have now assessed the information you currently have about the health problem you decided to address. You also identified the target audience that this problem affects, the ideal behavior for the audience to adopt, and the factors influencing its adoption. In this question, you will use this information to define your research objectives. You also will determine other research needs that you have not considered before, such as information for deciding what communication channels to use for your intervention.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Determined your other research needs, particularly the communication channels used by your target audience (Worksheet 6-1)
2. Explored and defined how to develop the research objectives to reflect these information needs (Worksheet 6-2)

Introductory Note

The purpose of your research is to gain an understanding of the audience for your intervention. The research should be designed to discover what differences among members of your audience affect their willingness or ability to adopt a proposed behavior and how to use the information about those differences to develop a communication strategy that will persuade the audience to adopt improved practices.

Before reaching to the example of Exercise 1, which will enable you to reflect on and develop your own research objectives, here is a brief summary of the elements you have studied thus far for your health communication plan. This summary will help you appreciate the importance of what you are doing in this question. The summary of elements is as follows:

1. Health problem. You have defined a single health problem in a precise way, including possible causes of the problem, known effects, and those affected.
2. Target audience. You have identified the primary and secondary audiences of those most affected or involved with your health problem.
3. Ideal behavior. You have learned how to compare current behavior with the ideal behavior to determine the feasible behavior to be promoted in your intervention.
4. Factors influencing the behavior. You have reviewed the factors that influence behavior change or adoption.

Now that these elements are fresh in your mind, you are ready to review the following background information.

Background Information

Additional research needs to appear when the right set of questions are asked. The first set of questions deal with the health problem, target audience, ideal and current behaviors, and the factors influencing behavior. The second set address the communication channel research needs.

Identifying Additional Research Needs

The following questions are important to ask in identifying additional research needs:

Health Problem

- Is the definition of your health problem comprehensive?
- Does your description include relevant epidemiology, impact, and mortality rates?
- If you need additional information, where will you get it?

Target Audience

- Is your target audience well defined?
- Do specific research questions need to be addressed to the secondary audience?

Ideal Behavior

- Is there a clear definition by a technical member of the team of the ideal behavior?
- Does the unit director or other authority who must ratify the decision agree with the definition of the ideal behavior?

Current Behavior

- Is there a clear profile of current behavior being practiced by members of the target audience?

- Do you need to find out more about the current behavior? What questions can you add to your list to make the current behavior profile more complete?

Factors Influencing Behavior

- Have you investigated all factors that influence the decision to adopt the new behavior?
- Do you need to know more about those factors? If so, what kind of research questions must you add?

Now that these key components are reviewed and consolidated, you can identify the communication research needs.

Identifying Research Needs to Determine Communication Channels

Members of the Honduran team knew that their intervention was going to use some channels of mass communication, but they were not certain which channels would be most effective in reaching their target audience. They did not know which radio and television programs were most popular, what was the most appropriate hours for airing, or which stations to use to air their messages. They also needed to find out which sources of information had the highest credibility with members of their target audience.

Questions to provide this information needed to be included in their formative research effort. To make sure that no major piece of information was left out, they used the following check list:

__ Which mass media reach our target audience?
__ Does the audience have television sets, radios, or regular newspaper delivery? Are television sets and radios in good working condition? Is electrical flow constant and regular?
__ What are their favorite radio and television programs?
__ At what time do they normally listen to and watch these programs?
__ Who are the most popular telecasters and radio announcers?
__ Whom do they believe the most?
__ What sources do they have for health information in their community?
__ How do they like to receive health information? In what format?
__ Who are the most credible sources of health information?
__ Are there any traditional channels of communication with the community that are popular, such as songs, community theater groups, puppets, dances, dance celebrations, or similar activities?

The answer to these questions will be used in Questions 15 and 17. Now that the communication research needs are identified, you can proceed to determine the research objectives.

Reflecting on Field Experience

Exercise 1. Determining the Research Objectives

Materials

Copies of Example 1, Health Team Identifies Research Objectives

Instructions

Read the example in small groups.
Define research objectives for the example and compare them to the one provided by a member of the Honduran team.

Example: Health Team Identifies Research Objectives

In Honduras, team members had gone through the process of identifying the health problem they would focus on: children under five years of age who were dying from dehydration during episodes of diarrhea. Through research, they determined that their target audience was mothers of these children and that the ideal behavior was for mothers to give ORS to their children as soon as they had diarrhea to prevent them from becoming dehydrated.

They identified the current behavior of mothers in their target audience as using homemade teas for diarrhea with no salt or sugar added. They also identified the factors that would influence mothers to change to the proposed new behavior.

While team members were doing this work, the director of the epidemiology unit happened to walk by and heard their discussion. Very spontaneously, he asked, "Why are you carrying out this research?"

Even though team members thought they had the answer to his question clear in their own minds, the person who answered gave evident signs of confusion about the research objectives. He said, "We want to find out the reasons why children die from dehydration even though there are ORS packets available."

What is lacking in his response? His definition does not show a clear grasp of the objectives of their research. To find out how to express these objectives, please review carefully the following information.

Background Information

Your research is clearly defined when you identify a specific set of research objectives. Frequently, however, research objectives are not well spelled out. They lack precision and do not relate the research to the future communication strategy.

To avoid this, please consider carefully the following definition of specific research objectives: A specific research objective for a communication intervention should yield information that will -

- Permit you to identify and understand the current behavior practices as they relate to the behavior to be studied in your research audience and the determinants affecting these practices.
- Give you an understanding of the sociodemographic variables and how they affect the behaviors to be studied.
- Give you a sense of the target audience's media preferences and uses.

For the field example above, the research objectives were as follows:

- Establish mothers' knowledge of the types of diarrhea and their treatments
- Find out if mothers have categories for severe diarrhea and its treatment
- Learn if mothers understand the concept of dehydration
- Determine what mothers do regarding feeding practices (including breast-feeding) during bouts of diarrhea
- Establish what oral solutions are used (purchased or recommended) and by whom
- Determine what channels of communication they have access to and how they use them
- Identify what channels of communication are trusted and respected

Compare this example of specific research objectives and go back to the answer given by the team member in the example. Analyze his answer and determine how it is incomplete. How would you now rephrase it? In what way is your phrasing different from the Honduras example given?

Determining the specific research objectives helps you focus once more on the reasons for doing the research. They force you to be precise in your thinking.

Synthesis

- To find out if you have any further research needs, review each of the health communication plan's elements thus far studied (definition of the health problem, identification of the target audience, definition of ideal and current behavior, and the factors influencing behavior adoption) and determine if you need to formulate additional research questions in any of these areas.

- Access to and use of the target audience's communication channels must also be determined by your initial formative research.
- The research objective includes the subject matter to be studied, the tools for conducting the study, definition of the target audience, and location of the research.
- Research objectives permit you to identify and understand the current behavior practices as they relate to the behavior to be studied in your research audience and the determinants affecting these practices.
- They also give you an understanding of the socio-demographic variables and how they affect the behaviors to be studied.
- Research objectives will furnish information of media preferences and uses.

Application

1. Complete Worksheet 6-1, Additional Research Needs, to determine the questions that will guide your further research needs, especially those relating to communication channels for your target audience.
2. Go to Worksheet, 6-2 Research Objectives, and complete the research purpose and objectives for your health problem.

Worksheet 6-1

Additional Research Needs

Research audience

a. Defined health problem

b. Behavior:

- Current
- Ideal
- Influencing factors
- Stage of adoption

c. Communication channels

Worksheet 6-2

Research Objectives

Primary Audience

Research objectives:

1.

2.

3.

Secondary Audience

Research objectives:

1.

2.

3.

Question 7

How Will We Incorporate Evaluation Indicators in our Research Design?

This question on evaluation indicators provides you with the last component that you will need to plan and organize your formative research effectively.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Identified the possible indicators for evaluation in the areas of health status, behavior, and knowledge/attitudes
2. Expressed these indicators as research questions
3. Developed possible evaluation indicators for your health communication plan (Worksheet 7)

Introductory Note

To see where evaluation indicators fit in the evaluation phase (Question 25) of your plan, it is important to understand the types of evaluations you will select from later. The chart below summarizes the types of evaluations you could use, the critical questions each type addresses, and the timing for performing them.

TYPE OF EVALUATION	CRITICAL QUESTIONS	TIMING
Formative Research (baseline data)	What is the health problem? Who is the target audience? What is its current behavior, knowledge, and attitudes? What form should the communication take? What channels can help reach the target audience? How will thein tervention be measured?	At the beginning of the plan
Monitoring	What is happening? Why is it happening? Is it happening according to the plan and strategy? How can problems be fixed?	Ongoing
Impact	Were health behaviors changed? How much? Compared to what? What were the causes of behavior change?	At transition points or at the end of the program
Outcome	Did the target audience's heath improve? How effectively was the implementation?	At the end of the program As needed

These types of evaluations will be discussed in Questions 24 and 25. This question focuses on the formative research (or baseline data) you will need to be able to evaluate your communication strategy, messages, and materials.

Reflecting on Field Experience

Often the baseline research or initial formative research does not include data that can be used to evaluate the intervention. Evaluation may not be thought of as necessary or important in the early stages of developing the health communication plan.

Such thinking is an unfortunate oversight. As you begin to think about your intervention, remember that you will want to be able to define the effect, impact, and changes generated by your efforts. The way to accomplish this is to have data gathered before and after the intervention has occurred.

The following example will illustrate how to introduce evaluation indicators in a research questionnaire.

The easiest way to evaluate the success or impact of your communication plan is to introduce indicators on the initial design of the formative research.

Exercise 1. Evaluation Indicators

Materials

Copies of Example 1, Examining Evaluation Indicators

Instructions
Read the example and discuss the ways it demonstrates how to determine evaluation indicators.

Example 1. Examining Evaluation Indicators

In a health communication program for oral rehydration salts (ORS) in Honduras, team members developed the following new behavior objective for periurban mothers with children under two years of age:

> *Give your child ORS every time he or she becomes dehydrated during an episode of diarrhea.*

For this behavior objective, they listed on a chart the general areas for evaluation and discussed possible specific indicators that would show what they expected as the outcome of this behavior. The evaluation indicators appeared on this list as follows:

New Behavior: Give your child ORS every time he or she is dehydrated during an episode of diarrhea.	
General Areas	**Specific Indicators**
Health Status	Fewer cases or less hospitalization is reported for dehydration during high diarrhea season.
Behavior	Mothers report early use of ORS packets when the child shows first signs of dehydration. Increased distribution of ORS packets is reported at health centers.
Knowledge	Mothers know how to mix ORS. They recognize signs of dehydration and understand how much ORS to give their children. They recognize that dehydration is dangerous. They recognize that controlling dehydration is more important than stopping the diarrhea.
Attitudes	Mothers are willing to recommend ORS to friends. Mothers are willing to go to health centers when their children have severe diarrhea. Mothers are willing to start using ORS when signs of dehydration appear.

As a result of developing this list of possible evaluation indicators, team members added the following additional questions to their list for the formative research.

- How many cases of dehydration currently are reported during this diarrhea season?
- How many ORS packets currently are distributed monthly at health centers?
- If they are using ORS, how do mothers currently mix it?
- When do they give ORS to their children?
- How much ORS do they give?
- How do they feel about ORS?
- Have they ever recommended ORS to a friend?

Before you begin to develop evaluation indicators for your own plan, review the following exercise to help become familiar with identifying these indicators.

Exercise 2. Evaluation Indicators

Materials

Copy of the example, Determining Evaluation Indicators

Instructions

Have team members read the following example and answer the questions found in the chart that follows. As you will note, the questions found in the right-hand column refer to general goals and are not specific to a particular intervention. By answering these questions, you will be able to come up with evaluation indicators for each of the three areas.

Example 2. Determining Evaluation Indicators

The Ministry of Health in Senegal was concerned about the country's infant mortality rate. Many infant deaths were related to diarrheal disease, although the ministry had an ORT public education program in place for several years. Based on their research, staff knew that mothers could recognize dehydration, feared its consequences, and could identify sugar-salt solution (SSS) as a possible treatment. Many reported trying SSS. Because there was a problem with distributing the packets, the ministry continued to promote home mixing despite having many problems in teaching mothers to mix SSS correctly.

Questions for Determining Evaluation Areas and Specific Indicators

Evaluation Area	Questions Leading to Evaluation Indicators
Health Status	Do the Senegalese need to know if the health status of their audience will improve as a result of the intervention they are planning? If they do, what specific indicators will they have to look at to assess having improved the audience's health status?
Behavior	What specific practices can they observe to determine whether the audience has adopted the behavior promoted?
Knowledge/Attitudes	Do they need to know whether knowledge and attitudes have changed as a result of their intervention? If they do, what specific knowledge needs to be changed to promote the proposed behavior? What specific attitudes need to be changed to promote the proposed behavior?

When you have finished answering these questions, you are ready to begin designing your research evaluation questions.

Synthesis

- Different types of evaluations respond to different critical questions and are done at different times in the intervention.
- Formative research (baseline data) is done in the planning stage for the intervention.
- Evaluation indicators must be included in the formative research.

- Evaluation indicators reflect the communication objectives for health status, behaviors, and knowledge/attitudes.
- Those indicators are turned into questions for the formative research questionnaire.

Application

1. Go to Worksheet 7-1, Evaluation Indicators, and using the chart suggested there, fill in your problem description, audience segmentation, research areas, and evaluation indicators. The completed worksheet will give you the evaluation indicators for both your primary and secondary audiences.

GREAT JOB! Now develop your own evaluation indicators for your research design.

Worksheet 7 - 1

Evaluation Indicators

Given each research audience and the new behaviors you have identified, what might be suitable evaluation indicators:

Primary Audience

Behavior

Areas	Need Indicators - Y/N	Specific Indicators
1. Health		
2. Behavior		
3. Knowledge		
4. Attitudes		

Secondary Audience

Areas	Need Indicators - Y/N	Specific Indicators
1. Health		
2. Behavior		
3. Knowledge		
4. Attitudes		

Question 8

What Research Methods Will Best Satisfy Our Information Needs? Can We Do This Ourselves or Do We Need To Hire Outside Resources?

Questions 6 and 7 have helped you organize and refine your list of research questions and information needs so that in this question you can effectively determine which research methods will best help you obtain this information. If you think you need additional information after completing this question, please see Appendix 8.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Examined the purpose and application of formative research methods
2. Learned to distinguish between qualitative and quantitative research
3. Examined how to choose the best research methods for your intervention (Worksheet 8-1)
4. Determined various qualitative and quantitative research methods and the skills needed to use each (Worksheet 8-2)
5. Identified reasons for using outside resources to conduct research (Worksheet 8-3)

Exercise 1. Formative Research

Materials

Copies of points one through seven

Instructions

Read the following points with your team.
Discuss each point until it is fully understood and there is a working agreement on the concepts.

Points one through seven create a foundation on which you can build your formative research, starting with the research structure.

1. **Definition of Formative Research**
   Formative research is the process of collecting information for use in developing an intervention appropriate for a designated audience. The information collected guides the development or design of activities, programs or materials, or products.

2. **Why Formative Research Is Important**
   Health communication interventions should be framed within a strategy based on an in-depth knowledge of the intended audience. Formative research provides such knowledge. Planners use this knowledge to devise appropriate behaviors or services, design persuasive messages for adopting the behavior or service, and select the media that will most effectively reach the intended audience.

3. **Types of Research**
   Research can be quantitative or qualitative. Quantitative research provides the scale and scope of what is happening, e.g., how many people are doing what and how often (40 percent of rural mothers initiate breast-feeding). Qualitative research gives that scale and scope feeling, texture, and nuance. It presents the information in a context with feelings; e.g., mothers who breast-feed feel they are part of an important ethnic tradition. A combination of qualitative and quantitative methods reveals audience points of view in depth and provides a baseline for measuring change. Quantitative research provides an overall picture, while qualitative research fills in the details and brings the picture to life.

4. **Qualitative and Quantitative Research Should Be Complementary**
   Qualitative and quantitative research methods can be undertaken independently, but generally they are used together to complement one another. The choice of a method depends on the research objectives, resources available, scope of the project, and time available to conduct the research. It is necessary to determine whether the research is intended to produce relatively precise, statistical, generalizable, and quantifiable findings or descriptive and qualifying information or a mix of the two.

   - From quantitative data, issues that need to be probed further in qualitative research can be isolated.
   - From issues raised in qualitative data, quantitative data can be collected to establish the extent and magnitude of those issues.
   - Qualitative data can give program planners an understanding of what may motivate the intended audience to change their behavior.

- By comparing findings from quantitative and qualitative research of a particular topic, consistency of the information being provided can be seen.

5. **General Characteristics of Qualitative and Quantitative Research Methods**
The following table compares qualitative and quantitative research methods. It deals with general characteristics of both methods, which enables you to see the differences and similarities between the two methods.

Comparison of Methods

QUALITATIVE	QUANTITATIVE
Enables the researcher to study selected issues, cases, or events in depth and gather information through direct quotation, interaction, and observation	Seeks to establish how many and the relationship between variables
Seeks to answer the reasons why	Facilitates the use of statistics for aggregating, summarizing, describing, and comparing data
Is in-depth and exploratory and permits probing	Allows for broad generalizations of findings to larger populations
Allows for interaction between facilitators and participants	Uses large, random samples
Records the participants' emotions, language, feelings, perceptions, attitudes, and what motivates them	Documents how norms, skills, beliefs, and attitudes are linked to particular behaviors
Is purposive, using small samples	Focuses on outcomes
Focuses on process	

6. **Comparison of Qualitative and Quantitative Research Methods**
The following table presents the strengths and weaknesses of qualitative and quantitative research methods. The decision on which one to use for a given purpose will depend on specific research needs. Remember that a good research design will use both qualitative and quantitative research in a complementary manner.

Strengths and Weaknesses of Each Method

	Qualitative	Quantitative
Time	Takes less time in data collection	Takes longer
Cost-effectiveness	Cost is higher in analysis	Collection is more expensive; higher yield in statistical data
Interview participation	High	Medium
Flexibility of protocol	High	Strict
Statistical basis	Credible	Valid and statistically reliable
Scope/scale	Inferential (we can infer that . . .)	Generalizable (20% of the total . . .)
Type of information	Richer and more in depth	Broader; number based

7. Common Qualititative and Quantitative Research Methods

Descriptions of qualitative research method approaches for gathering information to plan a health communication intervention follow.

Ethnographies are in-depth studies of the culture into which a given health practice fits. They are useful in determining how aspects within the culture can be used to support new behaviors and in identifying cultural taboos.

This approach to research has made it possible to construct several rapid ethnographic techniques. Among the most well known and commonly used techniques are the following:

- Participatory Rapid Assessment: Members of the target audience give researchers their point of view of the health problem to be studied. The technique uses sorting, mapping techniques, and taxonomies.
- Focused Ethnographic Study: The technique compiles ethnographic data as they apply to specific health problems.
- Rapid Assessment Procedures: This anthropological approach geared to improving health programs primarily uses focus groups, mapping, and observation techniques.

An ethnographic approach to research is heavily oriented toward community participation. It offers considerable opportunity for expression by those studied.

Focus group discussions are useful in developing hypotheses, exploring broad topics, and producing a large number of ideas. The group setting enables people to talk more freely about feelings, beliefs, and attitudes. Through such discussions, program planners and communicators become more sensitive to the values, concerns, and needs of target audiences.

Observation studies help describe actual behavior patterns or identify obstacles to adoption of new behaviors. Observing a specific behavior enables researchers to select ways to motivate the target audience to try the new behavior for the first time and gives them some cues on how to remind people to continue to perform the behavior. Observation studies are useful in determining how widespread a behavior is practiced or a product is used and whether the materials needed to support it are in place. Observation can be particularly useful in understanding and evaluating the interaction between health workers and mothers.

In-depth individual interviews are most useful in providing a greater understanding of particular values or viewpoints. Researchers typically use this method with a relatively small number of influential or knowledgeable persons (informants). The method is used to interview secondary audiences to determine how they interact with the primary audience and how they influence that audience.

The intercept interview is a research method that falls between traditional quantitative and qualitative approaches. It is qualitative in the sense that it does not use probability samples and quantitative in that it typically calls for large samples and tabulated data analysis. These studies involve stationing interviewers at points frequented by individuals from the target audience. Locations can be pharmacies, clinics, market places, health centers, bus stops, cafes, and outdoor eating places. This type of interviewing can collect information in a reasonably short time and be a cost-effective means of gathering quantitative data. Results, however, cannot be generalized to larger populations.

There are many quantitative research methods. The following are brief descriptions of the most common.

Sample surveys are useful in validating a hypothesis (e.g., people who use condoms are more likely to talk to their partners about sex) and in determining the relative prevalence of a given belief or practice. The sample survey can establish the prevalence of a belief or behavior and examine the relationship among beliefs, behaviors, background characteristics, and exposure to communication channels for a particular population. It incorporates interviews with a large sample chosen to represent the target population and typically makes use of highly focused questions that can be coded for computer-based analysis. This

research technique is most valuable when program planners have a specific notion of what they need to know and have generated well-developed research questions.

A **literature/record review** of health survey records of medical services or commercial firms may contain invaluable indicators of the reach of those institutions. Medical service records may suggest what proportion of the population is seen and how often they are seen, as well as where people with illnesses associated with the intervention are to be found. Records of commercial firms, for example, may indicate trends in the distribution of ORS packets or condoms over time and in different geographical regions.

A **knowledge, attitude, and practice (KAP) survey** used in health communication research looks intensively at the level of knowledge the target audience has regarding a specific health problem, their attitudes toward the problem, the desirable ideal behavior, and the current behaviors being used to deal with the health problem. Correlations are made among these factors.

The **baseline study** research method examines current behaviors in terms of the potential for people to change. KAP surveys often are used as baseline studies. The survey is repeated after the communication intervention has been completed. It serves to measure the results of the intervention.

Existing small studies can be useful to researchers. Universities or private voluntary organizations often carry out excellent and informative studies that might provide insights about a particular audience, region, or health problem. Contacting likely organizations for the results of these studies can enrich understanding and save program or project resources. Researchers in these groups often have good technical skills and access to communities they are studying.

Demographic health surveys are among the most common surveys done by health ministries. They serve to reveal epidemiological data and patterns of how the health problem evolved. They also serve as a source of comparative baseline data and impact indicators.

Reminder: You will find a longer description and training approach of some of these research techniques in the Appendix to Question 8. It is located at the end of this question.

Choosing the right research method is like working with a cookbook. You need to find just the right recipe to tell how to prepare the dish you want.

Exercise 2. Choosing the Best Research Methods for Your Information Needs

Materials

Copies of the chart, Research Methods for Information Needed, and the Example, Deciding If You Carry Out the Research

Instructions

Organize team members in two groups.
Each group will analyze the chart using information from the example to choose the best research methods for their information needs and complete the corresponding worksheet for their intervention.

To choose the right research methods for your needs, you need to determine what type of information your questions address. Questions may include why, what is happening, who, how, how many or how much, or what are the perceptions of needs and problems. By identifying the type of information needed, you can more easily determine what methods you should use to gather it.

The following chart illustrates the methods best suited to different types of information.

Research Methods for Information Needed	
Type of Information Needed	**Specific Research Methodology**
Questions about why	• Focus group discussion (FGD) • Interview • Rapid ethnographic technique (RET)
Questions about what is happening	• Epidemiology (EPI)/other survey • Knowledge, attitude, and practices (KAP) survey • Observation study
Questions about who	• Literature/record review • Observation study • Demographic health survey (DHS) • KAP survey • RET
Questions about how	• Observation study • KAP survey • Interview • Participatory rapid assessment (PRA) • FGD
Questions about how many or how much	• Sample survey • KAP survey
Questions about perceived needs and problems	• Observation • KAP survey • PRA • FGD

After you decide which research methods you should use, you need to decide whether you and your team want to carry out the research yourselves. If you do, assess whether you have the skills necessary to conduct the research methods chosen for your program. If you think that you do not have the necessary skills, determine where you can acquire the help you need. Also determine whether you have the time and resources to acquire such help.

See Question 10 for help in identifying local resources to meet your research needs.

Reflecting on Field Experience

Example 2. Deciding If You Carry Out the Research

A team involved in increasing the use of ORS agreed that it would carry out a small baseline survey and focus group discussion with their primary research audience. Team members decided that, if possible, they would like to conduct their own research. Using a skills checklist, they assessed their capabilities to conduct the baseline survey and focus group discussion.

Levels of Skills Checklist

	Level of Training Needed by Staff		
	Basic Skills Needed	Significant Experience	Refresher Only Needed
Qualitative Methods Require			
1. Listening techniques		x	x
2. Interviewing/questioning		x	
3. Ability to handle group dynamics		x	
4. Appropriate body language/non-verbal	x		
5. Ability to reflect and summarize		x	
6. Open attitude (at ease, not prejudiced)	x	x	
7. Good interpersonal skills		x	
8. Abililty to adapt on the spot		x	
9. Analysis ability		x	x
10. Sampling and logistics	x		
11. Program use of results	x		
Quantitative Methods Require			
1. Research design	x		x
2. Focus on detail	x		x
3. Cross-tabulation		x	
4. Attention to detail		x	
5. Data tabulation		x	
6. Program use of results		x	

An examination of the ORS checklist indicated that for either research choice, team members would need some refresher or basic training to be able to conduct the research. They decided they could make better use of their time and resources by enlisting out-of-house help to carry out their research effort.

What are the advantages to using this skills checklist? The disadvantages?

Synthesis

To make the best use of your resources and ensure that you will effectively gather the information you need, you should do the following:

- Match your information needs with the research methods that will best gather that type of information
- Assess your capabilities to carry out your identified research methods
- Decide whether you will carry out your research or if you will look for an outside resource to do it

Application

1. Complete the following three worksheets on Choosing Your Research Technique (8-1), Levels of Skills Checklist (8-2), and Evaluating In-House Versus Outside Research Resources (8-3). They should give you a clear direction for deciding what type of research you need for your intervetion and if you will carry it out yourself or hire an outside source.

Worksheet 8-1

Choosing Your Research Technique

What type of information do you need to gather? Fill out the table below to help identify the best methods to use.

TYPE OF INFORMATION WE STILL NEED	SPECIFIC RESEARCH TECHNIQUE (check)
List questions about why 1. 2. 3.	• FGD • Interview • RET
List questions about what is happening 1. 2. 3. 4.	• EPI survey • KAP survey • Observation study
List questions about who 1. 2. 3.	• Literature record review • Observation study • DHS • KAP survey • RET
List questions about how 1. 2. 3.	• Observation study • KAP survey • Interview • PRA • FGD
List questions about how many or how much 1. 2.	· KAP Survey
List questions about perceived needs and problems 1. 2.	· Observation · Interview · PRA · FGD

Do you want to carry out your own research? If not, it is not necessary to complete the following checklist. However, the checklist can be useful when selecting your outside resource, so keep it handy!

Worksheet 8-2

Staff Research Skills Checklist

If you plan to carry out your own research, do you have the skills needed to meet your informational needs? What skills training do you need? The following checklist will help determine your team's skill levels.

	Level of Training Needed		
	Basic	Significant	Refresher
Qualitative Methods Require			
1. Listening techniques			
2. Interviewing/questioning			
3. Ability to handle group dynamics			
4. Appropriate body language/non-verbal			
5. Ability to reflect and summarize			
6. Open attitude (at ease, not prejudiced)			
7. Good interpersonal skills			
8. Abililty to adapt on the spot			
9. Analysis ability			
10. Sampling and logistics			
11. Program use of results			
Quantitative Methods Require			
1. Research design			
2. Focus on detail			
3. Cross-tabulation			
4. Attention to detail			
5. Data tabulation			
6. Program use of results			

Worksheet 8-3

Evaluating In-house Versus Outside Research Resources[1]

RESEARCH METHODS TO BE USED	TEAM								OUTSIDE RESOURCE					
	1. Has the skills:		2. If YES, has the time to conduct:		3. If NO, has the time to be trained:		4. If NO, but has the money to be trained:		5. We have the money:		6. They can meet your schedule:		7. They have the skills:	
METHOD	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
1.														
2.														
3.														
4.														

[1] Remember to consider a combination; for example, you do one research method and an outside source does another.

A. If you answered NO to 2, 3, or 4, you should consider having an outside source conduct your research.

B. If you answered NO to 5, you should do the research yourself.

Appendix to Question 8

Research Designs and Techniques

This Appendix includes the following sections:

1. Special Uses of Comparative Evaluation Designs, which describes two common and easily used comparative designs and principles to help the researcher do comparisons between groups
2. Useful Research Techniques, which includes brief descriptions of commonly used techniques that can be used for all types of research
3. Steps Involved in Implementing the Research Effort in the Field, which includes practical steps involved in carrying out a survey; the steps can be adapted easily to other research techniques

Section 1. Special Uses of Comparative Evaluation Designs

Time-Series Studies

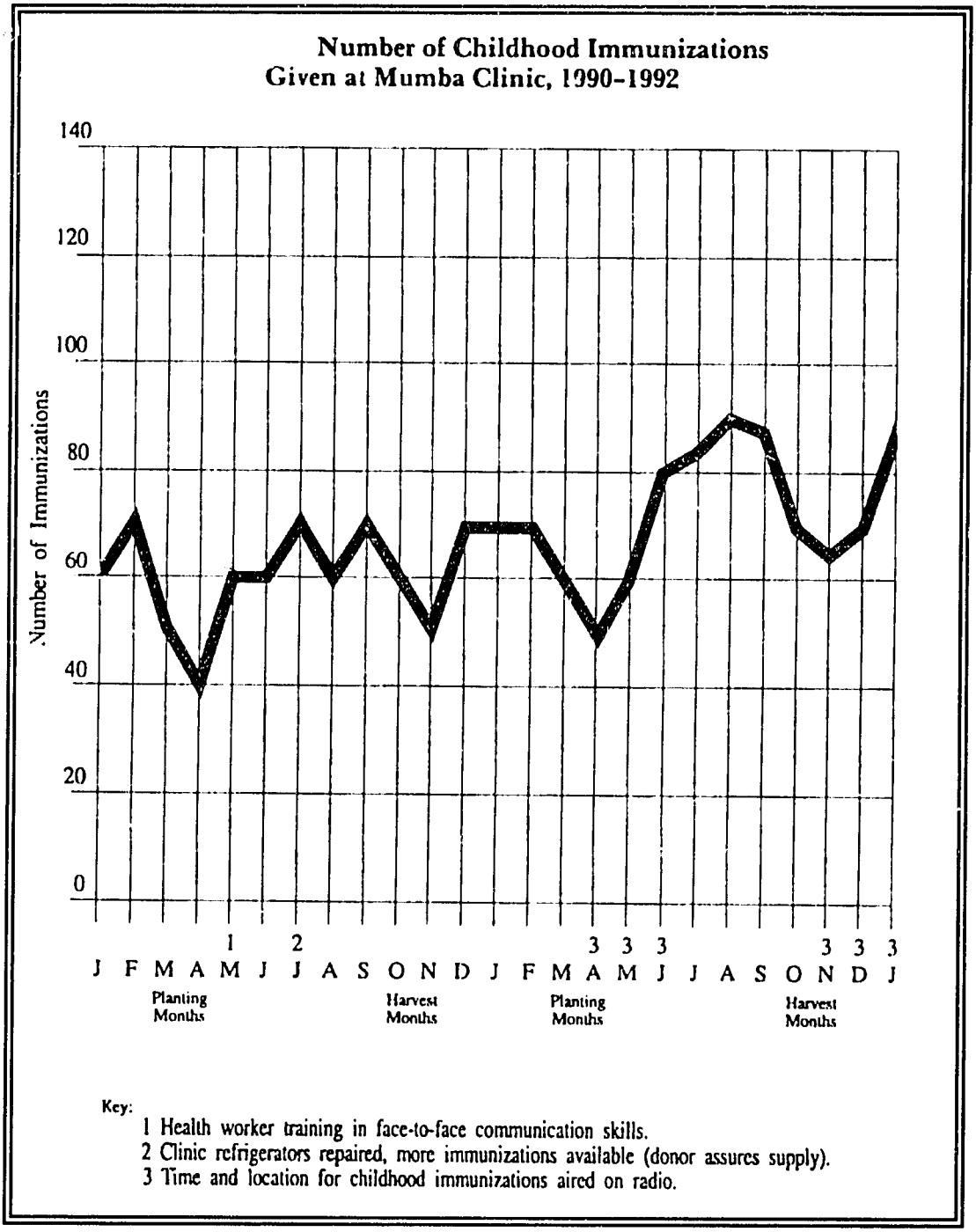
Time-series studies in behavioral investigations examine the behavior (or products of behavior) of interest over a period of time. This behavior is then graphed on a regular schedule to determine day-by-day or phase-by-phase fluctuations. In public health promotion, the behavior of specific individuals is not the sole interest. Far more emphasis is placed on the behavior or performance of groups, organizations, or entire communities. Therefore, the changes in attendance at clinics, accidents at the work site, mortality due to dehydration in an entire region, or immunization rates are graphed.

It is easier to count numbers of clients attending a prenatal clinic or a vaccination session than to measure the attitudes those clients have about these services. It is also easier to count packets of ORS distributed than to carry out in-home observation of mothers' ORS use. Existing reports that can help measure progress toward your objectives are an excellent, cost-effective option.

Numbers of vaccinations given, condoms sold, packets distributed, babies weighed, children with malaria brought to the clinic within the first 24 hours are examples of

activities that can be used to chart movement toward your program objectives. Time-series charts are a reliable and simple way to chart these data to identify relatively small trends toward your objectives. This approach can be useful because measurable improvements in health statistics and clinic reports often occur gradually, or only after your intervention has run for some time to include seasonal or natural (gestational, aging) periods.

An example of using a time-series study and graph follows:



The head of Mumba Clinic in a republic in central Africa made the preceding graph to track the number of immunizations her clinic staff administered monthly over a two-year period. She took the data from the regular clinic records, made the graph, and then showed it to the staff for discussion.

You may want to practice doing a time-series graph yourself, using the following example as a guide.

An intervention used neighbor-to-neighbor interpersonal communication to increase the use of boiled water and ORS in one neighborhood in a large city. Three weeks of conducting a baseline survey for ORS use showed weekly prevalences of 36%, 55%, and 46%, which changed to 57%, 39%, 49%, and 60% in the four weeks following the communication effort. Two weeks of baseline monitoring boiling water showed weekly prevalences of 13% and 8%, followed by 47%, 77%, and 50% after the intervention began. Graph these data and draw your conclusions.

Comparative A/B Designs

The simple baseline/intervention or A/B design is a simple comparison of behavioral data taken at two different points during an intervention. For example, an immunization monitoring effort was set up in which once each week mothers of children under five years of age attending a clinic had their well-baby cards checked. The percent of children fully up to date on immunizations was graphed at the beginning of the effort and after five weeks. This comparison and other possible comparisons are described below.

Pre/post research design compares the target audiences before the program with the target audiences after the program. It must have necessary preprogram data.

Post research/control group compares the target audiences after the program with similar groups not exposed to the program. No preprogram information is necessary.

Pre/post research/control group compares the target audiences before the program with the target audiences after the program and with similar groups not exposed to the program. It must have necessary preprogram data.

The following principles can help you make comparisons correctly between groups:

- **Points of comparison.** Base your evaluation on points of comparison. Take measurements of different program situations; for example, pre/post, in which you measure mothers' (or health workers') behavior, knowledge, and beliefs before and after the intervention. You can also compare groups with groups without or areas that benefited from the program with similar areas that did

not. Another option is groups now and groups waiting for the intervention. If your project is being implemented health center by health center, province by province, or training group by training group, you can compare those who have already benefited with those who have not.

Examples of points of comparison follow:

Area to area. The eastern part of the country has started a program and will be showing results before the western part. You can compare basic statistical differences as they arrive monthly from each area, such as the number of mothers bringing their children for second vaccination visits.

Before and after. You have baseline data in the statistical reports from the past year. As these reports change, you can assume an impact of your program. Remember that alternative causes can bring about the change, such as a new road to the clinic or early onset of the malaria season. A change may not be due to your program. It is important to look carefully at alternative explanations for changes and try to see how important they are.

Exposed and not exposed. You have trained health workers in three clinics. You can compare their performance and the reaction of their clients/ community to untrained health workers and their clients/community that are matched demographically with the trained group.

- **Comparable groups.** For an impact evaluation you must create a comparison group that is matched as well as possible with your audience. The group should be from the same ethnic, cultural, educational, and residential population as your audience to eliminate the possibility that these demographic or behavioral differences would explain any changes you measure.

- **Elimination of other explanations for change.** It is important that the two groups being compared are as similar as possible so that you can eliminate other reasons for any changes you find. For example, if you find that more mothers are coming to the centers in the months after your intervention, you would want to eliminate the possibility that an improved road or the onset of malaria season is the reason for the increase rather than your messages. In the same way, you would want to be sure one comparison group is not farther from centers, of a different ethnic group, or has more or less money than the other. If factors other than your intervention could explain any differences between the two groups, they should be accounted for or, better, eliminated during the research design.

- **Design for countable answers.** Design instruments with ease of analysis in mind. Open questions, too many questions, and unclear questions contribute to volumes of data that overburden the staff and make it difficult to find useful results. Look at the time and resources you will have for analysis before you design your research. Often questions are added to forms because "since we are asking anyway, it would be interesting to know..." with the result that staff receive too much information to analyze easily.

Section 2. Useful Research Techniques

The research techniques described here can be used during your formative research phase to develop the concepts and strategies for your intervention, pretest materials and media messages, monitor program implementation, and evaluate program process, impact, and outcome. Each of these purposes will call for different uses of a chosen research technique to answer different questions. The techniques themselves, however, follow certain basic rules. The descriptions of these rules are meant to familiarize you with these techniques and assist the staff who will be managing research efforts. These brief descriptions themselves will not be adequate for you to apply the techniques if you have no previous experience in doing so.

Focus Groups

Your first big decision is whether focus groups discussions (FGDs) are the right tool for your research. All too often, people start focus group research without looking closely at what they need to find out.

Qualitative research such as FGDs does not lead to numerical estimates. It gives the researcher a deeper understanding of what people think, feel, and do (e.g., some mothers feel breast-feeding is not modern). Qualitative research helps if you need insight into why your target audience thinks or acts as they do about a particular research topic.

Because only a relatively small portion of people takes part in focus group discussions, FGDs cannot be used as a basis for drawing conclusions about what most people think, feel, or do. Unless they are combined with quantitative methods, focus groups should not form the basis for large-scale policy decisions. In general, any qualitative research is best combined with quantitative research to achieve general research objectives.

Focus groups should be selected carefully so that participants are representative of the group you wish to study. Eight to ten participants is an ideal number. Someone well trained in group management is responsible for creating a comfortable environment,

encouraging the participation of all those present, and asking the group relevant questions. This person is the moderator. Another person will take notes on all of the various opinions provided during the course of the discussion for subsequent analysis. This individual is the notetaker.

The number of focus groups will depend on the homogeneousness of the audience. If the target population you wish to reach is homogeneous, it will be easy to draw conclusions based on a small number of groups. However, if the population is divided into subgroups having very different characteristics, it will be necessary to conduct some focus groups with each subgroup.

Focus groups can be used to gather opinions as well as to pretest concepts, products, and communication materials. In each case, the general rules tend to be the same.

An excellent interactive learning kit developed by HEALTHCOM is available without cost for projects in the developing world from the BASICS Project, 1600 Wilson Blvd., Suite 300, Arlington, VA 22209, USA. This kit is designed to be used by staff with or without previous focus group experience. It is hoped that, if you will be using focus group discussions, you will use this kit.

Direct Observation

By using direct observation, communicators can learn how individuals behave in their daily lives in their homes or on the job. They can learn first hand what cues give rise to or are linked to a behavior, what the consequences of the practice are for the individual, and what environmental conditions affect the likelihood of the practice. Although observation is labor-intensive, the sample can be small. Observational studies often are used in conjunction with other data-gathering techniques to test out or validate survey data or identify key components in complex behaviors or in behavioral interactions, such as those between health worker and mother.

The following example shows how interaction between a vaccinator and a mother can be observed and recorded with a guide that would give you indicators that the behavior is being carried out fully as taught by the communication messages:

The following checklist was developed in coordination with the EPI Division, Ministry of Health, Burkina Faso, to measure the content of messages and the rapport between health workers and mothers. An exit interview was used to measure mothers' learning from and reaction to the interaction.

Content of Messages	I.D. Number of Health Worker:		
Described side effects If yes, which? Sores	YES YES	NO NO	
Don't touch	YES	NO	
Clean only with water	YES	NO	
Fever	YES	NO	
Cloth	YES	NO	
Aspirin	YES	NO	
Clinic if severe	YES	NO	
RAPPORT WITH THE MOTHER:			
Waits until mother calms child	YES	NO	NA
Responds to her	YES	NO	NA
Interrupts the mother	YES	NO	NA
Scolds the mother	YES	NO	
Explains the new flyer to the mother	YES	NO	
Gives a flyer to the mother	YES	NO	
Mother takes flyer with her	YES	NO	

Binary Recording

When you are interested simply in whether a specific behavior occurred or did not occur, you can use binary (yes/no) recordings. This approach can be used, for example, in nurse auxiliary education when you want to make sure a student checks the temperature of vaccination storage, selects the correct dosage, selects a clean syringe, cleans the vaccination spot, and disposes of the syringe properly. Instructions can use a binary recording format, which simply indicates whether a behavior occurred in a given period of time. These checklists are easy to use and therefore fairly common.

This binary format is not only appropriate for a general statement as to whether a behavior occurred, but also may be used in interval recording to determine whether behaviors occurred in smaller subsets of larger blocks of time. Through such interval recording used with this binary format, overall frequency or duration can be estimated.
Frequency Recording

The observer simply counts each occurrence of the behavior during a predefined time period, often extended over a longer time if the behavior is of low frequency. The pur-

pose of frequency recording is to give an accurate record of frequency within a designated time period, thus estimating the rate at which the behavior occurs.

Frequency recording is used (1) when behavior is of moderate to low frequency and occurrences are similar in length and intensity, and/or (2) when an observer needs to record more than one behavior or more than one subject at a time. For example, one can record different subjects engaging in the same easily observed behavior (such as patients entering the clinic) or one can record more than one behavior for a single subject (such as the number of drinks consumed and cigarettes smoked by one patron in a bar).

Examples of frequency recording include counting the number of vaccinations given or the number of questions a physician asked her patient during an examination. The rate of behavior is then computed by dividing this frequency by the amount of time observed.

Duration Recording

The observer measures the total length of time that the behavior occurs during a predefined observation period. The purpose of duration recording is to provide a record of how long the behavior occurs within a given time period, while providing a relatively more accurate measure, especially when frequency alone is unrepresentative. Duration recording is used primarily when a behavior or behavioral process has an easily determined beginning and end, for behaviors with variable durations (e.g., length of interactions between health workers and clients in clinics), and for a behavioral excess of long duration and moderate to low frequency (e.g., alcohol-drinking binges).

Examples of duration recording may include an individual's total talk time in a conversation as observed by the clinician in a role-play, number of hours of sleep per night, the duration of a single breast-feeding episode, length of exposure to ill cohabitants in a small house, and length of wait in a clinic's waiting room.

Record Reviews

Simple observation (or notation) of the physical product, outcome, or permanent record of a behavior (e.g., the weight of a person, the test scores of a health worker trainee, or the number of clinic visits recorded on clinic records) usually can be measured at the end of a predetermined time period. Its purpose is to provide a retrospective measure of the effect of a behavior in place of observation of the actual behavior. Record reviews are best used when other methods may interfere with the behavior you want to measure, when it is too difficult or too time-consuming to observe behavior directly, or in conjunction with another method. Record review data provide an excel-

lent means of validating other types of recording or, in other cases (e.g., weight loss programs), represent the principal form of measurement. Given these applications and advantages, record review can be very useful in public health promotion monitoring and evaluation.

Surveys

Surveys are a research technique for obtaining quantitative information when that information needs to be used to describe a large population group. A written survey makes it possible to cover a large number of variables in a relatively short time, but it does not allow for any in-depth treatment of those variables. Ideally, for a complete perspective, the survey must be combined with complementary qualitative techniques. Quantitative research methods give numerical estimates (e.g., 20 percent of mothers surveyed breast-fed their last child). This type of research generates conclusive data. It estimates how many, verifies the number of times, or documents differences between things that can be measured in numbers.

Surveys can be of limited use in researching attitudes and behaviors, such as why mothers decide not to breast-feed, because the respondent may give the answer he or she thinks is expected of him or her.

Planning the Survey

In designing the survey, it is important to identify clearly the objectives of the research effort and the variables that you are interested in studying. A determination will be made about which objectives could most benefit from the use of a survey.

The questionnaire should contain those questions that can provide you with the information you are seeking for each objective. In designing a questionnaire, it will be necessary to choose the types of questions, their content, the way in which they will be expressed (the vocabulary to be used), and their order or sequence, as well as the general organization of the questionnaire.

Questions may be open-ended in those cases in which you wish to obtain the freely expressed opinion of the respondent or close-ended where the respondent must choose his or her response from among predetermined alternatives.

The questionnaire should contain only the number of questions necessary for adequately analyzing the material in which you are interested. The questions should be phrased objectively so they do not induce a particular response.

The language used should include words that are commonly used by or familiar to the people being interviewed to ensure that the people will thoroughly understand the meaning of the questions. Begin with questions of a general nature and proceed to

more specific questions. This approach will help the respondent to "warm up" to the subject. The questionnaire should be designed to ensure that it will be as short as possible (no longer than 30 to 40 minutes).

After the survey is designed and the interviewers are selected and trained, it will be necessary to test the questionnaire by interviewing a small group of individuals having characteristics similar to the sample to be studied.

Testing the questionnaire will make it possible to do the following:

- Determine whether the questions produce information needed on the subject you wish to study
- Determine whether the vocabulary and meaning of the questions are understood
- Identify several common responses that will make it possible to convert open-ended questions into close-ended questions with various fixed alternatives that can be selected, thus facilitating future encoding
- Train the interviewers in applying the questionnaire
- Anticipate potential situations and questions that might occur in conducting the interview
- Measure the time required to conduct each interview to plan the field work for the survey

With the results obtained from the field test, the necessary revisions and changes will be made to arrive at the final design for the instrument. The most common changes normally involve vocabulary, phrasing of the questions, converting open-ended questions into close-ended questions, including adding questions or eliminating questions that are not truly useful.

Analyzing the results involves interpreting the data obtained from the survey. This analysis should be compared to the results obtained using other techniques and consolidated with those results during the final analysis of the research effort.

During the analysis, the results should be compared to the objectives of the research activity to determine whether the survey is generating the information required to facilitate the decision-making process involved in developing a communication strategy.

For example, to properly segment the target population identified for the communication strategy, it will not suffice to count the number of persons providing a particular response and then calculate a percentage. The responses given to specific questions must be cross-tabulated with the variables that were previously selected as being most important for a particular segment. To properly analyze the practice of breast-feeding,

it is not sufficient for you to know that 20 percent of mothers do not breast-feed their babies. You need to know the characteristics of those women who do not breast-feed their children to define the type of mother on whom we should focus breast-feeding messages and relate those messages to other characteristics.

The In-Depth Interview

The most common alternative to focus groups for formative research and pretesting is the in-depth interview. It is a combination of focus group and survey techniques, combining the qualitative nature of the former with the one-to-one format of the latter. It is generally less logistically and technically complicated to organize than the focus group (although it may require more time to interview the same size sample or to analyze) and allows for the interview to be done in the respondent's home or other natural setting. The in-depth interview may be more appropriate for eliciting responses to partially completed products, alternative versions of products, or final testing, while the focus group is more appropriate for initial concept testing. When the respondent's experience with the use of a product is deemed important, an in-depth interview can be useful in collecting feedback on the experience.

This technique requires the interviewer to create a comfortable, nonjudgmental relationship with the person being interviewed. The researcher may use techniques similar to those for focus groups in developing the interview guide, selecting and training interviewers, and selecting respondents for the in-depth interview. Depending on the needs for and resources of the research program, however, the in-depth interview may take on a more empirical flavor than focus group discussions. For ease of analysis, the interviewer may begin the interview with some close-ended questions before continuing with open-ended questions or may weave close-ended questions throughout the interview.

A variety of questions that assess general characteristics of the target audience may be asked during the interview. For example, "Where do you get your health information or what do you like or dislike about the health behavior or product of interest?"

Intercept Interviews

Intercept interviews are another important form of audience research. Individuals can be stopped at the point where the audience is most likely to be found. For clinic users or people with special interest in a health-related problem, it might be a clinic waiting room, or for a general audience, a local market that draws women from many surrounding areas. Those interception points should be high-traffic areas, allowing the researcher to contact large numbers of respondents in a short period of time.

The procedure for the intercept interview involves approaching individuals, asking them some questions to determine whether they match the characteristics of the target

audience or consume the target product, showing them the products or materials being researched (either at the point of interview or at a nearby interview area set up for this task), and questioning them about the products.

Alternatively, exit interviews are conducted with people who (may) have already been exposed to a promotion or product. They combine brief, close-ended (or multiple choice) versions of questions developed for focus group and in-depth interviews, with some behavioral observation techniques, and allow for contacting in an efficient manner people who are engaging in or avoiding a target behavior. Interviews must be brief, however, and researchers can expect a high rate of refusal.

Intercept or exit interviews can be either qualitative or quantitative. To use the data quantitatively for generalization you would need to have a large enough sample, just as you would for other quantitative techniques.

Test Marketing

Test marketing gives the researcher the opportunity to answer questions about products or material through a small-scale, real-world test. In a carefully (and usually narrowly) defined market, a product is introduced with immediate tracking of audience reactions through intercept interviews, surveys, or other techniques. These data are then used to modify the product or promotional campaign, launch it, or in some cases, cancel it altogether.

Test marketing is especially useful when the product is considered close to its final form or has already been proven in other markets. The technique is also used when there may be a need for a success story to build on before a full promotional effort is undertaken. Limited real-world testing allows you to answer any final remaining questions and refine the product before production. It should be combined with more extensive qualitative research when a new or potentially controversial product is being introduced and the price of failure or problems may be excessive. Test marketing can take advantage of time-series or A/B group designs.

Section 3. Steps Involved in Implementing the Research Effort in the Field

The steps described below are not necessarily shown in sequence; rather some of them may take place simultaneously or in a different order. What is important is that they be followed to systematize the process of gathering information in the field. The steps describe the process of carrying out survey-type research but can be useful for organizing focus group or observation research as well.

Determine the Number of Individuals in the Sample and Where They Can be Found

True Random Sampling[1]

Whether it is for purposes of planning surveys or evaluations of child survival interventions, you may want to conduct scientific random sampling of your target population. In random sampling, each unit (e.g., person) in the sampling frame (e.g., community population) should have an equal chance of being selected for a study. Sophisticated statistical formulas will tell you how many individuals or other levels of subjects you will need to sample for a given study.

These formulas are based on differences between subject groups and variability within subject groups. Often in development research, however, you do not have data indicating what variation or differences to expect, nor may you have sufficient resources to calculate the sample needed or select a sufficiently large enough population to meet the sample size requirements. The common sense approach to appropriate research technology tells you that whether you are selecting community samples or random samples, the size of your study sample will be based on the budgetary and other resources that you have available.

Real-World Sampling

Although this is not how science is supposed to proceed, real-world research applications dictate that first you determine how much it will cost to contact one subject and from there, how many subjects you can afford to contact. For example, if the price of driving to one subject, interviewing the subject, and coding data from the one subject amounts to $8 and your budget for your entire survey is $800, you can only have 100 subjects. It is hoped that the variability of your data will be minimal and the reliability will be high. If such is the case, you will be able to make good use of the data form these 100 subjects. If not, other sampling methods (especially convenience sampling) or design alternatives (e.g., single subject/time series) should be considered.

Assuming that you are able to determine how many subjects you can afford to contact, you can proceed with your sampling. First, you need to determine what the population of interest is. Here are two possible scenarios: 1) mothers who attend a clinic, or 2) all mothers in a given village who could potentially attend a clinic. In the first case, you may be especially interested in satisfaction with services provided and, therefore, want to focus on only those mothers who are attending a clinic. You would then want to determine the total case load for the clinic in a given time period (e.g., in one week) and divide that number into the number of surveys or interviews you could afford to

[1] (ART) Appropriate Research Technology for Planning, Evaluating, and Improving Child Survival Programs, John Elder, Senior Technical Advisor, HEALTHCOM.

conduct. This number would give you your sampling framework. For instance, if you could afford 100 surveys in a clinic that served 1000 mothers, you would want to talk with every tenth mother who left the clinic after her visit.

Obviously, this will not always be possible. In some cases, your surveyors will not be able to stay in a village for an entire week. In other cases, the volume will be such that the surveyors cannot keep track of all mothers who leave the clinic. In both cases, the best approximation possible should be used. By avoiding mothers who are close friends or relatives with other mothers being interviewed and by conducting interviews out of hearing of service providers and other patients, you will help to avoid biases in the responses of the mothers you interview.

In another scenario, you may want to study the difference between mothers who use clinic services versus those who do not use it in a given village. In this case you will try to determine how many houses there are in a village (or other forms of domiciles in cities) and map out a random selection of the proportion of houses you can afford to contact. You will then go to each house designated in your sampling procedure and see if it is possible to conduct an interview with the mother who lives there. In many cases, the mother will not be at home or will refuse to be interviewed. The residents of a particular house may not have young children. In such cases, you can replace these potential subjects with their neighbors next door.

In many villages adequate maps will not be available to predetermine which houses will be contacted. In such cases, a rough estimate of the number of domiciles in that village should be made and an interviewer should simply proceed through the streets and knock on every nth door corresponding to the proportion of individuals to be represented in the sampling.

Cluster Sampling

When the population to be surveyed is physically or geographically dispersed, costs and time for studying individuals from this population can be very prohibitive. Cluster sampling is a method to reduce such resource requirements. Suppose you would like to survey potential buyers of an oral rehydration solution packet in a single region. The sample units would be households (or caretakers within households). A detailed map of the entire area would provide the sampling frame. However, it might be the case that our sample produces a wide dispersion of households and would take an excessive amount of time to reach everyone in the sample who was selected. A clustered random sample would have you, instead, select neighborhoods within a given area and then households randomly sampled within each neighborhood. In other words, this two-stage sampling procedure deals with two different sampling units: first, neighborhoods or other clusters and second, individual houses within the clusters. Similar random sampling procedures would occur at both levels of sampling.

Large versus Small Samples

In addition to your actual budget for sampling, other factors will contribute to whether you use large or small samples. Large samples may be indicated when (1) very serious or potentially costly decisions are being made, (2) the study sponsors demand a very high level of confidence in your data, (3) a high level or variation among the units in the sampling frame is expected, (4) project costs are not increased substantially with more subjects (e.g., in surveying domiciles in crowded urban areas), and, (5) of course, time and resources allow.

Small samples may be indicated when (1) no major decisions are pending before the study is complete, (2) the sponsors of your study require fairly rough estimates about your population or hypothesis, (3) the population is very homogenous regarding the variable being studied, and (4) you simply cannot afford large samples.

Another problem involves determining where to find individuals and how many should be interviewed in each site to achieve the required amount. One way of reaching this decision would be to relate the total target population in the area under study to the population in each particular site. For example, the number of families in a particular region totals 10,000 and you have decided to conduct a survey of 150 heads of family. In a community having 2,000 families (20 per cent of the total number of families in the region), it will be necessary to survey 30 heads of family (20 per cent of the total survey sample). This same rationale could be used to decide how to distribute the sample being studied for a particular group (e.g., health personnel, relatives of patients, or mothers of children who have been immunized at least once).

Another of the decisions involves determining the site where the various types of research are to be applied. For example, if you wish to conduct a focus group session with current tuberculosis patients and you know that a particular day has been set aside for such patients to receive treatment in a health center, you can select that day and that site as being most appropriate to find a number of patients willing to participate in the focus group.

The research team should meet and discuss these decisions so they do not leave information gathering to chance but rather ensure that the activity is carried out in a planned and systematic fashion.

Determine the Number of Individual and Group Interviews to be Conducted Daily

One of the results of testing the research instruments is a determination of the time necessary to administer them. Among other things, this approach helps you plan the number of instruments that might be applied over a particular period of time.

Suppose, for example, that out of an eight-hour work day you deduct one hour for reaching the site and organizing the activity and one hour for lunch. That will leave six hours for the activity itself. If your survey requires 30 minutes to apply, plus 10 minutes between the conclusion of one survey and the beginning of the survey with the next individual, you can conclude that a total of 40 minutes will be required for each instrument. By dividing the 360 minutes in the six hours available by 40 minutes per instrument, you estimate an average of nine surveys per surveyor per day.

Determine the Number of Researchers Necessary and Available

A large supply of trained workers in the health sector can be taught how to gather information in the field. Nurses, health promoters, and students following courses of study related to the work being performed (such as sociology, social work, medicine, and nursing) can be used in this activity. For the students, such involvement can be an extremely rewarding experience, and many professors may interpret it as such and be willing to count it as practical work for the students' classes.

Select the Researchers

From the supply of human resources available, select those having the greatest experience with the subject or in the research techniques to be applied. Also, remember that the nature of the subject to be studied must also be taken into consideration when selecting researchers. For example, if you are studying family planning subjects with women of reproductive age, it is logical that such women will feel more comfortable discussing this particular subject with other women. The same thing will be true if you are studying aspects of breast-feeding or the use of contraceptives. Interviewers will need to dress and conduct themselves during interviews in ways that help the respondents feel comfortable and at ease.

Train the Surveyors in the Application of the Research Instrument

The individuals that will be using the instruments must first be carefully trained in the subject being studied and its many variables. Such training may be the responsibility of the person in charge of the program or the epidemiologist, depending on the subject matter. Researchers must be trained to understand each of the research instruments they will use. For this purpose, they will review each of the questions contained in the instruments and analyze the reasons for including such questions, the information being sought, and the answers that may be received.

As practice in this training, the researchers will conduct a simulation of using the instruments, by placing themselves in the situation of the respondents and attempting to anticipate all possible situations for each of the questions. In addition, they will use the instruments with a small sample of the population, which will serve to provide a better, more definitive test of such instruments. Because personality and attitude play a key role in successful interviewing, invite more potential researchers to the training than you will need and then choose the best participants for your activity.

Establish a Calendar of Activities

To comply with all activities and deal promptly with any necessary precautionary measures, such as obtaining permits to interview people in health centers, a clear and realistic schedule of activities needs to be established for implementing all of the steps described. Special considerations (rainy season, religious festivals, elections) should be included in the planning.

Identify Logistical Needs (Gasoline, Transportation, Per Diems, Commodities)

This step is of fundamental importance for ensuring the proper implementation of the activities.

Reproduce the Guide and Instruments Based on the Number of Individuals Included in the Sample

It will be necessary to have available one-and-a-half or two times the number of research instruments sufficient to cover the previously established sample.

Gather the Information in the Field

Each day the surveyors will be deployed at the sites where the information is to be collected in accordance with the previously established calendar of activities. Each group of surveyors will have a supervisor. After administering a given number of instruments, each surveyor will deliver the instruments to the responsible supervisor. The supervisor will review the instruments, make any necessary recommendations and answer any questions that might arise.

When an instrument has not been properly filled in, it will be considered to be void, and a new instrument should be applied to another respondent.

Analyze the Data

The information gathered will be analyzed in accordance with the objectives formulated for the research activity.

Fill in the Analysis of Current Behavior Table

An appropriate communication strategy will be developed using the results obtained in the analysis. The media plans, creative briefs, and training plans will be developed based on the strategy. They also will reflect the research findings.

Prepare the Final Report

A report should be prepared, using the results obtained in the analysis, that will constitute a point of reference for the individuals charged with planning the communication strategy, as well as for those in charge of the overall program. This report should be given broad circulation so that health personnel will have a better knowledge and understanding of the views of the target population regarding the problem and can provide consistency and support to the communication effort.

Question 9

Now That We Have Decided to Conduct Our Own Research, How Do We Proceed?

This question provides information that is useful not only for conducting the research yourself, but also for supervising and managing an outside resource.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Described how to identify and organize your team
2. Identified resources who can provide research training or materials for research training
3. Planned and organized your field work
4. Developed your basic guide and/or questionnaire, organized your research team, and prepared your research field work plan (Worksheet 9)

Introductory Note

You have decided to conduct your own research, now what? At this point, you have the following:

- A categorized list of research questions (Worksheet 6-1)
- Your research purpose and objectives (Worksheet 6-2)
- Specific research techniques identified (Worksheet 8-1)
- A knowledge of what skills you have and what skills you need (Worksheet 8-2)

You can use these materials to organize your research training and field work. Keep the completed worksheets available because you will need them throughout Question 9.

Reflecting on Field Experience

Exercise 1. Identifying and Organizing a Research Team

Materials

Copies of Example 1, A Team Effort, the chart, Team Roles and Responsibilities
Copies of Worksheet 8-2

Instructions

Read and discuss the example. Ask team members to fill in the responsibilities column on the team role chart; answer the questions in the exercise.

Example 1. A Team Effort

In a Nepali district, a team from the MOH went out to a village to carry out focus group research with local women in preparation for a vaccination promotion activity. The team was made up of three people: Parbati, Ram Bahadur, and Thomas. In the first week, Thomas went to the village to organize the work, explain the purpose of the research, secure permission to conduct it, and arrange for accommodations. During the third week, Parbati and Ram Bahadur came out to the village to conduct six focus group discussions with mothers. They stayed in the village for four days. It was Thomas' task to screen women to select those who met the characteristics of the target audience (pregnant women and mothers with babies under one year), ensure that these women were available, and arrange for refreshments. Parbati conducted the focus group discussions with the women and explored with them their responses to vaccination. Ram Bahadur wrote notes about what the women shared with Parbati and recorded the nonverbal communication she considered significant.

After the field work, the team returned to their unit where Ana, a local professor, joined the group. Together they discussed the results of the focus group discussions and Ana organized the key findings as they went through the information. They discussed the trends and current behaviors of the women and recorded their observations and conclusions.

Using the synthesis and analysis of the information, Thomas and Ana prepared a research report that could be used in designing the vaccination communication intervention for that area. The report also would be presented to MOH officials and others.

Answer this question:
What were the roles of the four people participating in this effort?
Thomas _____
Parbati _____
Ram Bahadur _____
Ana _____

Experience has proven the advantage of having research conducted as a team activity rather than having it done by one individual. It is most effective if you identify your team members from the start and involve them in all activities. The following chart will help you identify roles and responsibilities for your team's intervention.

Team Roles and Responsibilities

Role	Responsibilities
Research organizer	
Researchers:	
Moderator/interviewer	
Notetaker/recorder	
Analyzer	

What other roles or responsibilities might you include for your team members, considering your own experience?

The following questions can guide the selection of your team:

1. How many people do we need? Does that number fit within our budget?
2. Who is available and when?
3. Who will be the organizer, researchers, analyzer, and report writer? Can some team members take on more than one role? Can they commit the necessary time?
4. Are they fully trained or is additional training necessary? What kind of training is needed? Who will do it? What are the costs and logistics involved?

Exercise 2. Deciding to Conduct Your Research

Materials

Copies of Example 2, Preparing the Basics
Copies of Example 3, Developing the Basic Guide and Questionnaire

Instructions

Have team members read both examples, respond to the questions, and do the exercises suggested; ask them to compare answers and obtain a common set of answers.

Example 2. Organizing Your Research

The Nepali MOH team decided to conduct their own research. The two methods they determined most appropriate for their research needs were focus group discussions and a small baseline survey. In examining their Skills Checklist, it became clear that a few team members were familiar with the concept of focus group discussions, but none of them had sufficient knowledge or experience to conduct them. Using the resource list from their Tool Box, they noted that the Academy for Educational Development (AED) had a video/manual training package, "A Learner's Kit for Focus Group Research," that was available at no cost. They wrote to AED to request this package.

While waiting for the kit to arrive, Thomas, the research organizer, decided that he would rather participate in the training than facilitate it. A team member explored whether researchers at the local university might be available. They located a university professor Ms. Helena who had experience with focus group discussions in a health setting. She was available to facilitate the training using the AED kit and to provide technical feedback throughout the actual field work. The MOH team contracted with her to conduct the training and provide technical feedback during the research analysis and report writing. The team had added an outside resource to their in-house team.

How might you acquire the skills you need to conduct your research? Some ways include the following:

- Train yourself and others using other self-training materials found in the Tool Box
- Obtain training materials and contract an outside facilitator to conduct the training
- Hire an outside organization to supply training materials and to train your staff

Review Worksheet 8-2 and the skills you need to acquire. Be sure you know your needs before you try to meet them. Also be sure that the means you select to acquire the skills fit with your time and budget.

Whether you conduct your own research or have outside researchers do it, you should be involved in developing the basic topic guides and questionnaires. This approach will help you effectively use and manage the information collected.

Remember the Appendix to Question 8 includes information on the different research design techniques and implementation steps.

Example 3. Developing the Basic Guide and Questionnaire

The Nepali team is now ready to develop their basic guide and questionnaire. They have decided to conduct focus group discussions with mothers about behavioral issues relating to vaccination and to complete a small baseline survey on evaluation and communication media issues. To carry it out, they used the following list of research questions to design their questionnaire.

Behavior Current

- Why do mothers who bring their children in for one vaccination not return to complete the series?
- What benefits would make them believe the next trip to the clinic was worth it?

Ideal

- What would make them consider performing the ideal behavior?
- What benefits and barriers do they perceive to the ideal behavior?

Factors

- Do they practice any other similar behaviors? What? How?
- What benefits would be most important?
- What are the perceived barriers and how can they be overcome or offset?
- Who influences their decision-making?

States

- At what stage of behavior adoption is the target audience found?
- What do they see as the most obvious outcome of having their children vaccinated?

Evaluation Indicators

- How many mothers complete the full series?
- How many mothers take their children for some of the vaccination series?

Communication Channels

- How could information best be passed along to mothers?
- What/who do they find as credible sources of health information?
- What/who are local credible information sources?
- What type of visual or auditory images, symbols, words, or phrases can be most useful in communicating with the target audience?
- What media are available and preferred regarding the problem?
- What are the most appropriate times for transmitting the messages?
- What is the literacy level of audience for print material use?

The above questions *are not* the actual questionnaire questions. For any one of these research questions you might have to develop several survey questions.

To answer the research questions on this list, the team developed a basic baseline survey questionnaire by expanding the research questions so they could quantify the information. For example, for evaluation indicators they asked:

- How many times do you take your child in for vaccination?
- When do you take him/her?
- How many vaccinations are in a full series?
- At what age should your child complete the series?

To identify appropriate communication channels, they asked:

- Through what sources do you acquire information about vaccinations? About other health information?
  - If they mention TV, ask if they own a TV? When do they watch it? Ask the same question for radio.
  - If they cite print materials, ask which ones? Where did they see them? Did they take any materials home? Which ones?

Exercise 3. Organizing and Planning Your Actual Field Research

Materials

Copies of the example, Getting It All Together
Copies of the list, Steps Involved in Implementing Research in the Field

Instructions

Read the example with your team and complete the list of steps that follow.
Ask your team to make a list of the steps involved in implementing the research effort in the field.
Then distribute the list of the steps found after example 3. Have team members compare it with their list.
Draw up one list that includes all the needed field activities for your intervention.

In Examples 1-2 you have categorized the list of research questions by behavior factors and stages, by evaluation indicators, and communication channels. You added questions where gaps were evident. This completed list is a basic topic guide and questionnaire for your research. These questions will need to be written in different ways now, depending on whether you will be conducting qualitative and/or quantitative research. For the purpose of this section, a quantitative research example is given.

You will develop your topic guide and questionnaire further during your actual research training. Specific forms of questions will depend on the research methods you are using. Also, it is essential to pretest your guide and questionnaire before using them to conduct actual research.

Example 4: Getting It All Together

The Nepali MOH identified their team members, and the teams were trained in relevant research methodologies. Before carrying out their research, the team met together for two weeks to discuss their work in the field. Discussion items included (1) creating a list of activities, (2) designing a calendar of those activities, (3) setting dates to achieve the activities, (4) establishing roles and responsibilities for the activities, (5) determining the research sample, (6) determining the number of interviews or group discussions per day, (7) finalizing the focus group guides and survey questionnaires for the interviews, (8) pretesting the guides and questionnaires, (9) revising the guides after pretesting, and (10) producing adequate numbers of the focus group guides and survey questionnaires for use in the field.

Team members started by determining how many of the research audience would be in the sample and where they would conduct their research. Using information from this discussion, they decided how many individual surveys and focus group discussions they would conduct daily.

They finalized their focus group guides and questionnaires and went during the second week to the local market to pretest them with members of the research audience. After receiving feedback, they revised the guides and questionnaires and made enough copies for their field research.

The team turned its attention to its logistical needs. These tasks included (1) preparing their field work budget, (2) completing the necessary transportation requisitions, (3) contacting local hotels and making lodging arrangements for the team, and (4) withdrawing and distributing per diems to the members of the team. While these arrangements were being made, one team member traveled during the second week to the research area and met with local health officials to explain the purpose of the research and the type of individuals needed for the research audience, and to receive approval from the officials. The officials helped the team member identify individuals and together they contacted them to arrange for interview dates and times.

The team member returned with this information and together the team completed their calendar of activities, specifying actual in-the-field dates for research, with individual and group sessions included. By the third week, the team was ready to leave for the field to carry out their research.

Steps Involved in Implementing Research in the Field

1. Determine the number of individuals in the sample and where they can be found
2. Determine the number of individual and group interviews to be conducted each day

3. Determine the number of researchers necessary and available (always recruit more than the number you need because some will drop out and others will not qualify)
4. Select the researchers; choose individuals you think are most appropriate for the interview approach you will use
5. Train the researchers in the application of the research instrument; choose the best trainees as your team members
6. Establish a calendar of activities, including pretesting the focus group guide and questionnaire
7. Discuss with your team what each activity represents, and, if there are doubts, read the description of each one in the reference section of the Tool Box
8. Identify logistical needs (gasoline, transportation, per diems, supplies)
9. Reproduce the guide and questionnaires based on the number of individuals included in the sample
10. Gather the information in the field
11. Analyze the data
12. Prepare the final report

(For more information on implementing research, see Section 3 in the Appendix to Question 8.)

Synthesis

Field research is organized and implemented with the following steps:

1. Examining the roles and responsibilities of team members and selecting the most appropriate individuals
2. Investigating ways to acquire the research skills needed and get the necessary training
3. Developing a topic guide and questionnaire
4. Planning and executing field work activities

Application

1. Go first to Worksheet 9-1 and select Your Research Team to help carry out your research effort.
2. Together with this team, complete Worksheet 9-2 to design Your Topic Guide and Questionnaire.
3. After both of these worksheets are complete, go to Worksheet 9-3 and develop your Research Field Work Activity Plan.

Worksheet 9-1

Research Team

1. How many individuals do you need? Does that number fit within your budget?

2. Who is available and when?

3. Who will be the—

   - Organizer? _____
   - Researchers? _____
   - Analyzer? _____
   - Report writer? _____

   Can some team members take on more than one role? Can they commit the necessary time? If yes, who?

4. Are they fully trained or is additional training necessary?

   _____fully trained _____additional training

5. What kind of training is needed?

6. Who will do it?

7. What are the costs and logistics involved?

Worksheet 9-2

Topic Guide and Questionnaire

1. Behavior

   Current

   Ideal

   Factors

   Benefits and Barriers

   Stages of Adoption

2. Evaluation Indicators

3. Communication Channels

Worksheet 9-3

Research Field Work Activity Plan

To get you started, here are some activities that usually take place during research efforts. Please change, add, or delete any activities as you think appropriate.

Activity	Time Frame: ___ month ___ week ___ day 1 2 3 4 5 6 7 8 9 10 11 12	Person Responsible
• Building a list of field research activities: • Selecting interviewers • Determining the sample • Determining the number of interviews or groups per day • Finalizing focus group guides and survey questionnaires for interviews • Pretesting guides and questionnaires • Revising guides and questionnaires after pretesting • Producing adequate numbers of guides and questionnaires for use in the field • Training interviewers • Conducting research in the field • Analyzing results • Preparing the final report		

Question 10

How Do We Select and Work With an Outside Source to Conduct Our Research?

If you have decided to work with an outside professional resource to conduct your research, this question will help you establish the criteria for selecting the resource and offer some guidelines on how to manage and supervise the work carried out for you.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Listed possible outside resources to contact
2. Established criteria for selecting an outside professional resource (Worksheet 10-1 and Worksheet 10-2)
3. Examined the steps in the selection process (Worksheet 10-3)
4. Initiated the selection process (Worksheet 10-4)
5. Examined how to clarify expectations and time tables in the areas of roles, responsibilities, and deliverables

Reflecting on Field Experience

Exercise 1. Selecting Criteria and Clarifying Expectations

Materials

Copy of the example, Selecting an Outside Professional Research Resource

Instructions

Read the example in the group. Answer the question that follows.

Example 1. Selecting An Outside Professional Research Resource

The African immunization team decided to have an outside resource conduct their research. They did not have the time or the in-house expertise to conduct participatory rapid assessments (PRAs) and a literature/record review. They did, however, have budget resources to have the research carried out by a professional firm or organization.

To effectively select the outside resource they needed, the team developed an initial set of criteria in the form of questions. Those criteria were intended to help them reduce the number of firms they had to choose from and eventually interview. Their questions included the following:

1. Does the firm or organization have expertise in conducting research on health topics?
2. Have they ever conducted research similar to our research (i.e., similar audiences and methods)?
3. Are they available during our time frame?
4. Will they work within our budget?
5. Do they have a reputation for working well with clients; i.e., will they work with us?
6. Do they use computer software that is compatible with our systems?
7. Do they react positively to our list of information needs and corresponding choice of research methods?

The team believed that to qualify for further consideration to carry out their research, each interested organization needed to be able to answer "yes" to all questions on the list. Team members did not want to waste their time and resources interviewing organizations that were inappropriate to their needs.

(What additional questions might you add to this list to ensure that research organizations qualify for further consideration?)

After the immunization team developed their list of basic criteria questions, they invited local firms, organizations, and universities with which they were familiar or that had been recommended to them to prepare a short response to their list of questions. They sent the following letter to 15 organizations:

September 29, 1994

Director...
Re: Invitation to Submit a Research Proposal
Dear ....

The Ministry of Health is developing a health communication program to promote behavior change interventions with mothers who have had their children vaccinated only once.

We wish to have research completed by March 31, 1995, to determine why some rural mothers are not taking their children in for the full vaccination series. More specifically, we want to determine

(1) What knowledge and attitudes/factors influence their vaccination practices.
(2) What groups influence their health decision-making.
(3) What factors might encourage them to take their children to the health center for full immunization.
(4) What media might be used to encourage them to take their children to the health center for the full series.

During our research planning, we reviewed possible research techniques and concluded that focus group discussions, followed by participatory rapid assessments and a literature/record review were the methods best suited to our information needs.

In this initial phase of selecting an outside resource to conduct this research, we are requesting that interested organizations provide us with a proposal responding to the following questions:

1. *Do you have experience conducting research on health topics?*
2. *Have you ever conducted research similar to the research we want to do?*
3. *Are you available during our time frame?*
4. *Have you worked as a team with Ministry staff members before? If yes, with whom?*
5. *What software package(s) do you use?*
6. *What do you think of our list of information needs and our corresponding choice of research methods?*

This proposal is due by October 15, 1994. Please do not hesitate to contact us if your have any questions. Those interested will be given further details for estimating a budget proposal.

Sincerely...

Have your team members draw up a letter similar to this to be sent to the outside resources you have selected.

The team received 12 responses. They were able to narrow their choices down to three organizations who could answer "yes" to every question asked in their letter. Of the eliminated organizations, five stated that the MOH list of questions lacked scope and depth and that their choice of methods showed a lack of understanding of the intricacies of research. They offered to use their own research methods that would provide comprehensive information. These organizations were eliminated quickly from the list because their comments showed a clear unwillingness to (1) work as a team, (2) work within the program's budgetary and time constraints, and (3) keep the research focused on the program's information needs. Another four organizations did not qualify because of availability and other logistic aspects.

The team summarized the responses of the three organizations under final consideration in a table. They did this so they could effectively support a case for whichever organization they decided to select and be assured of approval by their director.

Selection Criteria to Narrow Choice of Organizations

	Question	University	Research Firm	NGO Research Unit
1.	Do they have a background of conducting research on health topics?	Yes, child survival	Yes, MPH	Yes, family planning
2.	Have they ever conducted research similar to the research we want to do; i.e., methods, audiences?	Yes, both	Yes, both	Yes, both
3.	Are they available during our time frame?	from 11/1/94 to 5/1/95	from 12/1/94 to 4/15/95	from 12/1/94 to 4/30/95
4.	Will they work within our budget?	Yes	Yes	Yes
5.	Do they have a reputation for working well with clients?	Yes, worked with nutrition unit	Yes, worked with breast-feeding project	Yes, worked with family planning unit
6.	Do they use software that is compatible with our systems?	WP 5.1, Paradox, Lotus	WP 5.1, Lotus	WP 5.1, Paradox
7.	Did they react positively to our list of information needs and corresponding choice of research methods?	Yes and suggested specific PRAs	Yes and suggested how to save time	Yes, careful thought given to our questions

How else might this summary table be useful in the final selection of an outside resource?

After the team narrowed the list to three organizations, they set up interviews with each prospective resource. They provided them with additional information about the intervention and the proposed research. They asked each candidate organization to prepare a five- to seven-page proposal with a research design, budget, and timetable to present at the interview. Furthermore, they requested that the principle consultant and at least two researchers be present at the interview. They used the following, more detailed selection criteria during the interview to continue to narrow their choices and make a selection:

1. What additional information did the organization request from us to prepare for this interview? List:

2. What does their research design contain: YES NO

   - Problem statement?
   - Research purpose and objectives?
   - List of information needs?
   - Research methodologies? revised?
   - Research audiences?
   - Research team specifics?
   - Sampling plan?
   - Design of topic guide and questionnaire?
   - Analysis plan?
   - Preparation of research report?
   - Time table?

3. Did they bring the requested team members to our interview? YES NO

4. Did they discuss roles and responsibilities? YES NO

5. Did they include the MOH in the tasks they discussed? YES NO

6. Did they provide resumes of principle team members? YES NO

7. Did they provide references? YES NO

8. Were their references positive? YES NO

9. What additional criteria might you add to this list for use during the interviews?

10. How was their interaction with the MOH team during this interview? [choose one] poor fair good very good excellent

11. How flexible is their work plan? [choose one]
    not at all somewhat very too flexible

When the interviews had been completed, the university group clearly best met the MOH's more detailed set of criteria. Not only could the university group answer all questions, but they provided (1) written references as well as a list of references to con-

tact, (2) two alternative work plans, and (3) a chart of roles and responsibilities. The team completed the selection process by contacting two references provided by the university group.

The team then presented to their director the recommendation in favor of the university team, supported by (1) the summary table, (2) their research design, (3) the three completed interview selection criteria, and (4) their references. Within the week, their director approved their selection.

After the director approved the selection, the team met with the university team to establish and agree on clear expectations regarding roles, responsibilities, deliverables, and a time table. They presented issues agreed on in a chart.

Activities	University Team	MOH Team
Deliverables		
1. Topic Guide	Develop, pretest, revise	Review, provide feedback
2. Raw Data	Collect, organize	Review, provide feedback
3. Synthesized data	Organize key findings/topics	Review, provide feedback
4. Analysis	Do together	Do together
5 Final report	Prepare per format	Provide format, review, give feadback

Why is it useful to clarify expectations from the beginning of the work? What are additional activities that you would undertake to provide more clarification? Complete your own list of expectations.

Synthesis

To select and work with an outside resource effectively, you should take the following steps:

1. Establish initial selection criteria to eliminate inappropriate outside resources at the beginning of the process
2. Develop and mail invitations to submit a proposal presenting the basic criteria to qualify for further consideration
3. Narrow the choices based on responses to the invitation and summarize information in a table to facilitate later comparison
4. Establish a more specific set of criteria to use during interviews, arrange the interviews, evaluate each candidate organization, and make the final selection and submit for approval
5. Clarify expectations and establish roles, responsibilities, and deliverables and a time table with the organization selected

Application

1. Go to Worksheet 10-1, List of Possible Outside Resources to Contact, and develop a list of organizations to whom you could send invitations.
2. Use the checklist in Worksheet 10-2 to be sure your letter of invitation contains all the necessary elements.
3. Worksheet 10-3, Initial Basic Selection Criteria, will help narrow your resource choices.
4. Worksheet 10-4, Interview Criteria/Final Selection, will help you make the final choice.

Worksheet 10-1

List of Possible Outside Resources to Contact

Worksheet 10-2

Invitation to Submit a Proposal Checklist

Elements included:

1. Description of our organization
2. What we are doing
3. Why we want research conducted (purpose and objectives)
4. Deadline for research
5. List of information needs
6. Types of research to conduct
7. Criteria questions to answer
8. Length of research report
9. Due date for report submission

Worksheet 10-3

Initial Basic Selection Criteria

Complete a criteria sheet for each organization interested in conducting your research. Please add any additional questions you think appropriate. To qualify for further consideration, an organization should be able to answer "yes" to every question.

Organization _____ Date _____

Research Effort _____

QUESTIONS	YES/NO
1. Do they have a background in conducting research on health topics?	
2. Have they ever conducted research similar to the research we want to do?	
3. Are they available during our time frame?	
4. Will they work within our budget?	
5. Do they have a reputation for working well with clients?	
6. Do they use software that is compatible with our systems?	
7. Did they react positively to our list of information needs and corresponding choice of research methods?	

Worksheet 10-4

Interview Criteria/Final Selection

Complete a copy of this form for each organization interviewed.

Organization _____ Date_____

Research Effort _____

1. What additional information did the organization request from us to prepare for this interview? List:

2. What does their research design contain: YES NO

   - Problem statement?
   - Research purpose and objectives?
   - List of information needs? revised?
   - Research methodologies?
   - Research audiences?
   - Research team specifics?
   - Sampling plan?
   - Design of topic guide and questionnaire?
   - Analysis plan?
   - Preparation of research report?
   - Time table?

3. Did they bring the requested team members to the interview? YES NO

4. How did their representatives interact with the MOH team during the interview?

   [choose one] poor fair good very good excellent

5. How flexible is their work plan?

   [choose one] not at all somewhat very too flexible

6. Did they discuss roles and responsibilities? YES NO

7. Did they include the MOH in the tasks they discussed? YES NO

8. Did they provide resumes of principle team members? YES NO

9. Did they provide references? YES NO

10. Were their references positive? YES NO

Additional comments about the organization's presentation or the interview:

Question 11

How Do We Synthesize and Analyze the Information Collected About Behavior?

This question examines ways to summarize and analyze the research data you have collected about behavior so you can use it as the basis of an effective health communication plan. Even if your analysis is being done by an outside organization, you should understand the analysis process so that you can (1) supervise the research and (2) understand the meaning of the results to use them effectively in your health communication strategy design.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Described the basis for organizing your behavioral data
2. Summarized behavioral data you have collected
3. Described three components of behavior analysis
   - Placement in the stages of behavior adoption
   - Analysis of current behavior
   - Analysis of factors that help identify the barriers and benefits that influence behavior
4. Explained how each layer of research builds on the previous layer to complete the analysis
5. Begun your behavior analysis process based on the collected research (Worksheet 11-1 through 11-4)

Introductory Note

Basis for Organizing Your Behavioral Data

The purpose of collecting and analyzing information about audience behavior is to use the information to choose the strategies and approaches for your intervention to move segments of the audience from the current behavior to a more healthful behavior. To do this, it is necessary to compare an audience's current behavior with the proposed ideal. How are they similar? How do they differ? What is the gap between current behavior and the ideal behavior?

This gap will be the focus of your intervention. You will need to understand as much as you can about why people now choose the behavior they do. What does the audience perceive as the barriers and benefits for the current behavior?

The various factors that influence behavior will be demonstrated to help identify barriers and benefits that you may not otherwise consider. How can you decrease the barriers and increase the benefits of the proposed behavior? Setting priorities is important. How can you decide which factors are important influences on the behavior of your audience and which are less important?

You need to examine what actions members of your target audience are presently engaged in that might make it easier for them to perform your proposed behavior. What do these actions tell you about their knowledge and attitudes that will make adoption of the new behavior easier or more difficult? What knowledge, attitudes, and practices already exist? Which of those will you need to introduce or encourage in your intervention? These analyses will help you begin to determine a feasible behavior for your audience.

As discussed in Question 5, there will be variations among members of your audience, especially if your intervention covers large, periurban or urban areas. You will need to think about the relative importance of each segment of your audience as you decide where to target your intervention.

Reflecting on Field Experience

Exercise 1. Summarizing Behavioral Findings

Materials

Copies of Example 1, Key Behavioral Findings, Worksheet 11-1

Instructions

Ask your team to read the example, discuss it and then fill in Worksheet 11-1, Summary of Key Behavioral Findings, using the data in the example.

Example 1. Key Behavioral Findings

Researchers in Peru's MOH health communication division carried out a baseline survey to examine what mothers did when their children under one year of age had diarrhea. They had determined an ideal behavior: All mothers will use Salvadora (a local rehydration solution) for every episode of dehydration of their child.

The behavior section of their survey included a number of questions for 232 mothers whose children had recently had episodes of diarrhea. The questions were designed to provide the following information that researchers would need to understand:

- Audience's current behavior
- Audience's perception and attitudes about the ideal behavior
- Barriers and benefits of both the current and ideal behaviors
- Position of the audience in the stages of behavior adoption

Team members inserted their raw data into the following table. They used these data to help them decide which questions to ask of the secondary audience (health promoters) they had chosen to help them reach the mothers. As they collect data from their secondary audience, they will insert these data in the table as well so they can see a broader picture of what influences mothers' behaviors. The table allowed them to see at a glance the data from their research.

Summary of Key Behavioral Findings

(n=232)

Audience

Mothers whose children have recently suffered dehydration

Analysis of Current Behavior

80% treated dehydration
76% gave some treatment at home
45% treated only at home
63% provided >1 treatment
35% sought outside advice if severe

Of these,

20% sought advice from health centers
23% sought advice private/govt. hospitals
25% received antibiotics (outside sources)
25% received antidiarrheal
40% received Salvadora from health center
20% received Salvadora from other sources
59% gave extra fluid
26% gave special food
7% gave a purgative
30% of breast-feeding, stopped breast milk

Stages Behavior Adoption

79% heard of Salvadora
42% used Salvadora last episode

Ideal Behavior

Of those using ORS, 68% would consider using ORS more often if:

- were available
- knew how to use it

75% stated that use every time is unrealistic:

- no time
- no stock
- undesirable taste for children

Factors

When Salvadora was not used, why not used:*

38% not available
13% not recommended
13% did not know how to use
22% did not stop diarrhea
19% not needed, mild episode
19% used other home remedy
20% did not know how to recognize dehydration

*respondents could choose more than one option when answering this group of questions

Using this summary table, team members prepared the following narrative piece for the section of their research report dealing with current behaviors.

Compatible Behaviors

The researchers concluded that most mothers already are practicing behaviors that are compatible with the use of Salvadora. Most (80%) treat dehydration, showing that they think they can recognize dehydration and are concerned enough to take steps to treat it, and 76% already take steps to treat it at home. Sixty-three percent were concerned enough to give more than one kind of treatment. Fifty-nine per cent gave more liquids and most (70%) who were breast-feeding continued to do so. Many (35%) sought outside advice and help, primarily (53%) from health professionals, when they perceived the episode was severe.

Benefits

Mothers seem to fear dehydration and are prepared to take steps to manage it. They already are choosing good practices, such as giving more liquids, special foods (26%) and seeking advice. They do not seem to need to be told that dehydration is dangerous or need motivation to act to save their children.

Barriers

Constraints seem to involve the following:

- Lack of support from health authorities, which would give mothers more confidence in positive outcomes when using Salvadora
- Lack of skill or self-confidence in use of Salvadora
- Lack of access to Salvadora packets
- Possible lack of skill in distinguishing early signs of dehydration

Mothers report professionals recommend drugs and medicines to cure diarrhea rather than ORS to treat dehydration. A consistent difficulty that emerges is the neglect of ORS as a resource by health professionals. Because a large percentage of mothers understood the dangers of dehydration, were prepared to treat it, and had heard of Salvadora, the difficulty seems to be in helping those mothers accept the value of Salvadora and combat negative perceptions or develop realistic expectations for the solution. Increased credibility could come from medical support who could demonstrate confidence in ORS outcomes and help assure that mothers understand its function (treating dehydration).

Decisions

The team decided they would need to understand why health workers, the secondary audience that had been chosen as a group that could help the intervention reach the mothers, did not recommend Salvadora, and what barriers and benefits would influence their adopting this new behavior. They also wanted to find out more about the differences between women who knew about Salvadora but did not use it and those who did use it. Team members decided to conduct focus group research to compare these two groups.

Have team members come up with several conclusions about the way the Peruvian team summarized their findings. Compare these conclusions with the points made in the following section.

Background Information

Summarizing Data Is an Ongoing Process

As data are collected, they can be sorted and organized within established topics. If your data are collected according to a well-defined questionnaire or topic guide, the summary can be straightforward and relatively easy. As the same ideas and issues repeat themselves, you begin to establish your list of "key findings."

If you summarize your data as the research is being conducted, it enables you to effectively monitor the research process and adjust the research being conducted accordingly.

For example, if you see that the same ideas are being repeated from different audiences and within the same audiences, you have probably collected enough data on that topic. Or you might notice that you are not gathering sufficient information on a particular audience's current behavior and you can add or adapt research questions appropriately. You can redirect your research as questions are answered or new questions are raised.

Trends, patterns, and tendencies in responses emerge when research data, whether quantitative or qualitative, are clearly summarized. These trends form the basis for your analysis stage.

Analyzing Behavior

As you read in Questions 4 and 5, behavior analysis focuses on socially and personally significant behaviors that are observable and measurable current behavior. It identifies the factors that influence those behaviors and, in particular, the barriers and benefits for the audience in maintaining the old behavior or adopting the new behavior. After behavior has been properly analyzed, based on your research results, your health communication team can effectively design interventions to accomplish one or more of the following:

1. Provide the skills necessary to adopt the behavior (for example, demonstrate how to mix and give Salvadora)
2. Ensure that your audience feels confident enough to perform the behaviors (let mothers practice; praise efforts)
3. Ensure that your product or behavior responds to and meets your audience's expectations (explain that Salvadora treats dehydration, does not stop diarrhea)
4. Find ways to help a person take action (provide mothers with clear instruction)
5. Acknowledge and provide ways to overcome situational limitations (assure access to packets, adapt instructions to local containers or water quality)
6. Position your product or behavior to support a person's positive self-image (use logo that evokes a loving mother)
7. Reinforce perceived social norms (show support from credible leaders)
8. Reinforce perceived group standards (if working with health workers, show that their professional role requires new behavior)
9. Provide a positive emotional environment (link behavior to positive, strong feelings about self or children as love or safety)
10. Provide a positive, reinforcing health service (train health workers in effective communication skills)

The process of analyzing behavior is layered. Each layer must be complete to move on to the next. Each missing or incomplete layer weakens part of the foundation on which you will build your health communication strategy.

The following exercise will help you analyze your audience's current behavior.

Exercise 2. Analyzing Current Behavior

Materials

Copies of Example 2, Current Behavior, copies of Example 1

Instructions

Have team members reread Example 1 and write out what they think of the audience's current behavior. Compare their description with the one described in Example 2.

Example 2. Current Behavior

The Peruvian team analyzed the current behavior of the health workers and assessed their willingness to consider the proposed behavior using the following questions.

1. What practices/skills/ideas currently exist that can be applied to the performance of the new behavior? How can these similarities be used to facilitate the adoption of the new behavior?
2. What practices/skills/ideas are missing or different? What can you do to overcome or compensate for these differences?
3. What are the benefits of and barriers to the current behavior? How can you use the benefits to encourage mothers to move from the current behavior to the new?
4. What are the benefits of and barriers to the proposed behavior? How can you decrease the barriers and increase the benefits?
5. What would reinforce sustained practice of the new behavior by those who choose to try it?

The teams analysis was as follows:

1. Mothers are recognizing and treating dehydration at home with extra liquids and special foods. The project should congratulate them on the current behavior and add that, in addition to other liquids and foods, a special liquid, Salvadora, is needed to treat dehydration.
2. Mothers do not use Salvadora consistently and possibly not appropriately. They are distinguishing between severe and mild episodes of diarrhea, but they may not be distinguishing correctly the signs of dehydration. If they distinguish correctly, their behavior is appropriate.
3. Mothers are doubtful about outcomes. There is confusion about whether Salvadora treats diarrhea or dehydration. Strategy should include clarification of outcome to be expected from Salvadora from health workers and other reliable sources.

4. Mothers lack confidence that they can mix and give Salvadora correctly. Strategy should include teaching and giving feedback on mixing and administering skills to strengthen skills and confidence. Mothers report they cannot obtain packets. Strategy should include providing easy access and confidence-building information on how to acquire and prepare correctly the Salvadora packets.
5. Social norms seem to support treatment of dehydration with liquids and even Salvadora. Mothers may need to know that others, including credible sources, rely on it.
6. Mothers will need reinforcement if they are to continue the new behavior. Strategy should include praise from health workers and media congratulations linking use of Salvadora with valued qualities such as as modernity, compassion, and protection. Letters from the provincial office or charts showing their coverage rates are climbing could reinforce and support the mothers' new behavior.

The following exercise will help you place your audience in the stages of behavior adoption.

Exercise 3. Stages of Behavior Adoption

Materials

Copies of Example 3, Identifying Stages of Behavior Adoption, Worksheet 11-2

Instructions

Have team members read the example and complete Worksheet 11-2, Stages of Behavior Adoption Placement Checklist, using data provided in the example.

Example 3. Identifying Stages of Behavior Adoption

After the Peru team summarized their findings on current behaviors, they continued to examine what the findings told them about what they should do during their intervention to change behavior. They wanted to know where their audience was in the stages of behavior adoption, since that would determine what they needed to do to move the mothers to the proposed action.

Team members prepared the following chart to determine where their audience was in the stages of behavior adoption.

		Stages of Behavior Adoption
Is the audience concerned about the problem/issue of dehydration?	Yes	Awareness
Do they know that there are actions they could take to manage dehydration?	Yes	Knowledge
Do they know that Salvadora is effective in treating dehydration?	Yes	Knowledge
Do they see any benefits in taking the needed steps to use Salvadora in some cases, severe cases, mild cases, all cases?	Yes	Contemplation
Did they state their intention to use Salvadora? Some cases, severe cases, mild cases, all cases?	No	Intention
Are they using it? All cases? Some cases?	No	Action
Did they perceive positive outcomes when they used Salvadora?	No	Evaluation
Were they rewarded or motivated in some way to continue to use it? Some cases? All cases?	No	Reinforcement

Mothers are aware that dehydration is a problem, know that treatment is needed, and often give liquids. Most (75%) know about Salvadora and many (42%) believe enough in its effectiveness that they have tried it. Team members began to think about moving more mothers to action; that is, to use Salvadora for all diarrhea cases. A possible strategy would be to encourage action in all cases of diarrhea by providing reinforcement for consistent use by those who have already tried the solution and to encourage those who have heard of it but not tried it to give it a try. It was decided to focus on why these mothers do not want to use Salvadora or do not use it consistently. There would be a need to assess how feasible it actually will be for mothers to adopt this behavior, which is time-consuming and may seem difficult or unnecessary.

Team members also needed to find out what benefits mothers perceived from adopting the behavior. They will consider this more closely later when they determine feasible behaviors (see Question 15).

Exercise 4. Factors that Influence Barriers and Benefits of Behavior Adoption

Materials

Copies of Example 4, Barriers and Benefits

Instructions

Read the example and compare it with the immunization Example 2 in Question 5, Factors Influencing Immunization Behavior.

Example 4. Barriers and Benefits

After determining where the mothers are in the stages of behavior adoption and analyzing their current behavior, the Peruvian team examined factors that could help them identify barriers and benefits most influencing audience behavior. They wanted to remove or lessen the barriers and increase the benefits for the new behavior. Using the key findings, they determined that the following factors would most influence the adoption of their proposed ideal behavior.

1. **Expected outcomes.** Mothers may expect Salvadora to cure diarrhea. They need to know that this is not its purpose. The outcome of ORS use on dehydration is usually positive and immediate, so mothers should be pleased with the outcome once they are clear about the purpose of the solution.

2. **Self-image.** It seems accepted that good mothers treat dehydration, treat it at home, and seek help when the case is severe. A communication strategy should reinforce these practices as acts of loving mothers and encourage the addition of the best solution, Salvadora.

3. **Self-efficacy/skills.** Some mothers are not confident they can get and keep packets or use them correctly. Some feel they cannot recognize dehydration. Strategy should provide modeling of behaviors by media or health workers, reinforcement of mothers competence, and ease of access.

4. **Emotions.** It would help if mothers could feel really good about adopting the new behavior; for example, when children recover mothers could be encouraged to take pleasure in their skill and competence in restoring their children to health.

5. **Group norms.** Urban mothers may have different norms than rural mothers. Health workers may have their own norms that are different from those of the larger community. These special group norms should be considered in designing their strategy.

Team members now had the information necessary for their health communication strategy. Their next big challenge was to ensure that these analyses were transferred from data to communication objectives and messages that would be effective to promote and persuade target audiences to adopt the desired behavior(s).

Setting Priorities

To complete the process of behavior analysis, the various factors must be established in a priority scale which can be determined by the following:

- **Importance.** Which of the factors that you have identified have the most influence on the behavior of your audience?

- **Stage Order.** What factors need to be addressed first, chronologically? For example, you would usually start with the stage of behavior adoption in which your audience is found before moving to address a later stage.

- **Feasibility.** What factors can your intervention reasonably expect to affect? For example, you may be able to do little about an audience's inability to afford medication.

Synthesis

When analyzing behavior for your intervention, it is necessary to examine an audience's current behavior in light of the proposed ideal behavior. How do they compare? How do they differ? How can these differences and similarities be used to promote the new behavior? Furthermore, you need to examine what actions your audience is currently engaged in that might be applied to the performance of your proposed behavior. An analysis of current behavior is the next piece you must have to later determine feasible behavior for your audience. Identifying the factors that influence behavior directs the focus of your health communication strategy.

Application

1. Using the key findings summary table in Worksheet 11-1, Summary of Key Behavioral Findings, enter the data you have available by research topic stages of behavior adoption, current behavior, ideal behavior, and constraints and

benefits by audience.

2. By using Worksheet 11-2, Stages of Behavior Adoption Placement Checklist, you can quickly assess where your audiences are on the stages of behavior adoption. Determining this information helps you (1) understand how far you really need to take each audience to action, (2) what factors you need to address, and, (3) as you look at the gap between where they are and where you want them to be, begin to assess how feasible your ideal behaviors actually are.
3. Using Worksheet 11-3, Current Behavior Analysis, analyze each audience's current behavior in relation to the proposed ideal behavior; that is, how it differs from or is similar to it.
4. Identify and set priorities among the factors suggesting barriers and benefits that influence each audience's possible adoption of the proposed ideal behavior by completing Worksheet 11-4, Factors Influencing Behaviors. Brainstorm possible ways to address these barriers and benefits.

For those interested in more theory involving behavior change, please see the Appendix to Question 11.

CONGRATULATIONS! You are coming close to choosing a set of behaviors to promote that are feasible, realistic, and obtainable.

Worksheet 11-1

Summary of Key Behavioral Findings

This table is an example of what you might use to organize your raw data and summarize the key findings so you can use them in choosing strategies. Enter information from your analysis for each category. You will need to do something similar for each audience. You can compare key findings on different audiences as needed or useful. Information should be short and abbreviated. You can prepare the narrative portion of your research report using this information.

	AUDIENCE	
	PRIMARY	SECONDARY
Current Behavior		
Ideal Behavior		
Stages of Behavior Adoption		
Barriers and Benefits		

Worksheet 11-2

Stages of Behavior Adoption

PLACEMENT CHECKLIST

Answer the following YES/NO questions for each audience. When you answer No for the first time, you will have located where your audience is in the stages of behavior adoption. Answer these questions for each audience.

Audience: _____

1. AWARENESS Is your audience concerned about the problem/issue? YES NO

If you said No here, your audience is not yet aware of the problem.

2. KNOWLEDGE Do they know something about the problem/issue? YES NO
(causes, preventions, cures, etc.)

If you said No here, your audience is AWARE only, but lacks essential knowledge.

3. CONTEMPLATION Does your audience feel/believe that
what is proposed is good/effective/useful
for addressing the problem? YES NO

If you said No here, your audience KNOWS, but is not contemplating action.

4. INTENTION Can your audience give you reasons to address the problem/issues?
YES NO

If you said No here, your audience is CONTEMPLATING action, but has made no intention to change.

5. ACTION Has your audience taken action to address the problem/issue? YES NO

If you said No here, your audience INTENDS TO TRY but has not done any trials.

6. EVALUATION Has your audience had a positive outcome from their experience of the action? YES NO

If you said No here, your audience has TRIED but has not evaluated their trials.

7. REINFORCEMENT Does your audience believe there are reasons for them to continue use/action? YES NO

If you said No here, your audience has EVALUATED and liked the action, but lacks the reinforcement.

If you said Yes, these people can be helpful in your intervention because they are valuable sources of credible information to their communities. This group's behavior has been REINFORCED by the results of their actions.

Worksheet 11-3

Current Behavior Analysis

Complete one worksheet per audience.

Audience: _____

1. What practices/skills/ideas currently in place can facilitate adoption or performance of the new behavior?

2. What practices/skills/ideas are not in place? How can you overcome or compensate for the differences or gaps?

3. What are the benefits of and barriers to the current behavior? How can you use benefits to encourage the audience to move from the current behavior to the new?

4. What are the benefits of and barriers to adopting and sustaining the new behavior? How can you increase the benefits and decrease the barriers?

5. What would reinforce sustained practice of the new behavior by those who choose to try it?

Worksheet 11-4

Factors Influencing Behavior

Some influences on behavior are more important than others to your audience. Because both you and your audience have limited resources and time, you should choose the most important influences to make program priorities. Complete this worksheet for each audience.

Audience: _____

Factors to consider are: (1) expected outcome, (2) intention, (3) self-image, (4) skills, (5) self-efficacy, (6) emotions, (7) perceived social norms, (8) perceived quality of health service, (9) knowledge, (10) behavioral compatibility.

1. Review your key findings and use the list of factors above to determine which factors influence this audience's possible adoption of the behavior you propose.

2. Put these factors in priority order using the following criteria:
   - **Importance.** Which factors appear to be most important to the audience?
   - **Stage order.** Which must be addressed before you can address others?
   - **Feasibility.** Which are within your power to influence or change?

3. Often you will find that a factor that is very important is also more difficult to affect or change. If one or two factors do not emerge clearly as priorities based on all the criteria, work as a team to assign each factor a number between 1-5 for each criterion. A higher number indicates that the factor has higher priority according to that criterion, as shown in the following example:

Factor	Importance	Stage Order	Feasibility	Total
Self - Efficacy	3	2	2	7
Social Norms	4	2	3	9

The example indicates that self-efficacy is important, but it is difficult to address until the audience is knowledgeable about the problem and the solution, and that teaching most mothers the needed skills and giving them self-confidence will be difficult. Social

norms are more important. They fall, like self-efficacy, later in the stages of behavior adoption and can be affected somewhat easier by influencing selected community leaders rather than all mothers.

Choosing priorities will require serious thought and should include your entire team. These guidelines will not meet all cases. In those situations, you and your team members should base your decision about priorities on your knowledge of your culture, people, and circumstances.

4. Brainstorm what you might need to do to address each factor. REMEMBER: Do this in priority order. Often addressing one factor changes another that follows it or can give a clearer picture of what to do next.

Worksheet 11-4

Priority Scale of Factors

Factor	Importance	Order	Feasibility	Total
1. Expected outcomes				
2. Intention				
3. Self-image				
4. Skills				
5. Self-efficacy				
6. Emotions				
7. Perceived social norms				
8. Perceived quality of health service				
9. Knowledge				
10. Behavioral compatability				

Appendix to Question 11

Theories of Behavior

Research, experience, and theoretical work in behavioral and social science show that government investments in health promotion do pay off. As clinical and epidemiological knowledge has advanced, so too has knowledge of how to motivate new attitudes and actions in individuals, organizations, and communities. No single model has proved adequate to design and evaluate health promotion programs. However, planners can choose from an increasingly wide array of tools, forged in different disciplines, to analyze the human and social aspects of health problems and design custom solutions. These tools can be grouped in a number of ways. The brief summaries below examine the following:

1. Theories that focus on the determinants of behavior (the Health Belief Model, the Theory of Reasoned Action, and Social Cognitive Learning Theory)
2. A model of the stages of individual behavior change (Stages of Change [or Transtheoretical] Model)

To develop and choose among interventions to change human behavior, it is useful first to understand why people behave as they do. The more you know about the factors underlying the performance or nonperformance of a health-related practice, the more successful you can be at designing an intervention that influences that practice. Research can help determine which of several factors predicts or explains a particular behavior in a particular population. Interventions can then be developed to influence these determinants and thus encourage the desired prevention behavior.

Of the many different theories applied to health-related behavior, three have been most useful as bases for research on the prevention of cancer: the Health Belief Model, the Theory of Reasoned Action, and Social Cognitive Learning Theory. The basic principles for each of these theories are outlined in the following paragraphs, and examples of their application are provided.

Health Belief Model

The Health Belief Model lends itself to a fairly direct health education approach to behavior and intervention design. For example, the model has been used to analyze prevention behaviors, such as participation in illness screening, immunization, and checkup programs, as well as treatment behaviors such as taking medication for tuberculosis or complying with dietary plans. As the name implies, the Health Belief Model is based on cognitive variables. It assumes that health behavior is a function of four key beliefs or mental factors: (1) perceived personal susceptibility to a health threat, (2) perceived severity of the condition, (3) perceived efficacy of a particular behavior in dealing with the condition, and (4) perceived barriers to that behavior. Together these mental factors account for a person's inclination to act. Many proponents of the Health Belief Model recognize that cues to action can be very influential once a threshold of readiness has been achieved, and that a variety of personal and social characteristics such as age, sex, knowledge and culture play roles in modifying the behavior if and when it occurs.

A health promotion intervention designed to promote a "Five Times In the First Year...For a Lifetime" immunization behavior, for example, might be aimed at the health beliefs of the target audience; i.e., mothers of infants. The program might try to persuade the audience that full immunization could significantly decrease dangerous diseases, and thereby reduce lifetime risk (addressing belief 3). It might acknowledge the severity of the disease such as measles, while stressing the effectiveness of immunization (beliefs 2, 3). It also might create a tone and atmosphere of hopefulness or 'peace of mind' which is one outcome of completing the vaccination series, to reduce the anxiety that side effects can cause (beliefs 1, 4). Messages in the mass media and health worker reminders can provide cues to action. In general, the most important element of applying the Health Belief Model is identifying the relevant beliefs - psychological factors - of the target population.

Theory of Reasoned Action

The Theory of Reasoned Action provides a social-psychological approach to understanding behavior. It deals with the relations among beliefs, attitudes, intentions, and behavior. It assumes that changing a given practice requires changing the cognitive structure that underlies that practice. The theory has been used to understand behaviors from a variety of domains, including health. The theory is best seen as a series of hypotheses. At the first level, a behavior is assumed to be primarily a function of a person's intention to perform that behavior. At the second level, the intention to perform the behavior is seen as a function of two factors: a personal factor (an individual's attitude toward the behavior) and a social factor (the subjective norm associated with that behavior). The social factor, the norm, is really the individual's perception of whether

others think he or she should perform the behavior. Underlying the personal factor is a combination of beliefs about whether the behavior will lead to certain outcomes. Underlying the social factor is a complex range of beliefs about what particular individuals or groups think about the behavior and the person's own motivation to comply with those perceived beliefs. The Theory of Reasoned Action has been applied in interventions that address smoking, signing up for a treatment program, and preventing AIDS.

Again, the selection of factors to be addressed in a given campaign must be based on in-depth research with the target population of interest. Interventions based on this model gain from the depth of social context. For example, a smoking prevention campaign targeted at adolescents would exploit both this group's awareness that smoking can cause cancer and the even more powerful influence of peer pressure and social image. Portraying smoking as 'ugly' or 'not cool' might be vastly more effective with this group than portraying smoking as 'life-threatening.'

Social Cognitive Learning Theory

To change, people need not only reasons for altering their health-related practices, but also the behavioral means, psychological resources, and social supports to do so. Social Cognitive Learning Theory looks particularly hard at the potential barriers to personal change. It is based on a three-way relationship among the person, the behavior, and the environment through a process called 'reciprocal determinism.' In other words, although the environment largely determines or causes behavior, a subject uses cognitive processes to interpret both the environment and his or her behavior and also behaves in ways to change the environment and meet with more favorable behavior outcomes. This theory has been used effectively to explain and change a diverse set of health behaviors such as stopping smoking, reducing weight, and increasing exercise and contraceptive practices, and recently has been used in AIDS prevention.

According to this theory, two sets of cognitions are important in understanding and changing behavior: outcome expectations and self-efficacy. Outcome expectations include a person's interpretation of the consequences of performing a behavior. Self-efficacy is the person's belief in his or her capability and confidence in performing the behavior, and willingness to persevere. Social Cognitive Learning Theory is particularly helpful in dealing with behaviors that are unusually resistant to change. Program planners must remember that not just information but skills, confidence, and incremental changes in attitude and step-by-step behavioral trials are keys to self-efficacy. Face-to-face communication is often most effective in helping subjects make difficult behavior changes. For example, the personal interest of a physician in supporting smoking cessation, compliance with treatment regimens, or diets can determine a patient's success. Less personal channels, however, can also teach skills and make use

of behavior modeling techniques such as simple testimonialsto promote the possibility of behavior change.

Common Factors Underlying These Three Behavioral Theories

Fortunately for the program planner attempting to set priorities among interventions based on sound behavioral and social scientific theory, the three major theories described above overlap significantly. Theorists recently identified eight common factors listed and explained below. To change a behavior, people must accomplish the following:

1. Believe that the advantages or benefits of performing a behavior exceed the disadvantages (Expected Outcomes)
2. Form a strong, positive intention or be committed to perform a behavior (Intention)
3. Possess the skills to perform a behavior (Skills)
4. Have the conviction that they can effectively perform a behavior (Self-Efficacy)
5. Believe that the behavior will be more likely to produce an overall positive effect than a negative one (Emotions)
6. Believe that the performance of the behavior is consistent with their self-image (Self-Image)
7. Perceive greater social pressure to perform a behavior than not to perform it (Perceived Social Norms)
8. Experience fewer environmental constraints to perform a behavior than not to perform it (Barriers)

These factors not only represent points of consensus among the theorists but have been shown empirically to account for most of the variation in any given behavior within a particular population.

A Model of Behavior Change

Behavior change is most often a gradual process consisting of identifiable stages. Long-term change occurs as people gain skill and increase self-confidence through repeated trials and reinforcement. A dominant model of behavior change applied by health professionals today is the Stages of Change (or Transtheoretical) Model.

Stages of Change (or Transtheoretical) Model

The Stages of Change Model attempts to explain health behavior independent of specific theoretical factors. The model postulates that behavior change occurs in the following series of stages:

- Pre-awareness (Pre-contemplation). People in this stage have no intention to change behavior in the foreseeable future, are unaware of the risk, or deny the consequences of risk behavior.
- Awareness (Contemplation). People are aware that a problem exists, are seriously thinking about overcoming it, but have not yet made a commitment to take action.
- Intention (Preparation). People intend to take action in the near future and may have taken some inconsistent action in the recent past.
- Action. People modify their behavior, experiences, or environment to overcome their problems; the behavior change is relatively new.
- Maintenance. People work to prevent relapse and to maintain the behavior change over a long period of time.

The model assumes that individuals may initially lack intention to change, then may form weak intentions, strengthen these intentions, try the behavior inconsistently at first, and then finally adopt the new behavior as a routine part of their lives. Movement through these stages will vary greatly from population to population and from individual to individual. Some people may remain in the contemplation stage for months or years; others cycle back and forth among stages. Everyone is vulnerable to relapse.

Effective interventions first determine where the majority of a population is on this continuum and then address that specific psychological moment, attempting to move people to a subsequent stage. Careful baseline and follow-up research with particular audience groups is essential to these efforts. One particularly fruitful stage for research is with those who are in the occasional behavior trial stage. Many people who reach the stage of positive intention or first trial are subsequently discouraged by bad experiences. Such experiences might include negative encounters with the health care system (such as painful immunizations or unhelpful health workers) or unexpected frustration in maintaining new behaviors (such as a diet or exclusive breast-feeding). Complacencyafter several years of no serious childhood epidemics can also undermine sustained behavior. Careful research can uncover barriers that lie at the heart of behavior challenges and lead to more clearly tailored messages.

Usefulness of Behavior Change Theory

To be effective, intervention methods and messages must be sensitively geared to the specific needs and stage of a group at risk. The various factors identified by the three major theories can be studied within a given audience to help move people from stage to stage as envisioned in the Stages of Change Model. Researching the variables associated with practices that put people at increased risk is most effective when guided by sound theory. Theory-based research is also most informative for the design of interventions. And finally, measurement of behavioral change is most revealing for purposes of both monitoring and impact evaluation when focused on elements most intimately tied to the actual processes of change within individuals and groups.

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Question 12

How Do We Use Our Research Information to Prepare a Research Report and Rewrite our Health Problem Statement?

This question brings together all of the information you developed in the worksheets for Questions 2 through 11, which will enable you to use the information to make plans and decisions for implementing your health communication intervention.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Decided how to prepare your research report
2. Begun to prepare your final research report
3. Examined the importance of reviewing and redefining the initial health problem based on newly gathered information
4. Revised your health problem statement (Worksheet 12)

Introductory Note

A research report provides a structure for the information you have collected during the research phase of planning for your health communication intervention. It presents your findings in a clear manner to your team members, director, and collaborators.

After you have (1) defined the health problem, (2) identified your primary and secondary audiences, (3) determined their ideal and current behaviors (4) identified their preferred information (media) sources, and (5) analyzed the factors influencing their behaviors, you are ready to draft your research report.

Exercise 1. Preparing Your Research Report

Materials

Copies of Research Report Outline
Copies of worksheets from Questions 2 through 11

Instructions

Ask team members to select a section of the outline and fill in relevant findings to make a draft of it.
Read the drafts aloud and have team members make pertinent corrections to each finding so that research results are coherent and recommendations are consistent and logical outcomes of the report's conclusions.

Research Report Outline

I. Executive Summary
   A. Title
   B. Research Agency. Who is responsible for the research project?
   C. Overview of Research Activity. Why was the research conducted, with whom, where, when, and how?
   D. Summary of Main Findings. What was learned?
   E. Recommendation Summary. What are your recommendations for the intervention based on what you learned?

II. Background
   A. Health Program Overview. Program description, including information relevant to your health problem
   B. Program Goals. Health program goals that relate to your intervention

III. Problem Statement. What is happening to whom, where, when, why, and what are the consequences and possible causes?
   A. Epidemiology (mortality, morbidity, prevalence, geographic location)
   B. Behavioral Risk Factors
   C. Other Risk Factors
   D. Service/Supply Problems
   E. Anticipated Obstacles
      1. Economic
      2. Social
      3. Cultural
      4. Other

IV. Available Information Sources. Where was the research information obtained and who assisted in the research?
   A. Ministry of Health (central)
   B. Ministry of Health (provincial)
   C. Other Groups (media, religious, university, nongovernmental)

V. Research Overview
   A. Purpose. Why was this research undertaken?
   B. Objectives. What were your research objectives?
   C. Methods. What research analysis and methods did you use?
   D. Protocol. With whom did you conduct your research; where and what was your sampling size?
   E. Research Team. Who conducted the research and what was their background/training?

VI. Behavior Objectives
   A. Change. What are the behavior changes you have identified for each audience to solve or reduce the health problem?
   B. Evaluation Indicators. How will you know if you succeeded in encouraging the behavior or health status change?

VII. Key Findings by Objectives, Research Areas, and Variables. Specifics on what was learned

VIII. Conclusion and Recommendations. Based on the information you gathered

IX. Annexes
   A. Survey Questionnaire
   B. Guides
   C. Others (maps, etc.)

Use this outline to draft your research report. To do so, you may need all of the worksheets from Questions 2 through 11 and your summarized and analyzed research data. If you need to make changes, agree among yourselves on why changes are needed and what changes to make.

Reflecting on Field Experience

Exercise 2. Reviewing the Initial Health Problem

Materials

Copies of Example 1, Changing a Problem Statement

Instructions

Ask your team members to think of a health problem that they had initially thought they had understood until research results changed their thinking.
After reading the example, have them compare their experience with the example.

Example 1. Changing a Problem Statement

In their initial problem statement, the Ministry of Health (MOH) of a West African country noted the following:

Our infant mortality rate is 90/1000 and the under-age-five rate is 145. Diarrheal diseases are the second most common reason mothers bring their children to health centers and they cause 30% of reported infant deaths.

Because of a shortage of ORS packets, the MOH had conducted a communication program promoting the use of sugar-salt solution (SSS) to treat dehydration from diarrhea. Many mothers reported using the solution at least once, but they did not seem to be using it regularly. Mothers need to understand the value of SSS, be encouraged to try it, and be given information on when and how to use it.

Team members conducted focus group research with mothers who had used the solution. They found that these mothers were having trouble following the mixing instructions. They held a series of mixing observations in which groups of mothers were given the ingredients and asked to demonstrate how they mixed the solution at home. They found that only 26% of the mothers knew the correct salt measurement for SSS. They usually used too much salt, a heaping spoonful rather than a level spoonful. During the demonstration, most mothers chose to use fine salt, although normally they have only rock salt in their homes. When they did use rock salt, they did not grind it before measuring as recommended and, therefore, could not measure the correct amount.

Seventeen percent of mothers preferred using fine sugar and the majority of mothers said they had fine sugar in their homes. The instructions, however, were given only for sugar cubes. Most mothers had learned mixing from a health worker. Nonetheless, they made serious mixing errors. Even when mothers used the suggested salt measurement, the amount used exceeded WHO recommendations. Most homes have two types of teaspoons. Both spoons yielded more salt than WHO recommends. The larger teaspoon yielded a salt amount that is dangerously over the recommendation. Mothers who had tried the solution found the excessive saltiness unpleasant to taste

and reported their children would not drink it. As a result, using SSS had not had positive outcomes.

Recognizing that several of their original assumptions had been incorrect, the team restated their health problem:

> Diarrheal diseases are one of the most common reason for bringing children to the health centers. They are the cause of 30% of infant deaths. Although many mothers have been taught how to mix SSS, they are having trouble following current mixing instructions. New instructions must be developed that are easier to understand and perform and reflect the supplies that are available to them.

The team decided to recommend two three-finger pinches of salt and test the ability of mothers to use this measurement accurately. They continued to use the eight sugar cube measurement, but they offered an alternative for those who have only fine sugar. They tested using half a tea glass as a sugar measure, since most houses have this eight-ounce size glass. These measurements would be tested to be sure the amounts of SSS they produced met WHO recommendations.

Ask your team members what differences they noticed in the two statements?

What new information do you think most staff members gathered to help them revise their original statement?

Synthesis

The research report format reflects essential findings that will be used as the basis for all future decisions about the intended health communication intervention.

Revising the health problem statement based on newly gathered data helps to ensure that the health communication strategy will address its interventions to the following:

1. Most appropriate audiences
2. Actual causes of the problem
3. Factors most relevant to the solution

Application

1. Go to Worksheet 12, Revised Problem Statement, and rework your original problem statement. Remember to use your research findings to restate the problem.

Worksheet 12-1

Revised Problem Statement

After revising your problem statement, be sure to update your research report form. Write your original problem statement.

Now develop a revised problem statement based on your new information collected during formative research.

(If the information obtained does not change your problem statement, you are very fortunate. Generally it does. Complete the following exercise to determine what changes you will need to make.)

A. Epidemiology (mortality, morbidity, prevalence, geographic location)
[What is happening? Where? When? Why? To Whom? Possible causes?]

B. Behavioral Risk Factors [Causes]

C. Other Risk Factors [Causes]

D. Service/Supply Problems [Causes]

E. Anticipated Obstacles [Causes]

1. Economic

2. Social

3. Cultural

4. Other

Step 2

Plan

Questions 13 - 17

Question 13

What Are the Components of the Health Communication Intervention Plan? How Do We Develop the Health Education Unit? What Other Activities Have an Impact on Our Plan?

You have completed the first step, Assess, in developing your health communication intervention. In this question you will review the components of a communication plan. You will start by reviewing some ideas on how to develop your health education unit and then consider other (MOH) activities that potentially will affect your communication plan.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Examined all the components of a communication intervention plan
2. Completed an exercise in writing a description on a generic health communication intervention plan
3. Reviewed steps to develop your health communication unit
4. Identified and planned for other activities that may have an impact on your communication plans

Exercise 1. Components of a Health Communication Plan

Materials

Paper and pencils
Copies of the unorganized list of health plan components
Copies of the Health Communication Plan Outline

Instructions

Have your team members use the unorganized list included here to create an outline of all the components they think the communication plan should include.

Have them compare their outline with the Health Communication Plan Outline below.

Health Communication Plan Outline

I. Strategy Overview
   A. Health Education Unit Development
   B. Other Activities Impacting Communication Activities
   C. Health Problem Definition
      1. Program goals and objectives
      2. Target audiences
   D. Feasible Behavior(s)
      Communication objectives
   E. Messages

II. Communication Strategy Specifics
   A. Operational Communication Plan
      1. Creative briefs
      2. Communication channel selection
      3. Media mix
      4. Content message/distribution
      5. Pre-testing
      6. Materials production
   B. Training
      1. Methodology
      2. Audiences
      3. Objectives/outcomes

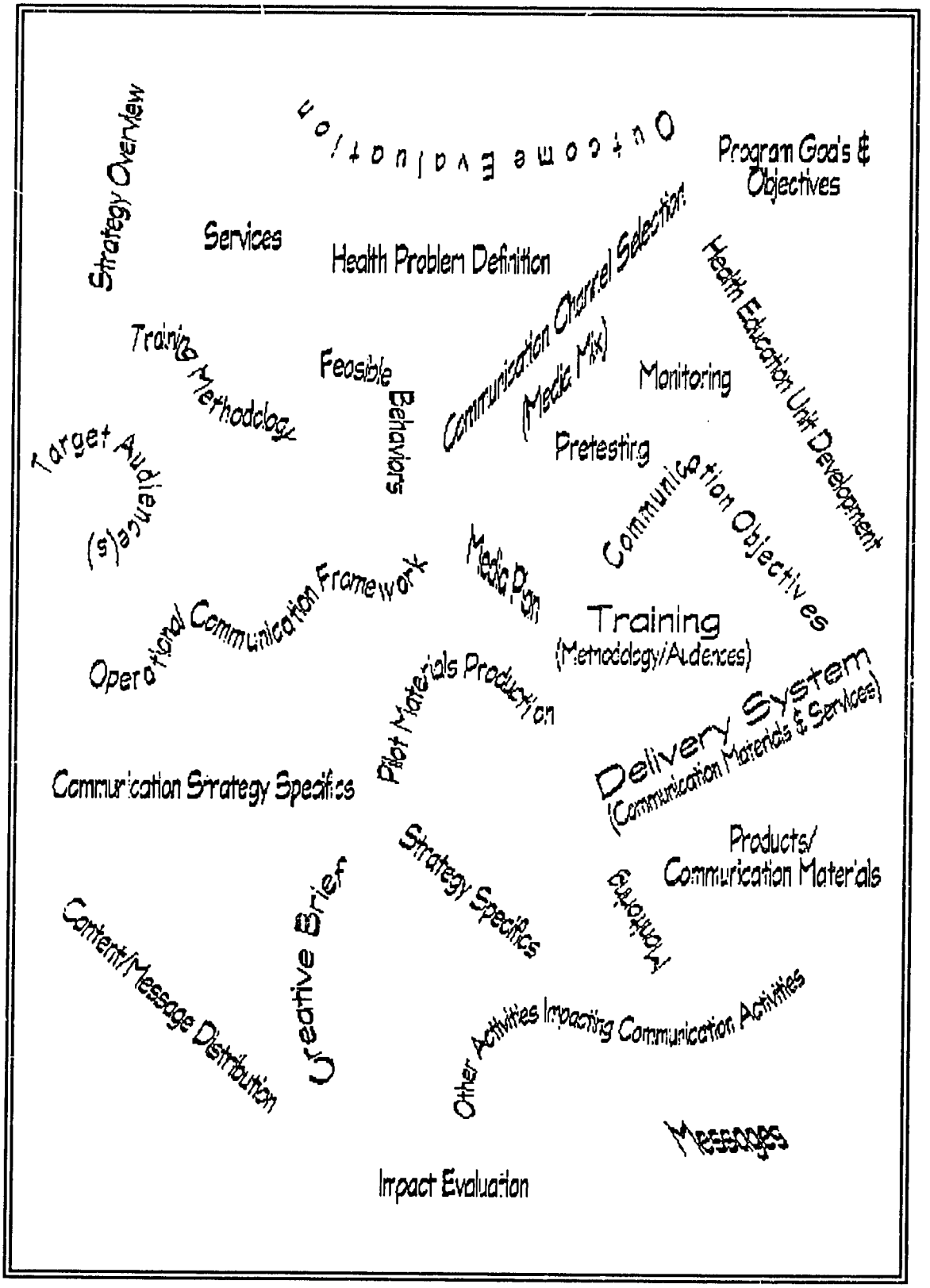
   C. Delivery Systems
      1. Products
      2. Services
      3. Audience access
   D. Monitoring
   E. Process Evaluation
   F. Impact/Outcome Evaluation

Exercise 2. Understanding the Communication Plan

Materials

Paper and pencils
Copies of the Generic Description of Communication Plan Components

Unorganized List of Health Communication Plan Components



Instructions

Ask team members to read the Generic Description of Communication Plan Components and discuss which components are new.
Note who among the team has had experience in carrying out any of these new components.

Generic Description of Communication Plan Components

I. Strategy Overview

A. Health Education Unit Development
Describes how the Health Education Unit should be put together, what its functions are, how it relates to the rest of the MOH and other institutions, and how its capacities can be strengthened during the intervention

B. Other Activities Impacting Communication Activities
Includes activities that by their nature tend to either become obstacles or barriers or make modifications to the desired communication activities

C. Health Problem Definition
Reiterates the health problem defined after the formative research

D. Feasible Behaviors
Lists the behaviors selected for promotion

E. Messages
Includes messages designed to convey and promote the behaviors, knowledge, attitudes, and awareness identified from the research results as needed to address the health problem

II. Communication Strategy Specifics

A. Operational Communication Plan
All the steps needed to implement the use of media; it includes plans for the materials production process and information about how materials should be pre-tested

B. Training
Usually used as an essential tool to achieve the interpersonal communication goals

C. Delivery System
It includes those elements that are to be delivered, anything from products to

services or from messages to materials; all activities that are needed for the behavioral outcomes to take place

D. Monitoring
A system that allows you to follow and verify that promotional materials, services, and products are in place the target audiences are exposed to them as planned, and that activities reflect program strategy (see Question 24)

E. Process Evaluation
Systems to collect data on program activities, products, and experiences during the intervention (see Question 25)

F. Impact/Outcome Evaluation Indicators
Includes designs for measuring changes in behavior and health status as a result of your intervention (see Question 25)

Reflecting on Field Experience

Exercise 3. Infrastructure Development

Materials

Copies of Example 1, Developing a Health Education Unit

Instructions

Have team members read the example in a group.
Ask them to list the reasons why it is necessary for them to have a clear strategy for developing their health education unit to implement a communication intervention successfully and efficiently. The questions included at the end of the example will help them think about what is needed for a health education unit.

Why is it necessary to include the health unit development in the plan? It may seem unusual that a communication intervention plan should include this component. The reason is simple. There cannot be any implementation of a communication plan if there is no executing unit. A serious communication intervention requires a minimal infrastructure of both personnel and equipment.

Example 1. Developing a Health Education Unit

In a Latin American country, the Minister of Health accepted a donor's Child Survival Project. The project's design called for the implementation of a comprehensive communication intervention with the objective of teaching mothers of children two years of age and younger to use oral rehydration salts (ORS) packets correctly when their children suffered from dehydration.

The epidemiological statistics of the MOH showed that 33 percent of deaths of children under age two were linked to dehydration. Informal data on possible factors affecting diarrheal diseases were collected by health workers. These included lack of safe water, poor access to wells or piped water, lack of firewood or other fuel to boil drinking water, and lack of understanding by mothers of the notion of dehydration. ORS packets were not found in the periurban shanty towns or rural areas. Severe diarrhea was treated ineffectively with anti diarrheal home remedies. Initial findings indicated that these were the basic causes for almost two-thirds of child mortality from diarrheal-related illnesses.

The proposed strategy was to start the intervention in a pilot region, learn lessons very fast in a relatively controlled situation, and expand to a national program using all communication channels found to be useful during the pilot phase of the project.

The project's donors provided sufficient financial aid to carry out this ambitious goal. When the donors first arrived at the educational health unit of the MOH they found that the head of the unit was a relatively elderly physician who was about to retire. He had been given this post as a last assignment because authorities considered he deserved a job after his many years of medical service to the MOH. A secondary education teacher who had received some health education had been assigned as his assistant. The assistant had become interested in health issues and was enthusiastic about doing something in the health area, but did not have much experience with communication methodology. The unit also had a secretary who had been in other units of the MOH, but who was not particularly motivated and had no health education experience. She was willing to learn, but overall she did not seem very enthusiastic about her work.

Because of the increased responsibility of the unit, health authorities decided to retire the elderly physician and bring in an energetic young one as head. The new appointee was willing to learn health education strategies and launch the project's communication intervention, but he did not know how to start planning the intervention. He wanted to boost his unit's position within the ministry, but he did not have any past experience in putting together a health education unit.

He therefore asked for help from an international health communication project and was given a strategic health education unit development guide to use. This guide had questions to help him improve the unit's ability and image and to position it correctly within the ministry.

Strategic Health Unit Development Education Guide: Organizing Internally the Health Education Unit

1. Where can you find anything written that describes how to put together and organize a health education unit?
2. How many people do you need to implement a communication strategy?
3. What level of expertise do these people need to accomplish the communication objectives and goals?
4. What needs to be included in the job descriptions for the unit's staff to implement a health communication project?
5. What is a probable functioning budget for one year; two years?

Discuss these questions with your team as they apply to your situation.

NOTE: Section 1 and 3 of the Tool Box includes managerial information that covers procedures, policy, and strategies. If you have not read this information, this is an excellent moment to do so. If you have, draw from it some answers to the above questions.

Background Information

Often health education units are not taken seriously within the ministry of health structure. Doctors may not value the contribution of health educators to MOH goals. Moreover, doctors and other health personnel tend to think that health educators do not know enough about disease to play a useful role. The role of health education is prevention and is linked to behavior outside the clinics, so it is difficult for the ministry to measure how useful these efforts are in achieving public health goals.

Prevention in general is not seen as a measurable activity since it is hard to find quantifiable data about outcomes. Medical staff often feel prevention education takes up too much valuable time from health personnel who already are overburdened with their regular chores. In general, health education is not seen as an important MOH activity, although there is some consensus that prevention could 'eventually' reduce the number of patients coming in for curative purposes.

Exercise 4. Organizing Your Health Education Unit To Operate More Effectively within the MOH and with Other Institutions

Materials

Copy of Question Guide for Organizing Your Health Education Unit

Instructions

Have team members discuss and answer the Question Guide below be small working groups.
One working group presents the answers to the first three questions.
The other group comments and a common set of answers is reached.
The other group presents the other three and proceed the same way.

Question Guide for Organizing Your Health Education Unit

1. Has your MOH had any past experience with health education? If so, to what extent have those experiences been considered successful?

2. What health problems were addressed by unit personnel? Which seemed to have had the most salient results? What type of recognition did the unit receive from the minister and directors of the health programs?

3. Do you know the directors of the various health programs? You will have to work closely with these directors because they are responsible for the technical content of your messages.

4. Have you made contact with the director of the training unit? Are you familiar with existing training programs for the health personnel you will work with? Is the technical content of your intervention already included in the official training or academic curricula of the MOH?

5. Is there already a consensus among MOH directors about the place health education should have within the ministry? If not, is there a probability that such a policy decision could be reached if the directors attended a one-day policy decision workshop around this topic? (See the example of a Policy Decision Workshop in Section 1 of the Tool Box. Read it and decide how you can use it.)

6. What other institutions, nongovernmental organizations (NGO's), or similar organizations can you start contacting so that they are part of your activities early in the process? Think of the expertise you lack and make an inventory of those institutions that may have that expertise. They will need to know about the unit's existence and the communication intervention you are about to initiate.

Answers to these questions should help you position your unit within the ministry and in relationship with other institutions.

Exercise 5. Other Activities Impacting Communication Activities

Materials

Copies of Example 2, Impacting Activities

Instructions

Have one member of the team read aloud this example.
In groups, identify other possible activities impacting the communication activities.

Example 2. Impacting Activities

MOH team members in the Caribbean Measles Eradication Initiative had drawn up their feasible behaviors and communication objectives. They then considered their next planning step: identifying the activities that could have an impact on their success in achieving their communication objectives. Together they brain-stormed a list of activities that they thought would also need to be addressed by the ministry to ensure the successful adoption of the promoted behavior: measles vaccination. Their list included the following:

1. Ordering and keeping on hand a sufficient supply of measles serum, syringes, and needles
2. Providing adequate training in immunization injection, as necessary
3. Maintaining sufficient health staff to provide immunizations
4. Working around a nationwide mobilization for AIDS prevention

They knew that although these activities were not communication activities, and therefore not within their domain, that without each of the first three activities being in place, their communication objectives could not be achieved. It would not be possible to receive a measles immunization if the health center had no syringes. It would not be possible to have a successful initiative if the health center did not have sufficient staff to handle the demand or if the staff present have not been trained to provide immunizations. They also knew that the AIDS program could compete with their intervention and that they needed to schedule their activities to avoid such competition.

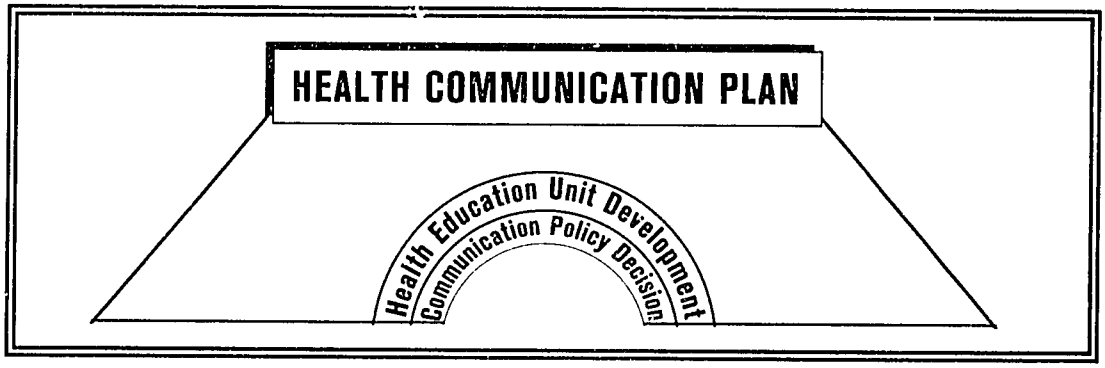
They held a meeting and presented their list and communication strategy to the unit's director and to the units responsible for each of the other activities. Together staff dis-

cussed ways to provide the necessary provisions and training so that the behavior to be promoted could be successfully adopted.

It was important for them to identify these activities before launching their communication intervention because health communication projects do not work in isolation. Every activity that is undertaken impacts on and is impacted by other projects within a unit and by other units within their division or ministry. To ensure that the communication objectives they wished to achieve and the behavior they wished to promote had every chance of success, it was necessary for them to coordinate with the units affecting their project.

Building the Communication Plan Graphic

If we were to start making a graph that will show all the components of the communication plan as we study them in detail in the next eleven questions until Question 25 is finished, the components we have just seen, the institutional building of the health education unit and the other activities of the MOH or outside institutions will fall on the graph in the following place.



Synthesis

1. A health communication plan is made up of two sections: strategy overview and communication strategy specifics. These in turn, have many subdivisions.
2. The health education unit must have a minimum core of personnel to be able to design and implement a communication plan. It must also develop internally creating links, contacts, and working relationships with other MOH units, as well as related NGOs and community-based organizations that could be involved in implementing the plan.
3. Many other activities within the MOH can impact the unit's communication plan design and implementation. These activities should be anticipated in advance.

Application

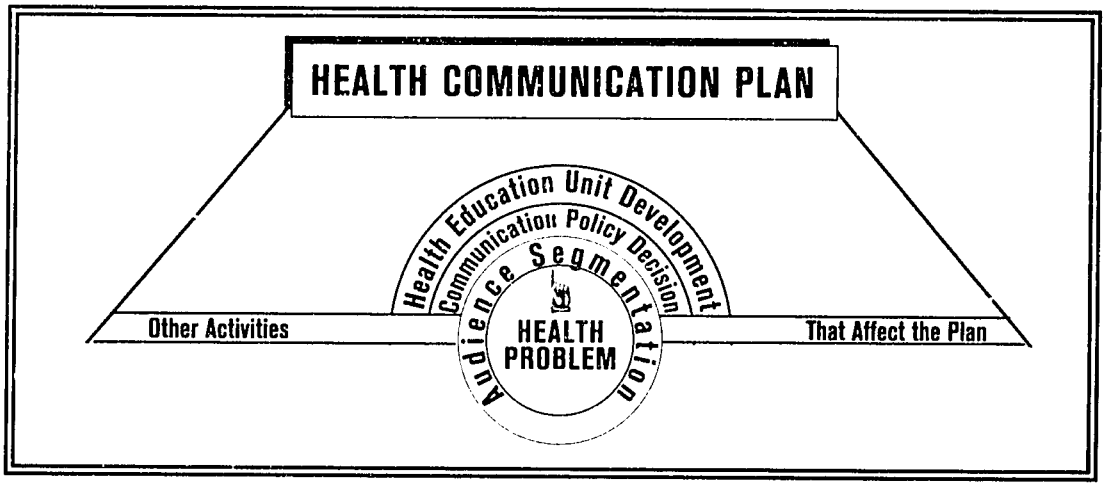
1. Make copies of the health communication plan outline. Give a copy to each team member. Make a large flip-chart size version to refer to as you draw up your communication plan in detail.
2. Make a separate plan on how you will develop the health education unit as you design and implement the communication activities.
3. Make a tentative list of possible MOH activities that will impact your future communication activities.

Question 14

How Do We Refine the Selection of the Target Audiences for Our Intervention and Make a Communication Strategy Statement?

In this question, as well as the subsequent ones, you will examine those elements that make up each component of your health communication plan. You will start with the refinement of the target audience as it relates to your revised health problem statement.

The step is shown here in the graph:



Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Defined the target audience for your intervention (Worksheet 14-1)
2. Written your communication strategy statement

Introductory Note

The health problem is the core of the communication plan. You initially developed your health problem statement in Question 2 and rewrote it in Question 12 after reviewing your research findings. This revised health problem statement is the starting point in developing your communication plan. You will use this statement in the remaining questions as you develop the health communication plan for your intervention.

The target audience for a communication intervention does not differ greatly from that of the audience for formative research. They coincide much of the time, although you may have to redefine a new secondary audience or narrow or amplify your primary audience as identified by the research results.

Exercise 1. Criteria for Selecting the Target Audience for Your Communication Intervention

Materials

Copies of the Criteria for Selecting the Audience for a Communication Intervention

Instructions

Have team members first make up a list of the criteria they would use for audience segmentation.
After they finish, have them compare their list with the following list and with Worksheet 3-1 and note the differences.

Criteria for Selecting the Audience for a Communication Intervention

Primary Audience

1. Who is most affected?

2. Which group would benefit most from the behavior change (highest impact)?

3. Which group might be most responsive to the behavior? (Where is the group in the stages of behavior adoption? What is their current behavior? What factors will influence them?)

Secondary Audience

1. Who might use the messages as your allies? (For example, health workers need to treat youth with respect to encourage others to participate.)

2. Who might influence the primary audience to listen and respond to the messages? (For example, parents needed to give permission; peers.)

Determining Variables

After you have selected your primary and secondary audience, use the following set of variables to further determine their characteristics. Identifying these characteristics enables you to more effectively design messages, illustrations, and music that will be appropriate and appealing to each audience. Ask who is the primary audience and who is the secondary audience?

Possible Criteria for Segmenting Your Audience	
Objective Measures	
General	**Behavior Specific**
Age of Adult	Contact with health system
Approximate income	Past behaviors (user/nonuser)
Sex of adult	Access to products
Place of residence	Distance to health center
Race, ethnic group	
Language	Behavior of relatives
Size of home	Behavior of community
Type of home	Hours watching TV
Number of children	Hours listening to the radio
Education	Distance to sources
Presence of husband	
Age of children	
Sex of children	
Community wealth	
Socio-Economic Standard Index	
Age of adult	

Assumed Measures	
General	**Behavior Specific**
Personality	Self-efficacy
Lifestyle	Perceived benefits
Values	Perceived costs
Risk preference	Hierarchy stage
Media preference	Message recall
Self-confidence	Relevant knowledge
Perceived health	Social norms
Discretionary time	Perceived risk
Innovativeness	Perceived severity
Attitude of community leader	Satisfaction with health centers

Applying the above criteria to the description of the target audience in Example 1 in Question 13, the primary audience will be as follows:

- Illiterate or semiliterate rural and periurban (shanty town neighborhoods) mothers of children under two years of age who will be taught where to find ORS packets, how to prepare them correctly, and how to administer the solution to their children when the first signs of dehydration appear.

The secondary audiences will be the following:

- The MOH directors from whom they will try to obtain a communication policy statement in which the Health Education Unit will get the recognition and responsibility needed to carry out its work; the unit also will request an official policy statement on recommendation and use of ORS packets by the MOH

- The health workers immediately in contact with mothers at the health centers, so they will offer the support mothers need to adopt the use of ORS packets; the health worker will be trained to understand the mothers' perspectives,

beliefs, and knowledge regarding diarrhea diagnosis and treatment and to recognize the dangers of dehydration

- The MOH doctors, especially pediatricians, who might offer resistance to the official use of ORS in the hospital setting

Background Information

A communication strategy statement includes the path selected to achieve communication and program goals. It includes the health problem to be tackled, the target audience selected, and the methodological instruments needed to achieve it.

Exercise 2. Communication Strategy Statement

Materials

Paper and pencils
Copies of Example 1, Strategy Statement

Instructions

Have team members write out a communication strategy statement for the intervention in the example, taking into account the target audience data described. Ask them to read the example, Strategy Statement and compare it with the one they wrote. Point out the elements they left out and ask them to reflect on the reasons why they did not include them.
Then ask them to write a strategy statement for your communication intervention as you have defined it based on the health problem chosen and the audience segmentation determined.

Example 1. Strategy Statement

The health education unit of the MOH will undertake a communication education campaign for one year in health region one for rural and periurban mothers with children two years of age and under as the primary audience. The campaign will teach mothers the signs of dehydration (unknown to them, according to research results), where to obtain ORS packets, how to prepare ORS correctly, and signs of dehydration so she will know to start giving the solution to her child as soon as she notices them.

The communication intervention will focus its strategy in the following two areas:

1. The institutional development of the health education unit. This area will provide the strongest and most effective intervention based on the unit's strength within the MOH.

2. The production of communication materials that will deliver the behavioral, knowledge, and attitude messages to the target audience through the radio (research findings). These materials will include some simple flyers and lists of community-based informants and ORS packet distributors. Health personnel will be trained to reinforce the radio messages with mothers and community-based personnel. They will be given appropriate visual material and taught simple interpersonal communication techniques so they can communicate with peers more easily. A TV and newspaper advertisement will be developed to promote the ORS packets and give them credibility and social recognition among doctors and opinion leaders.

   Training

   - Doctors. This training will be focused on understanding mothers' perspectives of diarrhea and how doctors can be active participants in the program goals. Trainers will use participatory techniques to enlist the doctors in feeling comfortable with their new roles. They will use the most sophisticated methods of visual presentation available to make the necessary impact on doctors. Training will be reinforced with highly polished print materials to give technical validity and seriousness to the ORS treatment.

   - Health Personnel. A highly participatory training will focus on the mothers' obstacles and barriers to adopting the use of ORS. It will help health personnel define and commit to a more individualized relationship with each mother, especially during the first phase of introduction of the ORS packet. It will emphasize the need to have unified message regarding ORS use: correct preparation plus feeding during and after a diarrheal episode.

     Training will also include demonstrations of correct ORS preparation. It will present criteria and logistic decisions regarding the management of ORS packets (storage), reporting of packets distributed, and mechanisms for replenishing diminished stock.

   - Community-based informants. These trainees will be mothers chosen within communities who will be trained to inform others mothers about how to recognize the first signs of dehydration, how to prepare ORS correctly, how to administer the ORS, what to do about feeding practices during diarrhea, and when to refer sick children to the health center. They also will be trained to manage and distribute ORS packets.

Synthesis

1. The target audience for an intervention does not differ greatly from that of the audience for formative research. Sometimes a redefinition of secondary audiences is necessary.

2. The following criteria are used for selecting a communication intervention audience:

Primary audience
- Most affected
- Group who would benefit most
- Group most responsive to behavior

Secondary audience
- Who might use messages as allies
- Who might influence the primary audience

3. Further criteria include the following:
   - Socio-economic measures most significant and determinant
   - Behavior-specific elements

4. The communication strategy statement will include the following:
   - Path selected
   - Health problem to be tackled
   - Target audience selected
   - Methodological instruments to achieve it

Application

1. Use Worksheet 14-1, Target Audience for Communication Intervention, to redefine the target audience.
2. Ask team members to write the strategy statement for your communication intervention using your defined health problem and target audience.

Good Start! Your Communication Intervention Plan is Beginning to Take Shape.

Worksheet 14-1

Target Audience for Communication Intervention

Primary Audience

1. Who is most affected by the health problem?
   (Age, socio-economic status, sex, language, children [sex, age, number], education, contact with health system, user/nonuser, access to products, social norms, channels of communication use)

2. Which group would benefit most from behavior change?

3. Which group might be most responsive to the behavior? (Where is the group in the stages of behavior adoption?)

Secondary Audience

1. Who might use the messages as allies?

2. Who might influence the primary audience to listen and respond to messages?

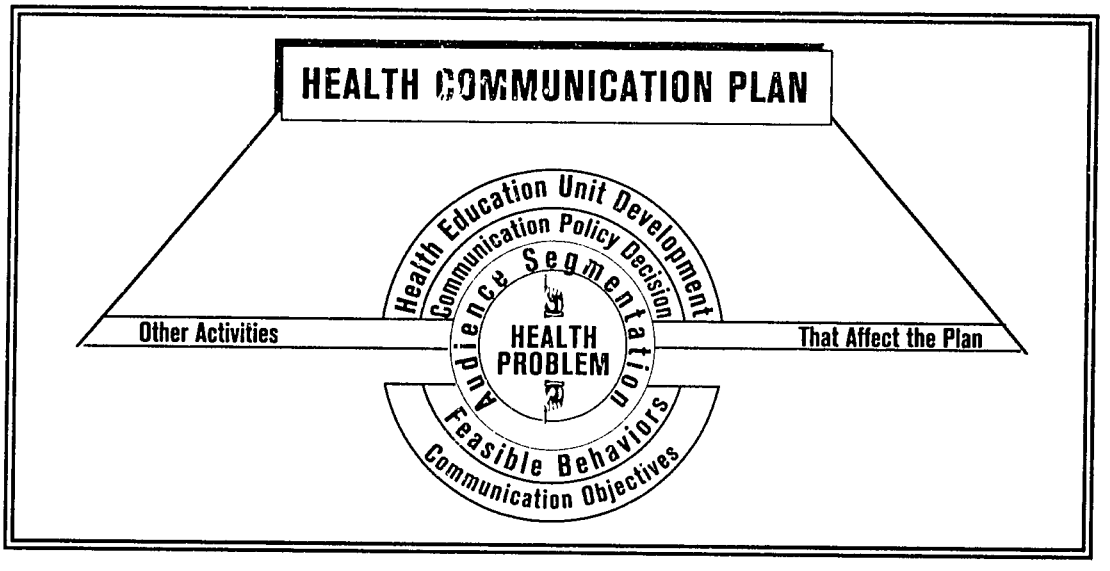
3. Who might act as gatekeeper of information or deter primary audience from trying or adopting new behavior?

Question 15

How Do We Define Feasible Behavior as Communication Objectives?

You have restated your health problem, redefined your target audience, and developed an overall strategy statement for your communication intervention. In this question, you will explain how to define the feasible behaviors that the communication strategy will address and the way these behaviors are translated into clear communication objectives. The Appendix to Question 15 provides additional information for defining feasible behaviors.

This step is shown here in the graph.



Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Reviewed how feasible behaviors are defined using the ideal behavior and the current behavior findings from the research (Worksheet 15-1)
2. Completed an exercise to define target audiences and feasible behaviors (Worksheet 15-2)

3. Studied the elements that make up a communication objective and how these are developed after determining the feasible behaviors
4. Determined and drafted the objectives of your communication intervention plan (Worksheet 15-3)

Introductory Note

Question 4 helped you identify the ideal behavior for your intervention. Even though your formative research had not yet been done, the team had some general knowledge of the current behaviors regarding the particular health problem. There was a gap between what the audience was doing and the ideal healthful practices. Research provided more details about that gap.

Now you need to find out what behavior is feasible for the target audience given the reality of peoples' lives and the barriers they face. Taking into consideration the barriers impeding their adopting the behavior, the possible lack of rewards involved in the new behavior, and the absence of group or social norms to support it, what can people reasonably be asked to do?

Example 1 in Exercise 1, will help you learn how feasible behaviors are determined.

Reflecting on Field Experience

Exercise 1. Behavior Analysis

Materials

Copies of Example 1, Applying the Behavior Analysis Scale
Copies of the Behavior Analysis Scale

Instructions

Read the example. Break into small groups and have members study The Behavior Analysis Scale and determine how it was applied in the example.
Ask a team member to explain how the scores were used to choose the feasible behaviors to be promoted.

Example 1. Applying the Behavior Analysis Scale

In Peru, MOH staff wanted to implement a communication plan designed to lower diarrheal morbidity through increased use of a newly installed community-piped water system. They needed to define the behaviors to be promoted.

Team members carried out observations in homes to identify factors contributing to diarrheal morbidity. Five risk factors were identified: (1) toys on the floor, (2) feces in or around the house, (3) unclean mothers' hands, (4) uncovered drinking water storage containers, and (5) baby bottles on the floor.

Many health education teams would have stopped here in their assessment process. They would design a program to inform mothers of the dangers each of the situations present and to urge mothers to improve all of these conditions in their homes. But these team members were concerned about the cost to mothers of performing new behaviors, so they attempted to reduce the list to promote a realistic number of behaviors. To do this, they applied nine categories from the following Behavior Analysis Scale to each of the five factors identified with diarrheal morbidity and to the behaviors mothers would need to adopt to eliminate these risk factors.

Category

Health Impact of the Behavior

1. No impact on health problem
2. Little impact
3. Some impact
4. Significant impact
5. Very significant impact
6. Eliminates the health problem

Positive Consequences (Effects) of the Behavior

1. None that mother could perceive
2. Few perceptible consequences
3. Some consequences
4. Significant consequences
5. Very significant consequences
6. Major perceptible consequences

Cost of Engaging in (Performing) the Behavior

1. Requires unavailable resources or demands unrealistic effort
2. Requires very significant resources or effort
3. Requires significant resources or effort
4. Requires some resources or effort
5. Requires few resources or little effort
6. Requires only existing resources

Compatibility with Existing Practices

1. Totally incompatible
2. Very significant incompatibility
3. Significant incompatibility
4. Some incompatibility
5. Little incompatibility
6. Already widely practiced

Similarity to Present Behaviors

1. Nothing like this is done now
2. An existing practice is slightly similar
3. An existing practice is somewhat similar
4. An existing practice is similar
5. Several existing practices are similar
6. Several existing practices are very similar

Category

Complexity of the Behavior (Ease/Difficulty)

1. Unrealistically complex (difficult)
2. Involves a great many elements
3. Involves many elements
4. Involves several elements
5. Involves few elements
6. Involves one element

Frequency of Behavior (Ease/Difficulty)

1. Must be done at unrealistically high rate to achieve any benefit
2. Must be done hourly
3. Must be done several times each day
4. Must be done daily
5. May be done every few days
6. May be done occasionally and still have significant value

Persistence (Duration)

1. Requires compliance over an unrealistically long period of time
2. Requires compliance over a substantial period of time
3. Requires compliance for a week or more
4. Requires compliance for several days
5. Requires compliance for a day
6. Can be accomplished in a brief time

Observability

1. Cannot be observed by an outsider
2. Is very difficult to observe
3. Is difficult to observe
4. Is observable
5. Is readily observable
6. Cannot be missed

Using this scale, each behavior was given a score of 1-6, based on the criteria for that category. The total score was then compared to the scores of the other behaviors. These scores helped the team members make some hard decisions about selecting one or a few target behaviors. Their scoring looked like the following:

CATEGORIES	SCORES				
	TOYS	FECES	HANDS	WATER	BOTTLE
1. Health impact of behavior	2	3	4	4	2
2. Complexity of behavior	3	2	2	2	3
3. Positive effects of behavior	1	2	3	3	1
4. Frequency of behavior	1	2	2	3	1
5. Cost of performing behavior	1	1	2	2	1
6. Duration (persistence)	1	1	1	1	1
7. Compatibility with existing behaviors	3	1	4	4	3
8. Observability	5	5	4	4	5
9. Similarity to present	2	1	3	3	2
TOTALS	17	18	25	26	17

Team members looked at the scores and chose to focus on the two highest scoring situations affected by water: mothers' hands and storage of drinking water.

Their research had revealed that morbidity was five times higher in situations in which mothers did not have clean hands compared to homes with uncovered drinking water.

It also revealed that children under three years old were infrequently given water to drink. These findings led team members to focus their attention primarily on mothers' handwashing practices. Team members, however, continued to look closely and systematically at just what they were going to ask mothers to do. They wanted to find a compromise between the important differences correct handwashing would have on diarrheal morbidity and the complexity and high cost this practice would have for mothers. Team members, therefore, chose two strategies: increase correct handwashing practices and construct, install, and use a Tippy Tap. (A Tippy Tap was an inexpensive device, easily made from a large household plastic bottle, that limits the amount of water used in handwashing. It helps to ration the amount of water needed and therefore reduces the amount of water to fetched.)

At this point in their behavior analysis, team members focused their attention on how many steps were necessary for mothers to wash their hands correctly at critical points in the day and to maintain sanitary handwashing conditions with the Tippy Tap. To assess this, team members washed their hands, using materials generally found in the home. They found that each handwashing took 600cc of water and two minutes to perform (duration). In addition, there were 26 times (frequency) a day that mothers should wash their hands to maintain proper hygiene. These include washing after using the latrine, after changing a dirty diaper, before preparing food, before eating, before giving food to the infant, upon entering the home, before going to bed, and before cooking and drinking water. This amounted to 52 minutes of handwashing a day plus an extra 16 liters of water to bring into the house. Simple handwashing alone took 46 steps and the combined process of handwashing and making and maintaining the Tippy Tap required 121 steps. Clearly, correct handwashing at critical points in the mothers' daily routines would need to be rethought before making it a focal point of a communication intervention because the behavior involved considerable 'cost' the to mothers.

Team members needed to find some intermediate point between ideal handwashing and current handwashing practices. They asked an epidemiologist to identify the times handwashing could have the most impact on diarrheal morbidity. As a result from this information, the recommended frequency of handwashing was reduced to before preparing meals and before feeding children under three years old. Using the scale again helped team members reduce steps of handwashing with the Tippy Tap to the following:

1. Have appropriate handwashing materials
   a. Tippy Tap installed
   b. Tippy Tap with sufficient water
   c. Soap tied to the Tippy Tap
2. Pull string on top of bottle until the handle fills with water

3. Wet hands with stream of water from handle
4. Soap hands
5. Rub hands together
6. Pull string again until handle fills with water
7. Rinse hands with stream of water from handle
8. Dry hands on clean towel/cloth

> ***Note.*** *In the appendix to this question you will find additional information on defining feasible behavior.*

Exercise 2. Defining Communication Objectives

Materials

Copies of Goals and Objectives

Instructions

Ask team members to write out their descriptions of what a communication objective should be and the qualities it should have.
Have them compare their description with the one provided.
If there is much of a difference, ask them to rewrite their definition. The definitions they should use for comparison are in the copies.

Goal and Objectives

- Goal and objectives have three levels.

    - The broad **program goal** specifies the expected overall impact of the integrated program activities to which the communication strategy will contribute; e.g., impact on mortality or morbidity rates.
    - The **program objective** defines the expected specific result of the program to which the communication strategy will contribute; e.g., increased immunization rates.
    - The **communication objective** indicates the expected change in health status, behavior, knowledge/attitude, or process in the audience as an end result of the communication strategy; e.g., mothers can state the number of visits needed to complete the series, can state how to manage side effects, and will complete the series.

- The communication objective identifies how the audience will change.
    - What will be addressed (health status, behavior, knowledge/attitude, process)
    - To what degree
    - Over what period of time

- The communication objective corresponds to the behavior change that the audience will be encouraged to take, the feasible behaviors.

Each objective should do the following:

1. Be directed to a single **target audience**
2. Specify expected **changes in behavior, knowledge, and attitudes** of the audience
3. Describe expected results
4. Be **specific and precise**

A well-defined objective should be interpreted in the same way by all those who read it. If there is any misunderstanding or confusion, the objective needs to be changed to make it clear. Accordingly, an objective should not include vague or confusing words or words that may lend themselves to a number of different interpretations. It should use action words.

Examples of confusing words: internalize, know, understand, appreciate, value, enjoy, motivate, learn, sensitize

Examples of action words: complete, use, try, enumerate, define, explain, design, summarize, resolve, construct, prepare, make, arrange, organize, select, compare, list

A danger that exists when preparing objectives is that of describing activities instead of the desired results. Some of the dangerous words (words that describe activities instead of describing the desired results) are study, read, present, expound, discuss, analyze, persuade, and teach. For example, teaching mothers is a program activity, but the communication should describe what mothers are expected to do as a result of the teaching.

When objectives are being developed, the following questions should be asked:

1. Could another person use these objectives to understand exactly what the target audience needs to do?
2. Is there any objective on the list that is vague or confusing? If two people have different interpretations, the objective will need to be changed to make it clear.

3. Does this list describe all the results that should be achieved?
4. Is there any objective on the list that describes an activity instead of a result?

There are three types of objectives to consider in educational communication: changes in knowledge, changes in beliefs/attitudes, and changes in behavior. All three types are important, but objectives involving changes in behavior are the most critical for achieving the program goal; i.e., improving in health status. Team members therefore generally begin by stating the objectives in terms of the behaviors they wish the target audience to perform based on the feasible behaviors that are selected. Each behavioral objective may have one or two knowledge or belief objectives. For that reason, team members should first formulate the behavioral objectives and then, for each behavioral objective, ask, "What does the target audience need to know and/or believe to perform this behavior?" The answers to this question will form the knowledge or attitudes objectives.

The following process and format are useful in developing measurable objectives:

1. Describe the specific segment of the target audience; e.g., mothers with children under two who will recite the ORS mixing instructions correctly
2. Use an action word to describe what you want the target audience to do
3. Define the amount of change that can realistically be expected and over what period of time

Exercise 3. Defining Communication Objectives

Materials

Copies of Example 2, Defining Communication Objectives

Instructions

Read the example and discuss how the team defined their communication objective.

Example 2. Defining Communication Objectives

After the Peruvian team completed their behavior analysis, they defined their communication objectives as follows:

Audience.
Mothers with children younger than 18 months
living in urban and

Segment.
Periurban areas

Action.
Mothers with children younger than 18 months living in urban and periurban areas will mix ORS correctly

Amount and rate of change.
After six months, 80 percent of mothers with children younger than age 18 months living in urban and periurban areas will be able to demonstrate correct mixing of ORS (using a correct measure of one liter without adding salt, sugar, or other ingredients to the solution).

Here is how they presented the communication objectives:

- Mothers will state that not washing their hands before feeding their child may cause the child to have diarrhea.
- Mothers will install Tippy Tap receptacles in 40-50 percent of the households within six months of initiating the campaign.
- Fifty percent of mothers will use the Tippy Tap correctly to avoid spillage and waste of water.

Synthesis

1. Feasible behaviors are those that will have a positive impact on the health problem and that are realistic behaviors for the audience to perform.
2. A behavior analysis scale can help identify and give priority order to feasible behaviors for an intervention.
3. Communication objective should describe the feasible behaviors and should do the following:

    1. Be directed at a single audience
    2. Specify expected changes in behavior, knowledge, and attitudes of the audience
    3. Describe expected results
    4. Be specific and precise

Application

Now that you know how to define the feasible behaviors to be promoted, do the following exercises with your research results and your desired ideal behavior.

- First define your feasible behaviors using the Behavior Analysis Scale in Worksheet 15-1. Pick the three highest-scoring behaviors.

- Go to Worksheet 15-2, Identifying Target Audiences and Feasible Behaviors, and fill in the feasible behavior(s) you chose using the Behavior Analysis Scale. List them by primary and secondary audiences.
- Use Worksheet 15-3, Communication Objectives, to decide if you need additional research data on defining the target audience you may need. If you do not need more data, do not complete Worksheet 15-3.

Worksheet 15-1

Behavior Analysis Scale

CATEGORIES	LIST OF BEHAVIORS (write behavior in each box)		
	1.	2.	3.
Health Impact of the Behavior 1 No impact on health problem 2 Little impact 3 Some impact 4 Significant impact 5 Very significant impact 6 Eliminates the health problem			
Positive Consequences (Effects) of the Behavior 1 None that mother could perceive 2 Few perceptible consequences 3 Some consequences 4 Significant consequences 5 Very significant consequences 6 Major perceptible consequences			
Compatibility with Existing Practices 1 Totally incompatible 2 Very significant incompatibility 3 Significant incompatibility 4 Some incompatibility 5 Little incompatibility 6 Already widely practiced			
Frequency of Behavior (Ease/Difficulty) 1 Must be done at unrealistically high rate to achieve benefit 2 Must be done hourly 3 Must be done several times each day 4 Must be done daily 5 May be done every few days 6 May be done occasionally and still have significant value			

CATEGORIES	LIST OF BEHAVIORS (write behavior in each box)		
	1.	2.	3.
Persistence (Duration) 1 Requires compliance over an unrealistically long period of time 2 Requires compliance over a substantial period of time 3 Requires compliance for a week or more 4 Requires compliance for several days 5 Requires compliance for a day 6 Can be accomplished in a brief time			
Cost of Engaging in (Performing) the Behavior 1 Requires unavailable resources or demands unrealistic effort 2 Requires very significant resources or effort 3 Requires significant resources or effort 4 Requires some resources or effort 5 Requires few resources or little effort 6 Requires only existing resources			
Similarity to Present Behaviors 1 Nothing like this is done now 2 An existing practice is slightly similar 3 An existing practice is somewhat similar 4 An existing practice is similar 5 Several existing practices are similar 6 Several existing practices are very similar			
Complexity of the Behavior (Ease/Difficulty) 1 Unrealistically complex (difficult) 2 Involves a great many elements 3 Involves many elements 4 Involves several elements 5 Involves few elements 6 Involves one element			
TOTAL (highest score = most feasible)			

Worksheet 15-2

Identifying Target Audiences and Feasible Behaviors

HEALTH COMMUNICATION PLANNING

TARGET AUDIENCE	DESIRED FEASIBLE BEHAVIOR
Primary	
Secondary	
Allies	

Worksheet 15-3

Communication Objectives

1. Consider the objectives you wish to include and write them below.

2. Make sure each outcome objective is written in specific behavioral terms according to the guidelines found in Example 2, Defining Communication Objectives (what, by whom, how long/much, when).

HEALTH COMMUNICATION OBJECTIVES

Primary Target Audience Behavior

_____

Knowledge

_____

Attitudes

_____

Secondary Audience Behavior

_____

Knowledge

_____

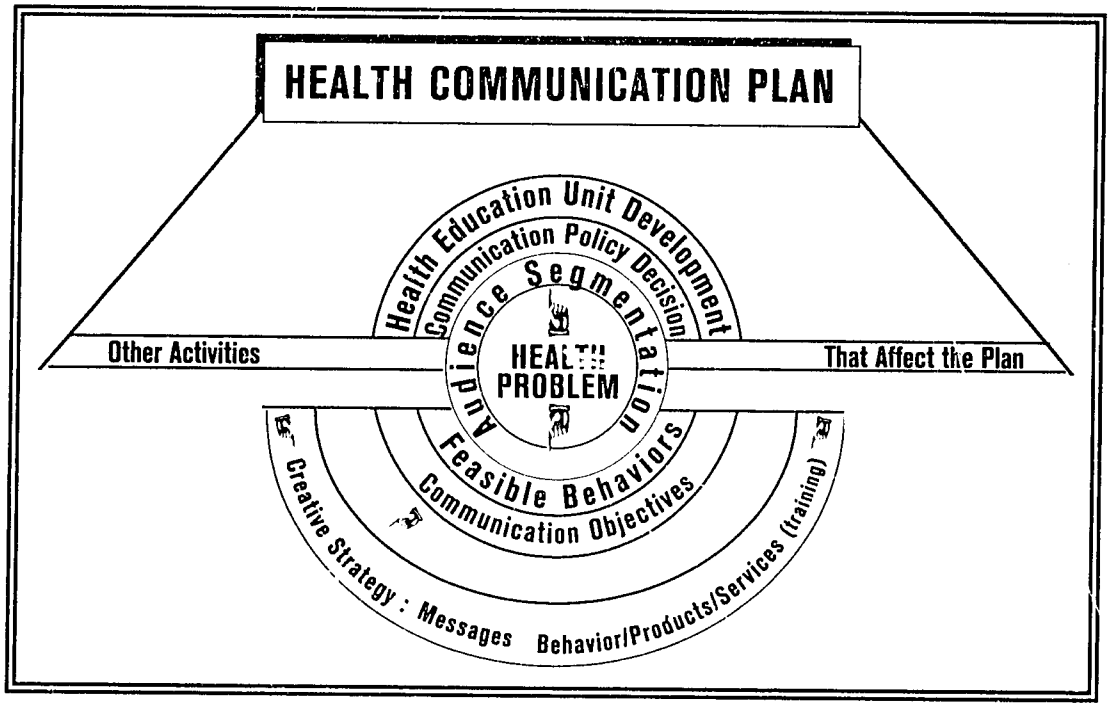
Attitudes

Question 16

How Are the Communication Strategy and Message Linked to Behaviors, Products, and Services?

This question addresses the systematic way a communication strategy is developed and how it guides the message definition. Messages are defined and structured around the feasible behaviors you determined in previous steps and the products and services you are offering.

These new elements are shown in the graph in the following position:



Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Reviewed the components of a communication strategy
2. Understood the process of defining messages on which the communication intervention will be designed

3. Completed an exercise in defining a message based on the feasible behaviors you have chosen
4. Understood the link between formative research and messages

Exercise 1. The Communication Strategy

Materials

Copies of Communication Strategy and Message Development

Instructions

Ask team members to study the text.
Have them share their versions and use their ideas to develop a communication strategy statement for their communication intervention.
Follow the same steps to develop a list of messages.

Communication Strategy and Message Development

The communication strategy describes the guiding principles of the intervention. It includes the benefit the product provides to the target audience, a support statement or reasons why the target audience should believe in that benefit, the tone that materials should convey, sources of information, communication channels to be used, and the phases (if any) in which the communication strategy will be developed.

The communication strategy helps your team develop materials that will break through the clutter of promotions, services, and ideas to which the audience is exposed. It is developed from and directly related to research findings on your audience's level of knowledge, their attitudes, practices, cultural beliefs, and values. The intervention should be sustained for a significant period of time; continuity of the communication intervention over time is essential to sustaining behavior change.

Components of a Communication Strategy

- **Support Statement or Reasons Why.** To simply say that your product or behavior will provide a benefit is not sufficient. The promise of benefit needs to be supported. You must give an explanation of why the target audiences should believe the promise of the benefit. The support statement provides credibility to the key promise. The reasons a person should trust the product and key promise may be rational (epidemiological data, scientific evidence, or case studies, for example) or emotional (the experience of other credible individuals or their own experiences or feelings). The support statement is directly related to the benefit. It provides solutions to the obstacles that the target audience may have in adopting the product or behavior. In defining the support statement, you must select an appropriate benefit and complete it with a support statement. Here are some examples:

- When I give Salvadora to my child, *it will give me* great confidence and peace (benefit) *because* Salvadora will not allow him to get dehydrated (support statement).
- When I take my child for her immunizations, *it will give me* a sense of security (benefit) *because* I know she will be protected from measles and other childhood illnesses (support statement).
- When I give Salvadora to my child with diarrhea, *I will have* protected him from dangerous dehydration (benefit) *because* Salvadora restores the salts and liquid lost during diarrhea (support statement).
- The vaccines *are good* to protect my child from polio and measles. I know this is true *because* the doctors and nurses explained to me how to protect my child (support statement).

- **Tone.** Tone refers to the emotional context of the materials. The tone will guide how the target audience will feel after they hear or see the program messages. Examples of tones include: happy, humorous, serious, family-oriented, scientific, emotional, folksy, didactic, authoritative, traditional, rural, loving, patriotic, urban, or modern. The tone may vary for each health program and/or target audience. For example, the appropriate tone of the materials promoting oral rehydration salts (ORS) may be serious and scientific. Those promoting breast-feeding to parents may be loving and emotional; whereas, breast-feeding messages targeting medical staff may be serious and scientific. The appropriate tone should be the one that convinces your audience to adopt the behavior that you have targeted.

- **Source of Information.** The formative research should try to discover who is a credible source of information for the health topic selected and incorporate that source into the intervention, especially in the graphic and mass media materials. The source of information will vary depending on the health topic and audience. In a Latin American country, for example, mothers in rural areas perceived that a physician was the best source of information regarding treatment for infant diarrhea, so the communicators created a fictitious Dr. Salustrano (Healthy) to be the central figure in the radio spots and graphic materials. These same women felt that breast-feeding was something women understood better than a physician. The source of information of the radio materials in this intervention was two women talking about their own experiences and solutions.

  The source of information may be a real person, an actor/actress, religious leader, political leader, or other respected individual. It also may be a fictitious person who personifies a credible source of information: Dr. Healthy, Mrs. Loving Mother, or the Dedicated Nurse. It may be a caricature such as a comic strip character.

Sources of information should be tested with the target audience to understand which source is most credible, understandable, and persuasive. The planners of a breast-feeding communication program avoided an embarrassing situation when pretesting showed that the soccer player they were planning to use in a radio spot aimed at fathers was considered to be a 'macho male' and was not a credible spokesperson for being a good father or spouse.

- **Slogan.** The slogan is a short, catchy phrase that normally contains a benefit and/or a 'call to action;' i.e., what you want your audience to do or think. It is used in all of the print, television, and radio materials and provides continuity and recognition to the communication program over time. It also can be put to music to provide an identifying jingle for radio and television materials.

- **Logo.** The logo is a graphic that represents the image or positioning of your program or product. Oftentimes, the slogan appears alongside or is integrated within the logo.

- **Phases of the Communication Intervention.** Not all of the messages can be transmitted at the same time. The planning team will need to set priorities for the messages and select those that are absolutely necessary for initial knowledge and an effective first trial. As the target audience learns and acts on these messages, the communicator can move on to other messages in succeeding phases. If the team is using a systematic communication approach for the first time in a specific health area, it is frequently necessary to initiate the program with a phase for training service providers and other secondary audiences and assuring the supply of educational materials and products before creating a demand for services.

The following example illustrates the phases of a growth-monitoring communication strategy.

Phase I: Focus on secondary audiences. Service providers are trained to improve their skills in weighing, recording weights on the growth charts so that the experience is more useful and pleasant for mothers who attend, and interpersonal communication with mothers about growth monitoring. They are introduced to research findings that help define the health problem as seen by the primary audience: "Mothers worry and care about whether their children are growing strong and healthy, and they want reassurance. However, they fear the health workers will scold them if their child is not gaining weight." The research findings also help identify the key messages: "Growth monitoring lets mothers know whether their children are growing as they should. Bringing your child to growth monitoring shows you are a good mother."

Phase II: Creation of demand/motivation for trying the service. Promotion of the key promise: "I feel assured and happy that he is growing up healthy and strong when I take him to growth monitoring each month." Call to action: "Take your child to the health center each month and feel assured and happy that he is growing healthy and strong as he should."

Phase III: Maintenance/Reinforcement of the New Practices. For the primary audience, continuing promotion of the key messages and promise. New messages can be selected based on what the monitoring and evaluation indicate that the target audience has learned and is doing. For the health workers, positive feedback on improved performance in communicating with mothers.

Background Information

Developing the Messages

How does one define the messages to be used in the communication intervention? Here are some criteria for successful message selection and examples of possible ORS messages for each criterion.

- Be specific in what you want your target audience

  To know (signs of dehydration).
  To feel (ORS is the best treatment).
  To believe (ORS will prevent your child from dying from dehydration).
  To do.

  Search (find out where ORS is available)
  Ask (how it is prepared)
  Demand (the ORS packet)
  Look for (the logo or ORS packet)
  Go to (nearest health center)
  Prepare (one packet in one liter of clean water)
  Add other behaviors (if needed)

- If the feasible behavior is related to a product, specify this in your message:

  What it is (oral rehydration salts)
  How to use it (one packet in one liter of water)
  What benefits it has (takes away worrisome signs of dehydration.)
  Where it can be obtained (health centers/community distributors)
  How much it costs (free)

Who recommends it (doctor/nurse/health worker)
How to recognize it (the ORS child logo)

- If the feasible behavior(s) is related to a service, specify this in your message:

  Where to obtain it (at health center in a specifically named place)
  What time is the service open (morning/afternoon hours)
  Who to ask for the service (attending nurse)
  What to mention to her (signs of dehydration)

- Identifying a main message
  It is probable that you will find yourself overloaded with messages. Do not worry. You will do an exercise later to distribute the message content among the best channels of communication. For the time being, you need to find one principle message that will serve as the 'umbrella' theme for your communications.

The above ORS program example suggests one main message that would cover the other messages: "Dehydration during diarrhea is the child's enemy. Dehydration can kill your child. Prevent that by using ORS."

Example 1. Changing a Main Message

In the Caribbean Measles Initiative, the team went about defining and qualifying their main message. Caribbean team members asked themselves, "Given that youths, parents, and health workers alike do not believe that the elimination of measles is a priority, how can we motivate them? What one main message can we use to encourage them to participate and be immunized (or, in many cases, re-immunized)?" Based on their key findings, they designed two message strategies that were tested with their target audiences:

Message for Strategy #1: Security/protection
Although we have done a good job in immunizing/getting our children immunized, we are still not measles-free. Just last year, there were more than 4,000 cases of measles in the Caribbean and several deaths caused by measles-related illness. With this last measles shot, which has to be given to every child 9 months through 15 years of age, whether or not they have previously been immunized or had measles, we can all be secure that measles will never affect us again.

Message for Strategy #2: National/Individual Pride
Because of the incredibly high rates of immunization already achieved, the Caribbean is the first region in the world with the capacity to be measles-free. We are already so close. This a tribute to the Caribbean health worker, teacher, parent, teen, and child, without whose efforts and cooperation we never could have come this far.

In the concept test stage the two message strategies were tested with the target audience. Message Strategy #2 was the clear winner because it was more positive, empowering, and, therefore, more motivational than the more 'fearful' approach. Based on these results, the Caribbean team briefed the local creative team who came up with the slogan/call to action for the communications that ran across all channels, "MAKE MEASLES HISTORY."

Synthesis

1. The communication strategy forces team members to see their intervention from the point of view of the target audience.
2. Writing the communication strategy forces them to consider all the elements thus far obtained: overall strategy statement, feasible behaviors, communication objectives, and messages and to place them in a strategy that will attempt to give the target audience the motivation to adopt the proposed behavior/product.

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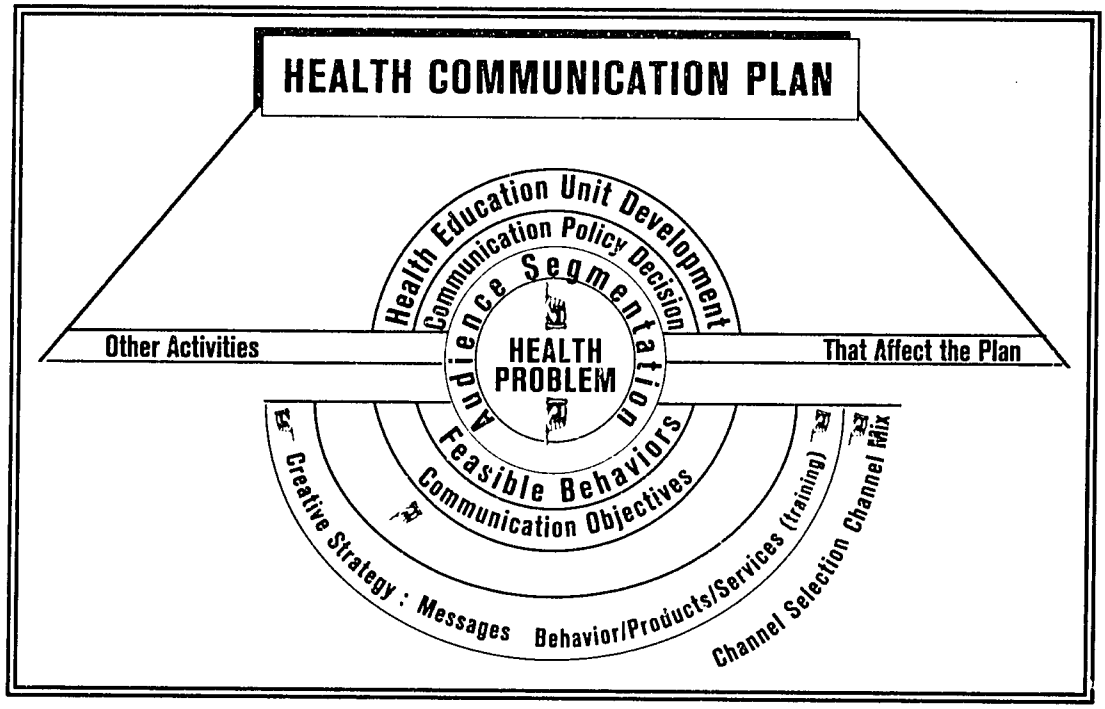
Question 17

How Do We Choose the Communication Channels for Our Intervention?

Question 16 explored how a communication strategy and its messages are developed and linked to behaviors, products, services, and training. This question discusses how to select the best communication channels for your message mix and how to use these channels to obtain the most efficient and powerful communication package possible.

Here is how these new elements fit into the overall communication intervention plan:



Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Reviewed the criteria for selecting communication channels
2. Explored the concept of a communication channel mix

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3. Filled out the matrix of communication channel selection and mix (Worksheets 17-1 through 17-10)
4. Examined the elements of a creative brief and completed an exercise for developing one (Worksheet 17-11)

Introductory Note

Concept of an Operational Communication Framework

The messages defined in the previous question, as they relate to products and feasible behaviors, need to be placed inside a larger framework and become operational. This is the operational framework. It will help you group the overall communication strategy, objectives, purposes, and goals for your intervention as you defined them in Question 15. It will provide an overall structure into which your messages will fit to become the core of the intervention, including the choice of most appropriate channels of communication, adequate channel mix, and creative brief.

Determining the Most Appropriate Channel of Communication

Message content is not transmitted with equal ease or effectiveness by every communication channel available. Certain channels may carry one part of your message better than others. Certain channels of communication are more effective in transmitting information, while others are better at creating an image or an atmosphere. Still others lend themselves better to reader or listener participation. For example, brochures are a good way to get your message into the home and serve as a constant reminder while providing the necessary space to explain how to do something. Face-to-face meetings with health workers lend credibility and confidence. Television remains the master at creating an emotional atmosphere with the potential of deeply moving an audience. The ultimate decision in selecting channels should be based on what your target audience is already listening to, viewing, or reading. This question presents criteria to help you select these channels.

Exercise 1. Comparing Channels

Materials

Copies of Types of Channels of Communication
Copies of Strengths and Limitations of Each Channel of Communication

Instructions

Ask team members to define what they know as channels of communication and the type of communication for which each is best suited.
Have them compare their definitions with the ones provided in Types of Channels of Communication.

In a group, ask team members to list the strengths and limitations for each channel. Have them check their list with the one provided in Strengths and Limitations of Each Channel of Communication.

Types of Channels of Communication

- **Interpersonal.** Face-to-face communication, community distribution, home visits, group discussions, counseling, two-way local theater groups, puppet shows, local musical festivals
- **Graphics and audio-visuals.** Pamphlets, posters, point-of-purchase displays, videotapes, slides, flip charts
- **Mass media.** Radio, television, newspapers, magazines, movies, billboards
- **Traditional.** Drama, songs, puppet shows, community theater, celebrations (note that these also may be interpersonal)

Strengths and Limitations of Each Channel of Communication

Interpersonal	
Strengths	**Limitations**
Provides credibility to messages	Time consuming
Provides detailed information	Reaches small numbers of individuals
Helps the target audience develop complex skills with demonstrations, modeling	Requires practical skills training and support of field workers
Discusses sensitive, personal topics	Requires critical attention to message design
Creates support at the community level for new behaviors, ideas, products	
Motivates individuals	
Counteracts negative ideas and beliefs and supports positive action	
Involves the target audience in a participatory process	
Allows for immediate feedback on new messages	

Graphics and Audio-visual	
Strengths	**Limitations**
Provides timely reminders	May not be cost effective
Attracts the attention of the target audience at the place of exposure	Often used out of cultural and educational context
Provides basic information on the product and its benefits	Training necessary for proper use and display
Demonstrates steps of behavior	
Provides complex information	
Is handy and reusable	
Supports interpersonal communication	
Provides accurate, standardized information	
May be produced locally	
Provides instant feedback	
Gives confidence and credibility to person communicating messages	

Mass Media	
Strengths	**Limitations**
Reaches many people Provides frequency of messages Creates a demand for the service or product Reinforces important messages delivered through interpersonal communication and print channels Provides status to the program and its messages Initiates and sustains new social norms Provides timely information Promotes community dialogue Uses influential opinion leaders	May have limited rural distribution Difficult to coordinate with service delivery Difficult to tailor program to specialized audiences Difficult to obtain audience feedback Requires power source Requires access to radio and TV

Traditional	
Strengths	**Limitations**
Uses traditionally acceptable forms Puts health messages in a familiar context Uses local talent and gets the community involved Is less costly	Reaches relatively small audience May not be available when needed Too few trained practitioners Requires investment in training and support

Exercise 2. Selecting a Communication Channel

Materials

Copies of Criteria for Selecting a Channel of Communication

Instructions

Read in a group Criteria for Selecting a Channel of Communication and discuss how these criteria can be applied to your communication intervention. Do this exercise to determine the channels of communication to be used in your communication intervention.

Criteria for Selecting a Channel of Communication

1. Use research findings, which will tell you the following:

   - Which channels your target audience uses and has access to
   - Which channels they say they like
   - Which channels are most effective for communicating your tactical and image messages to each audience
   - Where your audience is in the stages of behavior adoption and what channels might be most effective in moving them along

2. Match the ability of the channel to deal with specific message content by applying the following guidelines:

   - Is the channel of communication a credible source of information, motivation, or invitation to adopting a behavior for your target audience?
   - Does the communication format of the channel lend itself to the content of the message? For example, radio can by effective for some content, but less so for text that requires supporting visuals.
   - Is the language or image you want to use to convey your message more visual or more audio (sound) based? Is it a combination of both? Does it rely primarily on written words? Answers to those questions will help determine whether the channel should be print, radio, or audiovisual.
   - Can the chosen channel provide the message frequency or reach that you need?
     •Does the channel match the purpose of your messages; for example, do you want a channel that can treat the subject in depth or one that introduces a new idea?

3. Determine production difficulties and costs as follows:

   - Some channels are more costly than others in production. They either require more professional expertise or more personnel. Radio production costs are considerably less than television. Even if there are funds for production, is there money to continue to air the messages? Is the goal to transmit a simple idea or create an image?

- Some channels will take much longer than others to get operational. Time constraints may be important.

4. Analyze frequency and reach as follows:

   - Different channels available will have different audience reach and coverage. While one channel can reach thousands of people at the same time, another channel may only reach a small number of individuals at the most. What reach is needed at what moment in your strategy?
   - Similarly the communication channels differ in their frequency of presentation. Some, like radio, can repeat a message up to 15 times per day at a reasonable cost. What is needed in terms of the frequency of exposure?

5. Inventory the logistic efforts needed as follows:

   - All channels of communication involve logistical challenges, but some require much more effort than others. Distributing 10,000 posters to 300 health centers is more demanding logistically than sending out 15 audiocassettes to 15 radio stations. What can be accomplished with the personnel and other resources you have available?

Mass media channels are in general more complex than the other channels of communication. This is true in production procedures, costs, time, and expertise required and in their potential to achieve communication objectives. It is therefore necessary to look at their use carefully to make sure that your selection of any one mass media channel has been carefully thought through.

The summary table below compares the characteristics of mass media channels.

Characteristics of Mass Media Channels			
Television	**Radio**	**Magazines**	**Newspapers**
Potentially largest/wide range of audiences, but free air time not always available when you want to broadcast your messages. Highest cost.	Various formats offer potential for more audience targeting than television (e.g., teenagers via music stations).	Can specifically target literate segments of public (young women, people with an interest in health).	Can reach broad literate audiences rapidly.
Government regulations may require stations to broadcast free public affairs programming.	Government regulations may require stations to broadcast free public affairs programming.	No government requirement for public service announcements (PSA's); PSAs more difficult to place. Need contacts.	PSAs virtually nonexistent.

Opportunity to include health message via news broadcasts, public affairs/interview shows, dramatic programming.	Opportunity for direct audience involvement via call-in shows.	Can explain more complex health issues, behaviors.	Can convey health news/break-through more thoroughly than TV or radio and faster than magazines. Feature placement possible, if budget allows.
Visual as well as audio make emotional appeals possible. Easier to demonstrate a behavior.	Audio alone may make messages less intrusive.	Print may lend itself to more factual, detailed, rational message delivery.	Can convey an interest of public opinion.
Can reach medium income and other audiences not as likely to turn to health sources for help.	Can reach audiences who do not use the health care system.	Audience has chance to clip, reread, contemplate material.	Easy segmented audience access to in-depth issue coverage is possible.
Passive consumption by viewer. Viewers must be present when message is aired. Less than full attention likely. Message may be obscured by commercial "clutter."	Generally passive consumption. Exchange with audience possible, but target audience must be there when aired.	Permits active consultation. May pass on. Read at reader's convenience.	Short life of newspaper limits rereading, sharing with others.
Messages can be expensive to produce and distribute. Feature placement requires contacts and may require high budget.	Live copy is very flexible and inexpensive. PSAs must fit station format. Feature placement requires contacts and may be time consuming.	Public service announcements are inexpensive to produce. Ad or article placement may be time consuming.	Small papers may take public service announcements. Coverage demands a newsworthy item.

Reflecting on Field Experience

Example 1. How the Criteria Can Be Applied

This example shows the additional criteria to be considered when you are thinking of using a mass media channel of communication. The Caribbean team identified the following media for their program: radio, TV, brochure, posters, buttons, and information kits. How did they decide on this combination of communication channels?

First the team listed each of their identified audiences and research-identified channels. Then they matched the audience, messages, and research-identified channel. After reviewing the list, they decided that both informational and motivational messages were not sufficiently covered, so they examined the listing of media types and their

characteristics. They chose appropriate media to ensure coverage of messages, reach of target audiences, and necessary frequency of exposure. They matched audience, cost, human resource, and financial resource capacity. They ended with a list of well-matched audiences, messages, and media.

Since the campaign had to reach several islands, regional radio and television networks were selected. Fortunately, both were headquartered on the same island, which facilitated production, dissemination, and monitoring.

Radio was heavily listened to by both the parents and health workers being targeted in the intervention, so it was seen as an excellent source of information dissemination. Since radio was more economical to produce than television, the team produced five radio spots, each one designed to combat the misperceptions and doubts that their research told them parents had. The specific objective of the radio portion entitled "Myths About Measles" was to combat the complacency that parents felt about measles.

Television, being more costly to both produce and run, was used more sparingly. Three spots were produced, generic enough in nature to complement the local communication efforts on each island. Each spot was a tribute to their audiences: teens, parents (mothers), and health workers. Television was used, then, as a more emotional vehicle, allowing the team to give the audience a motivational pat on the back.

Posters and buttons were used as reminders of the campaign theme and were posted and distributed at health centers and schools as well as in information kits that also included press releases and newspaper announcements for potential press use.

A brochure that carried the same visual as the poster was designed to answer the many questions that health workers, teachers, and parents had. All of the campaign materials were tied together with the same printed or spoken tagline and slogan: Ask your health worker about making measles history.

The team prepared a chart for each communication channel to determine financial and logistical costs.

Communication Channel by Criteria of Financial and Logistic Cost					
Primary Audience: Low-Income Youth, Ages 12-15					
Message	**Television**	**Radio**	**Folk**	**Interpersonal**	**Information Kit**
Reach	20%	80%	15%	30%	35%
Frequency	Medium - low	High	Low	Medium - low	Medium - low
Relative Cost	High: $20 per person	Low: $1.80 per person	Medium: $13 per person	Medium: $10 per person	Low: $2.75 per person
Human resource capacity to develop, produce, distribute	Have to contract	Free talent available Contract	Contract at good price	Own personnel and voluntary non governmental organizations (NGOs)	Own distribution services
Financial resource capacity	Financial help needed, but promised	Financial cost covered	Finance assured	Finance through OPS/WHO	Own budget

Channel Mix

The content load of messages is usually greater than any single channel of communication can handle. The success of a communication intervention depends on an adequate and efficient mix of those channels of communication available to you and your audience. What one channel leaves out, another channel picks up and makes the center of attention. What one channel is not capable of handling, another one highlights by treating that portion of the content with the level of detail or emphasis necessary. The goal is to mix your communication channels so that in balance they give you a communication package that will be far more effective than trying to achieve all your communication objectives with one channel.

You should therefore not talk about a communication channel that is best. Nor should you simply select the channel you personally prefer or are familiar with. The target audience's access and acceptance are by far the more important criteria. And, your dissemination budget will also play an important role.

Mixing your channels of communication in the right combination gives your communication intervention its greatest impact. It allows maximization of coverage, repetition, depth treatment, reiteration, validation of concepts, changes in social norms, and motivation to act.

Channel Mix - Not Channel Competition!

After you make the decision about the channels of communication you will use for the defined number of messages you plan, make a summary sheet similar to the following chart made for the Caribbean measles initiative and keep it at hand when you develop your draft material.

Exercise 3. Channel Mix

Materials

Copies of Example 2, Channel Selection Chart

Instructions

In small groups study in detail the example, Channel Selection Chart, for the Caribbean team.
Discuss whether group members think the channel mix proposition made by the team is sound.
Can it be improved? If so, how?
Go Worksheets 17-1 through 17-8 and fill in the matrix of your channel selection and mix so that it corresponds to your communication intervention.

Example 2. Channel Selection Chart

MESSAGE/OBJECTIVE	CHANNEL TV	CHANNEL Radio	CHANNEL Print
Youths 1. Convince them to get (re)immunized 2. Empower them to lead their younger siblings in the effort	Special Spot, special		Poster, button
Health Workers Convince them to support this effort and not feel threatened	Spot		Poster, brochure, button
Parents 1. Convince them to have their children immunized against measles regardless of previous vaccinations or previous history of measles disease 2. Create doubt to combat complacency	Spot	Spot	Poster, button Fact sheet

All 1. Answer all of the many doubts, questions, and concerns 2. Compliment them on the great job they have done thus far protecting children against measles. 3. Encourage them to continue through this campaign	Spot Special (youth), Spot (youth)	Spot (all)	Fact sheet (parents), Brochure (health workers, parents) Button (all) Poster (all)

Background Information

Creative Briefs

The creative brief is both a process and a product. The process is to think, decide, and write out the elements needed by the people who will create (write) and perhaps go on to produce the program materials. The brief should translate all the steps completed thus far, including your research findings, into feasible communication objectives and show how they should be distributed among various channels of communication.

Writing the creative brief is a crucial step. It is an instrument that forces you to restate your target audience, communication objectives, obstacles to be expected, key benefit, support statements, tone of the messages, communication channel to be used, and other necessary creative considerations such as different language versions or gender considerations.

The brief assures that all partners in the intervention are in agreement on the key elements and the communication strategy. Whether your team is going to undertake the task of creating the materials itself or is going to have it done by an outside creative team (copywriter/art director) or advertising agency, drawing up the creative brief assures clear definition of the communication objectives, paints a clear picture of audiences, and integrates relevant research findings. The creative brief is insurance that your materials will reflect the analysis that you have done.

The creative brief is prepared for briefing (1) the team members or the selected firm for the creative development of the materials and (2) your team members (or the Ministry authorities) for giving them a precise idea of what the communication is

meant to accomplish. With the above considerations in mind, you can now turn your attention to the process of developing the creative brief.

The Importance of a Creative Brief

The creative brief is important because it

- Is a crucial link between research and communication strategy.
- Helps you translate all background information into actual materials.
- Ensures that your interventions will reflect and address the concerns and needs of your audiences.
- Is like a contract between the client/manager of the intervention and the creative people.

Elements of a Creative Brief

A creative brief includes the following elements:

- **Target Audience.** Who do you want to reach with this communication?
- **Communication Objective(s).** What will this communication make the audience feel, think, believe, or do?
- **Obstacles.** What beliefs, cultural practices, pressures, and misinformation stand between your audience and the communication objectives?
- **Key Promise/Benefit.** What is in it for the audience? What is the benefit of doing, thinking, or feeling what you want them to do? Be single minded!
- **Support Statement/Reasons Why.** Why does the key promise outweigh the obstacles?
- **Tone.** What feeling should this communication have?
- **Media.** What channel(s) will you employ to best reach your audience?
- **Creative Considerations.** What additional points need to be considered while designing this communication?

Applying the Research Results to the Creative Brief

The specific information you need for completing your creative brief is found in your research reports, as follows:

- **Target Audience.** Often there is a primary and a secondary audience. Your research should tell you just whom you want to reach with your message. Is it the audience that you want to change? Or is it the audience that has the most influence on them? Or is it both?
- **Objective.** What do you want your audience to do? Or think? Do you want them to do more of what they are already doing? Or change altogether?
- **Media.** Does your audience listen to or even have a radio? How about television? Or perhaps they would prefer listening to a health worker. But their mother-in-law may be even more credible. Can they read?

- **Key Promise/Benefit.** What benefit will your audience perceive upon hearing your message?
- Support Statements. Can you prove what you say? These statements should be motivating enough to overcome the obstacles.
- Obstacles. What stands in the way of your objective? Tradition? Family? Religion?
- Tone. What tone works best with your audience? Are they emotional about this issue? Religious? Do they listen more to authority?

Exercise 4. The Creative Brief

Materials

Initial copies of Example 3, Designing Creative Briefs
Copies of Importance of a Creative Brief, Elements of Creative Brief, and Applying the Communication Strategy and Research Results to the Creative Brief in the Background Information prior to this exercise

Instructions

Have team members read the example in small groups.
Ask each group to make a short summary of what they have learned.

Example 3. Designing Creative Briefs

The Caribbean team had prepared their communication strategy overview. Now it was time to delve into the specifics of their intervention. They had all the information they needed to start thinking about a specific intervention directed to specific audiences designed to communicate specific messages. Taking their overview and key research findings and analysis, they wrote the following creative brief.

Creative Brief

BACKGROUND
The Mission: The countries of the English-speaking Caribbean, in collaboration with the Pan American Health Organization, agreed to embark on a mission to eliminate measles from the Caribbean by 1995. As the initial step, in addition to routine immunization, the countries worked together to carry out Measles Elimination Month, planned for May 1991. To ensure the success of this effort, national and regional information campaigns were necessary if the health services were to reach their target audiences and convince parents and adolescents that everyone between 9 months and 15 years of age to get immunized. Managers of the Caribbean immunization programs agreed that the key strategy for interrupting measles transmission in all countries was the elimination of all susceptibles under 15 years of age simultaneously, regardless of previous vaccination status or previous history of measles disease.

TARGET AUDIENCES: Parents of children 9 months to 15 years of age
12- to 15-year old youths
Health workers

OBJECTIVES: (1) to convince adolescents to get immunized by empowering them to lead the effort; (2) to convince parents to have their children immunized, regardless of previous vaccination status or previous history of measles disease by creating doubt to fight their complacency; and (3) to convince health workers to support this effort by answering the youths' and parents' many doubts, questions, and concerns.

OBSTACLES: Parents did not consider measles severe. Health workers did not understand (or trust) the necessity of reimmunizing so many children. Not only did it undermine their credibility (they had told immmunized clients they did not need re-immunization), but they worried about side effects. Teenagers did not consider measles elimination a priority.

KEY PROMISE: By helping to make the Caribbean the first measles-free region in the world, you will be proud and your children/brothers and sisters/patients will be safer.

SUPPORT STATEMENTS/REASONS WHY: Because of your efforts, we are already close to being measles free. Of all preventable diseases, measles is the biggest killer.
TONE: Encouraging and authoritative

MEDIA: Radio to address parents' complacency, television to pay tribute and encourage all audiences, brochure to answer all doubts and questions, buttons, and posters to serve as reminders

CREATIVE CONSIDERATIONS: This is a regional campaign meant to complement the local campaigns that all of the separate islands are running. All on-camera and voice talent, as well as music, should easily cross all islands.

Synthesis

1. The messages must be communicated to the target audience through the most appropriate channels of communication. The selection of the best channel for communication is based on several criteria: target audience's access of the channel and preference, credibility of source, coverage, frequency of emission, cost, availability of technical production, and logistics of distribution.

2. The channels selected must be complementary, not competitive channels. The idea is to choose a channel mix that reinforces and enhances the messages.

3. A creative brief restates the intervention's target audience objectives, obstacles, key benefits, tone, support statement, channel, and other creative considerations. It assumes that all partners in the intervention are in agreement with key elements of the materials and the communication strategy.

We Are Now Close To The Creative Step, Transforming All The Previous Work Into Actual Communication Pieces!

Application

1. Have team members fill out the creative brief chart (Worksheet 17-10, Summary of Channel Selection, and 17-11, The Creative Brief) using the feasible behaviors they chose in the last question, as well as their communication objectives. This will enable the team to fill in the other sections of the brief.
2. Complete Worksheet 17-9, A Communication Channel by Other Criteris, as a summary of messages per channel.

Worksheet 17-1

Mass Media Selection Matrix

(fill in for possible media choices)

CRITERIA	Radio Spots	Radio Programs	Radio Other	TV Spots	TV Newscasts	TV Other
Reach % of the population that it can reach						
Frequency of contact with the message it can provide						
Relative cost per capita						
Human resource capacity to develop, produce, and distribute it						
Financial resource capacity to develop, produce, and distribute it						

Audience: _____

Message: _____

_____

Worksheet 17-2

Mass Media Selection Matrix

(fill in for possible media choices)

CRITERIA	Magazine Ads	Magazine Other	Newspapers Ads	Newspapers Other	Other Other
Reach % of the population that it can reach					
Frequency of contact with the message it can provide					
Relative cost per capita					
Human resource capacity to develop, produce, and distribute it					
Financial resource capacity to develop, produce, and distribute it					

Audience: _____

Message: _____

_____

Worksheet 17-3

Mass Media Selection Matrix

(fill in for possible media choices)

CRITERIA	Posters	Billboards	Pamphlets	Booklets	Photo-comic books
Reach % of the population that it can reach					
Frequency of contact with the message it can provide					
Relative cost per capita					
Human resource capacity to develop, produce, and distribute it					
Financial resource capacity to develop, produce, and distribute it					

Audience: _____

Message: _____

_____

Worksheet 17-4

Mass Media Selection Matrix

(fill in for possible media choices)

CRITERIA	Stickers	Comic Books	Murals	Shopping Bags	Other	Other
Reach % of the population that it can reach						
Frequency of contact with the message it can provide						
Relative cost per capita						
Human resource capacity to develop, produce, and distribute it						
Financial resource capacity to develop, produce, and distribute it						

Audience: _____

Message: _____ _____

_____

Worksheet 17-5

Mass Media Selection Matrix

(fill in for possible media choices)

CRITERIA	Video	Flip charts	Slidetape	Other	Other
Reach % of the population that it can reach					
Frequency of contact with the message it can provide					
Relative cost per capita					
Human resource capacity to develop, produce, and distribute it					
Financial resource capacity to develop, produce, and distribute it					

Audience: _____

Message: _____

_____

Worksheet 17-6

Mass Media Selection Matrix

(fill in for possible media choices)

CRITERIA	Primary Audience	Secondary Audience
Reach % of the population that it can reach		
Frequency of contact with the message it can provide		
Relative cost per capita		
Human resource capacity to develop, produce, and distribute it		
Financial resource capacity to develop, produce, and distribute it		

Audience: _____

Message: _____

_____

_____

Worksheet 17-7

Mass Media Selection Matrix

(fill in for possible media choices)

CRITERIA	Primary Audience	Secondary Audience
Reach % of the population that it can reach		
Frequency of contact with the message it can provide		
Relative cost per capita		
Human resource capacity to develop, produce, and distribute it		
Financial resource capacity to develop, produce, and distribute it		

Audience: _____

Message: _____

_____

_____

Worksheet 17-8

Communication Channel by Message

Target Audience

Message	Channel	Channel	Channel	Channel	Channel

Worksheet 17-9

Communication Channel by Other Criteria

Target Audience

Message					
Reach					
Frequency					
Ralative Cost					
Human Resources Capacity to develop, produce, distribute					
Financial Resource Capacity					

Worksheet 17-10

Summary of Channel Selection

By message

Message/Objective	Channel	Channel	Channel

Worksheet 17-11

The Creative Brief

The Creative Brief
1. Background *What is the background of this intervention? Why are you doing it?*
2. Target Audiences *Who do you want to reach with your communication? Be specific.*
3. Objectives *What do you want your target audience to do after they hear, watch, or experience this communication?*
4. Obstacles *What beliefs, cultural practices, pressures, and misinformation stand between your audience and the desired objectives?*
5. Key Benefit *Select one single benefit that the audience will experience upon reading the objective(s) you have set.*

The Creative Brief

6. Support Statements/Reasons Why

These are the reasons why the key benefit outweighs the obstacles and the reasons that what you are promoting is beneficial. These reasons often become messages.

7. Tone

What feeling should your communication have? Should it be authoritative, light, or emotional? Pick a tone.

8. Media

What channel(s) or form will the communication take? Television? Radio? Newspaper? Poster? Point-of-purchase? Flyer? All of the above?

9. Creative Considerations

Is there anything else the creative people should know? Will it be in more than one language? Should they make sure that all nationalities are represented?

Step 3

Draft, Pretest and Produce

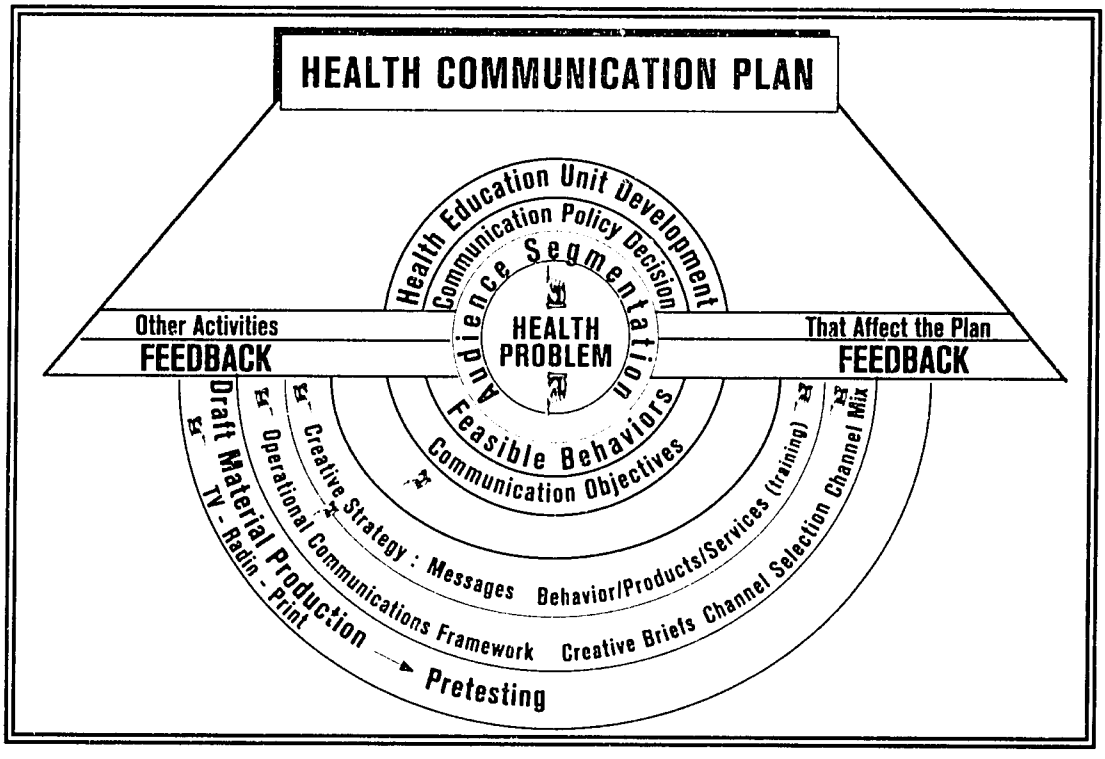
Questions 18 - 21

Question 18

How Do We Translate Our Creative Brief, Messages, And Communication Objectives Into Draft Materials? Why And How Are They Pretested?

In Question 17 you developed your creative briefs based on the messages you had defined and you selected the most appropriate communication channels and their best mix. In this question, you will examine important elements to keep in mind when developing print materials (posters, flyers, brochures) and radio and television spots.

This question fits into the overall graphic in the following position:



Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Listed the qualities of a good message
2. Listed the qualities of effective communication materials and used them to do an exercise in print design
3. Discussed criteria for effective pretesting
4. Named the necessary skills and steps involved in pretesting
5. Decided (1) with whom to review, (2) with whom to pretest, (3) what pretest methods to use, and (4) the number of rounds of pretesting and pretests per round
6. Completed pretest preparation and organization (Worksheet 18)

Introductory Note

What You Need To Know To Produce Draft Materials

Before starting to make your draft materials, decide who is going to do the material. In Question 8 you did an exercise to determine if you could do formative research yourself or if you needed outside help. In Question 10, you reviewed the process involved in selecting a firm to do the research.

A similar process, using basically the same criteria, can be used to decide whether you are going to produce the material for your intervention or if you are going to hire an outside firm, institution, group, or free-lancer contractor to do it for you.

The decision is based on your answer to several questions:

- Do you have the experienced personnel: graphic artist, radio and/or TV scriptwriter, illustrator, television producer, camera person, and performing artists to create, design, and produce an acceptable draft of any of the materials to be done? If not, then consider outside help to do the drafts.
- If you will be doing some of the drafts, which ones cannot be done by your team and therefore require outside help?
- Which materials can be done in final professional form by your team?
- Do you have the equipment needed, such as good drawing materials, recording facilities, video cameras, editing equipment, copier machines, and studios? If not, then you are better off contracting out these services. This is specially true with television because it is the media channel that requires the most expertise, involves the greatest number of persons, and is most costly.

The one most important thing to keep in mind at this moment of the process is that whatever originally is produced, it is...

Only a Draft

The biggest and most common mistake is to envision your first draft as being your final communication piece. Whatever is produced at this stage - a poster, a radio spot, a TV spot - it is only a draft. It is only a draft until it is tested to find out if it is understood and accepted by the target audience for whom it is intended, and if it plays the role designed for it in your overall strategy.

Whether you prepare the communication materials yourself or hire someone to do them, you must use several qualities of effective communication materials as criteria either to judge what is presented to you or to judge what your team produces.

Exercise 1. Qualities of Effective Communication Materials

Materials

Copies of Qualities of Effective Communication Materials

Instructions

Have team members read individually one quality and present it to the others in his or her own words.

Qualities of Effective Communication Materials

1. Establish a personality. Effective communication messages give the material a vivid, appealing personality that helps them stand out from the crowd. Like a friendly face, they signal genuine values in likeable ways. In Mexico, the oral rehydration salts (ORS) packet (see illustration) was designed based on ideas obtained from mothers in focus group research. The suggestion of a tree (life, energy) and a happy boy with exuberant, outstretched arms and grand smile identified the product as safe, healthy, and efficacious. This was the final package design for the ORS.

Building a personality takes consistency. Your messages, packaging, promotion (print materials and others), and product design all must speak with the same voice. Building personality takes time as well. Awareness can not be achieved overnight. Familiarity and acceptance take longer. But once created, this personality can be the most valuable and enduring asset of a product or intervention.

In the Central American country of Honduras over a period of three years, the ORS packet named Litrosol became the best known product for children under two years

old who were dehydrated. At the start of the intervention, there was no ORS product being advertised to help mothers treat children with dehydration caused by diarrhea. The product's personality (Litrosol) had to be built from scratch. It was done with an image of a sound, reliable medicine that would prevent and/or take care of dehydration produced by diarrhea. The concept of dehydration also had to be taught.

2. Position the material. Effective communication must make clear how the material fits into the audience's life. Is it valuable because of its style or its utility? Is the value in its quality or its economy? Positioning picks the area in which the product is most likely to succeed. It lets the audience focus quickly on whatever specific benefit is being offered.

The ORS packet in Honduras was positioned as a new, modern, effective medicine to be used by mothers to prevent deadly dehydration when a child had diarrhea. The positioning was that of a serious, respected, readily available medicine that was as effective as others in the market, but was available at a lower price.

3. Feature the most compelling benefit. Effective communication materials address real needs. They speak as competitively as the facts and good taste allow. Messages are specific and single-minded. They may use imagery, but technique should never compete with the main message and the benefit. The benefit emerges as the star.

Again, the ORS packet was presented as the most effective product available to prevent and treat dehydration. The benefit was in its ability to compete with more expensive diarrhea medicines with equal reliability. Litrosol was the most efficient and least expensive way a mother could protect a child in danger of dying from diarrheal dehydration.

4. Break the pattern. Effective communication materials excite the ear and the eye with a look and sound of their own. They separate themselves from surrounding communication, just as they separate the product from competing products. This excitement comes from the material itself in ways that reflect the character of the message.

To achieve this separation, the ORS was given a name that combined many of the qualities listed above. In Spanish, Litrosol (Sun-liter) has two definitions, that of 'liter' (which is the size of the bottle to be used as a measuring device) and 'sol,' which means sun but also stands for 'solution', which is what the ORS packet is about.

5. Generate trust. Members of an audience will not try out a behavior they hear about from someone they do not trust. Effective communication materials, therefore, must not only speak truthfully, they must ring true in every way, even when fantasy is used. Materials that are simple, direct, and emphatic can generate trust in what they

say. Credibility should never be replaced by creativity. Straight-forward design is a better basis for trust than fanciful material. Trust is not necessarily a product of innovation. Trust is generated by tone, presentation, serious images, credibility, and a solid foundation.

The Litrosol research pointed out that the audience felt a doctor was the most credible source of medical advice. A doctor for the radio spots was conceived. Named Dr. Salustiano (Dr. Healthy), his voice (tested and chosen for the purpose) communicated warmth, trust, and confidence. He was fondly remembered by mothers well after the intervention concluded.

6. Appeal to both the heart and the head. No decision to try something new is made entirely in the mind. Trials are decided partly in the heart. Effective communication materials and messages, therefore, must do more than present practical reasons to try a behavior. They must invest the message with real emotional value consistent with the product's personality.

The ORS packet, Litrosol, was associated with the mother's anguish and fear in seeing and experiencing the child's pain and discomfort due to diarrhea. The ORS was presented as a help in the mother's situation and a solution to the legitimate anguish she felt. It was a product that reflected empathy with her needs. This emotional aspect was easier to achieve through the radio medium where real-life situations were depicted in drama and emotions were abundant.

7. Material responds to communication strategy. Often materials lose the very reason why they were created—to be translators of the communication strategy. Be sure to check that whatever is produced is in fact an accurate response to your communication strategy statement. Does it maintain focus? Is it directed to your target audience? Does it deal with the defined health problem? Is it addressing the feasible behaviors?

Exercise 2. How the Public Perceives Health Messages

Materials

Copy of the statement, How the Public Perceives Health Messages

Instructions

Have team members read the descriptions of how the public perceives health messages. Ask them to comment on each of the descriptions and invite them to add their own experience of the profile of their audience to the list. This exercise will enable you to match the profile of your audience with the criteria for making effective communication material.

How the Public Perceives Health Messages[1]

Thinking about how the public perceives health messages before message development can help assure that the public will hear and heed the information you want to convey. Factors affecting public acceptance of health messages include the following:

Health risk is an intangible concept. Many people do not understand the concept of relative risk, and so personal decisions may be based on faulty reasoning. For example, the public tends to overestimate their risk of car and airplane accidents, homicides, and other events that most frequently make the news and underestimate their risk of less newsworthy, but more common, health problems such as strokes, diabetes, and preventable diseases.

The public responds to easy solutions. The ability to act to reduce or eliminate an identified risk not only can lessen actual risk but can abate the fear, denial, or mistrust that may result from new health information. The public is more likely to respond to a call for action if the action is relatively simple (e.g., get a blood test to check for cholesterol) and less likely to act if the 'price' of that action is higher or the action is complicated (e.g., quitting smoking to reduce cancer risk). Therefore, when addressing a complex issue, there may be an intermediate action to recommend (telephoning for information, preparing to quit).

People want absolute answers. Some people do not understand probabilities. They want concrete information on which they can make certain decisions. In the absence of firm answers from a scientist, the media will sometimes draw an inappropriate conclusion, providing the public with faulty but conclusive-sounding information that the public finds easier to accept and deal with. Therefore, you must carefully and clearly present your information to both the public and the media.

The public may react unfavorably to fear. Frightening information, which sometimes cannot be avoided, may result in personal denial, disproportionate levels of hysteria, anxiety, and feelings of helplessness. Worry and fear may be accentuated by faulty logic and misinterpretation and may be compounded if there are not immediate actions an individual can take to ameliorate the risk.

The public relies on the verity of science. The public believe in scientists for reliable information. Thus, they may tend to believe a scientist's endorsement of health products.

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[1]U.S. Department of Public Health, PHS (NIH). *Making Health Communication Work*, 1989.

The public has other priorities. New health information may not be integrated as one of an individual's priorities. When the National Cancer Institute conducted focus groups in the USA with retired shipyard workers, they found that a futur threat of cancer from a long-ago exposure to asbestos paled in importance in comparison with their daily infirmities. Conversely, teenagers, many of whom may never have experienced poor health, may find it inconceivable that they will be susceptible to future illness. For many people, intangible health information cannot compete with more tangible daily problems.

Individuals do not feel personally susceptible. The public has a strong tendency to underestimate personal risk. Another survey found that 54 percent of respondents believed that a serious illness "couldn't happen to them" and considered their risk as less than that of the general public, regardless of their actual risk.

The public holds contradictory beliefs. Even though an individual may believe that "it can't happen to me," he or she can still believe that "everything causes cancer," and, therefore, there is no way to avoid cancer "when your time comes," and no need to alter personal behavior.

The public lacks a future orientation. The public, especially lower socio-economic groups, has trouble relating to a future concept, and many health risk messages foretell of outcomes in their future. Focus group participants who were convened to help plan a health promotion program agreed that it would take an actual health scare or seeing a health problem in a friend or loved one to make them alter their own behavior.

The public needs to personalize new information. New risk information is frequently described in terms of its effect on society (such as predicted morbidity and mortality rates). The individual needs to translate that information into personal risk to understand it.

The public does not understand science dynamics or technical terms. Technical and medical terminology, the variables involved in calculating risk, and the fact that science is not static, but evolves and changes over time, are all poorly understood by the public. Therefore, individuals lack the basic tools required to understand and interpret health information that depends on data to be fully comprehensible.

What You Need to Know to Do Pretesting

Up to this point, you have found out what your target audience thinks, does, and believes about the health problem. You have defined feasible behaviors by comparing the technically ideal behavior with the behavior most commonly practiced by the tar-

get audience, derived from these steps your communication objectives, transformed the objectives into messages, and designed subsequent draft materials according to the channel mix.

Your solid methodological effort will be rendered useless and invalid if the pretest step is skipped.

Without pretesting, most program communication efforts become inefficient and detached from the target audience. They will reflect instead the notions of program directors or creative people that assume, incorrectly, that they "know the audience sufficiently enough to decide what material is okay for them."

When this happens, your material is neutralized, or worse, it does its job incorrectly because it transmits useless information, makes the wrong appeal, does not motivate, has no persuasive power, cannot modify negative attitudes, challenges unnecessarily longstanding traditions, or does not build upon positive existing practices.

Exercise 3. Understanding the Concept of Pretesting

Materials

Copy of the information on Pretesting

Instructions

Ask team members to read the information on pretesting in small groups and comment on the text.

Pretesting

Definition

What is pretesting? What do we pretest?

Pretesting is testing the draft materials or concepts and messages with representatives of your target audience before the materials are produced in their final form. You should pretest the materials for the media; interpersonal and traditional channels of communication; concepts; products and product ideas, packaging, symbols, and slogans.

Need

Why should we pretest? Is it worth taking the time to pretest?

Audience's viewpoint: People see, hear, and interpret messages according to their various backgrounds, education, and knowledge; therefore, communicators cannot assume that their messages will be perceived the way they intend. To ensure that materials developed in any communication channel are understood and accepted by their target audience, communicators must pretest them with members of that audience.

Objective of pretesting: The purpose of pretesting is not to get the 'right' answer or make the respondent/audience see what you see, but to get the material 'right' from the audience's perspective. Pretesting ensures comprehension (that the audience understands the message and action your program is encouraging them to take) and cultural appropriateness. If the audience has participated in the development of their materials, this adds credibility to your intervention.

Economy Factor: Pretesting saves money. It is easier to change materials before they are finalized than to find out after a large investment of time and expense that the materials are inappropriate. Pretesting cannot fix 'poor' messages. Messages that are not audience-centered, research-based, and resulting from a communication strategy cannot be 'fixed' through pretesting.

Audience

With whom do we pretest?

Your pretest audience includes those for whom the materials were developed and those who will use the materials.

But, there are also the gatekeepers. These are intermediaries who act as gatekeepers (program directors and secretaries controlling the distribution channels for reaching your target audiences). Their approval or disapproval of materials may be critical. If they do not like a poster or a booklet or do not believe it to be credible or scientifically accurate, it may never reach the intended audience.

Gatekeeper review of rough materials is not a substitute for pretesting materials with target audience representatives nor for obtaining technical clearances from medical experts, but it can prevent authorities from blocking materials.

Reasons not to pretest

The following arguments are most frequently heard.

I don't have the time or money.

When this is true it is often because neither the time nor the money were asked for in the annual programming budget request. If you do not have the funds or the time for pretesting, you run a serious risk of producing materials that will not be effective.

My boss will not support pretesting.
Beautiful materials and an elegant program design cannot guarantee that the target audience will pay attention, understand, and relate to your messages. It is cheaper to find out whether the materials have a chance to work before they are produced than to have to start over later, or worse, to be responsible for an unsuccessful program.

I can tell the difference between good and bad materials; I do not need to pretest.
Your training and experience are essential credentials, but are you sure you can react objectively to materials you have created or are responsible for? Can you really assume the role of a disinterested observer and see your materials through his or her eyes? Can you defend your decision with those who may disagree with the material without objective evidence?

Our artist/producer says that pretesting cannot be used to judge creativity.
Graphics staff, artists, and creative writers may be sensitive to criticism from nonprofessionals, including members of the target audience. Involving them in the pretest process will generally help them understand and appreciate the process. Explain that you are testing all elements of the communication—color, tone, attraction, message, comprehension, the presentation—and not their work.

Exercise 4. What Do We Measure in the Material when We Do Pretesting?

Materials

Copies of Five Pretest Variables

Instructions

Ask team members to define individually the five pretest variables and what question each one answers.
Have them compare those definitions with the ones provided below.

Five Pretest Variables

There are five variables measured during the pretest: Comprehension, Attractiveness, Acceptance, Involvement, Inducement to Action (CAAII)

1. **Comprehension.** The materials should convey the message in a comprehensible way. Comprehension measures not only the clarity of the content of your materials but also the way in which it is presented. A complicated or unknown word may be responsible for the target audience's failure to understand the message. Or, it may be that the message is clear and the language appropriate, but the use of typeface is too small and makes it difficult for the target audience to read the message. Also the transmission of too many ideas may confuse the audience and make them miss what you wish them to do.

Materials should also accomplish the strategy objective. If your strategy calls for the materials to evoke the tenderness of a mother to her infant, you should be certain that your audience sees this in the messages.

2. **Attractiveness.** Communication materials should be attractive. If a particular material is not attractive, many individuals exposed to it will not pay much attention to it. A pamphlet filled mostly with text does not reach out and invite people to read it. A poster may go unnoticed if it has been printed in a dull color or if the illustration is of poor quality or is irrelevant. A boring radio program may encourage listeners to change stations.

   Attractiveness in materials is achieved through the use of sounds, such as music, tone, and format, in the case of radio; visuals, such as color and illustrations in the case of graphics; movement, action, illumination, and animation in the case of video.

3. **Acceptance.** The messages must be acceptable to the target population. The messages and the way in which they are communicated must be acceptable to those to whom they are directed. If communication material contains something that offends, is not believable, or generates disagreement among the target audience to which it is directed, the audience will reject the message conveyed.

4. **Involvement.** The target audience should be able to identify with the materials and recognize that the message is directed toward them. People will not pay much attention to messages that they consider do not involve them; i.e., that are not specifically directed to them. To ensure communication materials will be considered by the target audience as actually involving them, it is necessary to make appropriate use of the symbols, graphics, and language used by the particular population group involved. Illustrations should faithfully reflect that particular population segment, together with its environment and characteristics, such as clothing and furniture.

5. **Inducement to action.** The materials should indicate clearly what it is that we wish the target audience to do. Most of the materials have a message that asks, motivates, or induces members of the target audience to carry out a particular action (based on the feasible behaviors). No matter how good a particular piece of communication material is from the technical standpoint, it will be worthless if it fails to transmit a message that can be done. Even those materials that create awareness should induce the listener or viewer to take action, seeking more information on the subject, and thus moving him or her to take steps that will lead to the required action.

Note: If the material does not ask for action, this point is not pretested.

Exercise 5. Carrying Out the Pretest

Materials

Copies of Carrying Out the Pretest

Instructions

Ask team members to read the 13 points in small groups.
Discuss each point, looking for the similarities and differences of these points compared to the steps taken when your team did the formative research.

Carrying out the Pretest

1. Preparing draft material for the pretest
   Keep in mind the following steps:

   - **Check the objective and content of the material.** Verify that there is an intrinsic link between the feasible behaviors, communication objectives, and the messages.

   - **Have the script written for the material to be produced.** The script is written either by the technical communication team or by a contracted service provider.

   - **Review the draft with the technical team.** Even before you go out to the field, you should first make an in-house pretest of the material, especially with the health education team. The technical aspect of the message should have no errors; it would be a waste of effort and money to pretest a message that is technically incorrect. Such pretesting would only contribute to circulating incorrect knowledge among members of the target audience.

     Be aware that a delicate situation may arise from this step because members of the technical team may disagree about the way the message is presented (i.e., color, characters, type of letters, drawings, or setting). Remind them that the target audience is the one that decides during the pretest on these points and that you are seeking their confirmation on the technical accuracy of the message.

   - If you are doing the draft with your team, be sure that pre-production steps are carried out. Make sure creative briefs are at hand, sound effects compiled, appropriate music selected, and artists or actors chosen for television or radio production. If it is print material, have the graphic artists ready with drawing materials, pertinent photographs, visual models, and reference material handy.

- Have the draft material produced. Make sure the production team knows with sufficient lead time the date they must furnish you with an adequate draft that you can pretest.

A Note About the Draft Material

Even though you are pretesting a draft and not the final version of your material, the draft must come as close as possible to the final version. This way these that are interviewed have an opportunity to judge a piece of material that closely resembles the final product. Otherwise, their observations and opinions are not really going to be about an early finished material.

This point means that if you are pretesting a poster, the draft of the poster must be of the approximate size as the final poster, have similar colors (markers or washable inks), and have the same background elements (houses, decorations, trees, or whatever will make up the context of the final product).

If the draft material is a radio spot, it is sufficient to do an in-house production of the spot, which should contain the same elements as the final version. If it includes music, use the same or very similar music; if several characters are in a dramatic format or in a straightforward information format, at least gender and age of the voices should be the same; if it contains sound effects, use the closest possible to the ones you will have in the end product.

If it is a video spot, ask your contractor to give you a videotape of your spots done with good amateur actors (to be cost efficient). If this is not possible, then you should ask for an animation of the story board, which consists of taping sequentially the drawings of the story boards (see Question 21).

Prepare the draft scrip, art, or the video for the field pretest.

2. **Do a fast in-house "pretest."** By showing the draft to people who work inside your organization and who belong to the target audience, you may catch errors that are obvious to them before you take the pretest out to the field. These people can be those comparable to the status of target audience, such as janitors, coffee ladies, cleaning people, porters, guardsmen, chauffeurs, messengers, or office assistants. If they are not easily available in the building, then continue the pretest as planned.

   If possible, this fast, less systematic pretest will help you detect gross comprehension errors, obvious formal distortions, negative impacting of colors or sounds, music not in accordance to text, or any other similar dissonances. Correcting these errors at this time will allow your pretest to be narrowed down to the most salient issues.

3. **Determine the sample for those audience segments with whom the material is to be pretested.**

Same group characteristics. The overall sample must have the same characteristics as the target audience to whom the materials being pretested are directed; for example, communities that are typical of the ethnic group or of the region or characteristic of the neighborhood (if the material is to be directed toward audiences living in suburban areas of cities). It is always advisable to select several sites having the same characteristics and not concentrate on a single site. (For further details, see Getting It In Focus: A Learner's Kit for Focus Group Research in the Toolbox Bibliography.)

Same individual characteristics. Criteria should be established in accordance with the characteristics of the individuals to whom the material is to be directed. For example, in the case of a material on family planning aimed at rural women of reproductive age who already have several children, possible criteria might include being between 25 and 45 years old, married or in union, with at least two children, and having the intention of not getting pregnant again:

Women aged 25-45 years, two children, not wanting to get pregnant

Convenience sample. One easy way to select people to be interviewed for pretesting is by sample of convenience. After the characteristics of the respondents have been defined, the interviewer goes to those sites where a large number of such individuals will presumably be found and selects individuals using screening questions.

Community stores, water sources, public washing places, health centers, hospitals, clinics, and markets are places where it is easy to find women and mothers. Bars, municipal offices, warehouses, factories at closing time, and fields are places where it is easy to find men to be interviewed.

Size of sample. Regarding the size of the sample, there actually is no preset formula. HEALTHCOM's experience acquired in developing programs in Latin America, Asia, and Africa, is that sample sizes of between 50 and 200 are best depending on the number of audience segments, complexity of the problem, and the amount of the available budget and resources required to reach that number of people. It is, however, always better to pretest materials using a well-selected sample, even if it is very small (20-30 persons), than to not pretest at all.

4. **Select the techniques to be used in the pretest**
   The pretest may be conducted individually or in groups, depending on the nature of the material, which suggests the type of technique to be used. In the next questions, you will find suggestions about when to choose which technique and with what material.

5. **Design the pretest guidelines and instruments for each technique**
   In accordance with the material and the specific techniques selected, design pretest focus group guidelines or individual interview instruments and the codes to be used for eventual encoding of the data chosen.

6. **Select interviewers**
   The technique for pretesting is more complicated than the technique involving research. There are two kinds of pretest implementers: those doing individual interviews and those conducting discussion or focus groups. A person conducting the pretest must be experienced. University students from communication or psychology faculties can be trained as interviewers. A skilled moderator is needed to lead focus group discussions.

> ***Note:** It is advisable for those people who have produced the materials to have a role in their pretests. Their exposure to audience reaction to their material can be very persuasive in demonstrating the value of pretesting.*

7. **Train interviewers**
   Pretesting training should include the reasons the pretest is important. Make it clear to the interviewers that you have not done the drafts and will not be hurt by pretest results. Training should also include the creative brief for the material and the points in doubt as perceived by producers or the technical team.

   The instrument to be used in the pretest should be explained to the interviewers. Instructions should be provided regarding the criteria for selecting those to be interviewed and the use of a screening questionnaire. Mechanics and procedures to be followed in conducting the pretest interview when done individually and when done in focus groups should be explained. Interviewers should practice first among themselves in training.

8. **Test the pretest guidelines and instruments**
   Just as research questionnaires have to be tested, it is also advisable that the pretest instruments be tested to assess whether the mechanics designed for con-

ducting the interviews will achieve the pretest objectives and whether they are easy to implement. To test a pretest questionnaire, it will suffice for each interviewer to conduct three or four interviews and subsequently analyze the results with the person in charge. In the case of pretests with focus groups, it will be sufficient to form a single trial focus group to test both the guidelines and the proper implementation of that focus group.

9. **Make the necessary logistical arrangements**
   Assign a person to be in charge of logistics, such as transportation, meeting places, permits, and authorizations so that everything will be clearly understood before the initiation of field work.

10. **Explain the reason for your visit.** Using simple language, telling the person in your pretest audience what you are pretesting and for what reason.

11. **Determine whether the individual is willing to be interviewed and whether this is the proper time for it.** Explain that it will take very little time and stress the fact that his or her opinions will be very necessary for purposes of testing the material.

12. **The pretest process.** Conduct the interview by using the instrument for pretesting that you developed.

13. **Complete the pretest process and say good-bye.** When you have completed the pretest interview, thank respondents for their opinions and stress once more the importance of their suggestions in making the material better and more interesting for all concerned. Remind them that when they will see the final material in the community or hear it in the radio or see it on TV that they helped make that material effective.

Exercise 6. Steps for Pretesting with Focus Groups

Materials

Copies of Steps for Pretesting with Focus Groups

Instructions

Ask team members to read in groups the description of each of these steps and discuss the content among themselves.
Clarify any doubts either by checking AED's Learning Kit for Focus Group Research or ask a qualitative researcher to help you clarify.

Steps for Pretesting with Focus Groups

1. Deciding when to use a focus group for pretesting purposes

Material is for group exposure/use/consumption. One strong argument for using a focus group for pretesting is if the material you are producing is intended to be used in group circumstances or people are likely to be exposed to it in a group setting. In either case, if the overall characteristic of the material is its group use or consumption, then pretest it in focus groups.

Difficulties doing individual interviews. The fact that individual interviews need interviewers may pose a sufficient obstacle to think of the focus group as the alternative, either because you do not have the budget to pay for those interviewers or the logistical control. For example, if you are pretesting television spots, it is not easy to carry a portable television set from house to house to interview people individually. The alternative is to invite your participants to the nearby location where you have the video equipment and monitor and pretest in a focus group.

The topic/theme/content is sensitive. Many times you are dealing with a topic/theme/content that is culturally sensitive such as birth control or sex education. You have to be sure that the treatment is correct. The theme needs to be treated inside the social norms and its parameters used by the target audience. The vocabulary or images must not be offensive. Focus group discussions can often reveal truer feelings than individual interviews.

The concept development is not clear. Focus group interviews are especially useful in the concept development stage of the communication process. They provide insights into target audience beliefs and perceptions of message concepts, and they help trigger the creative thinking of communication professionals.

For example: You want to find out if mothers have any compelling feelings regarding the concept of vaccination to prevent deadly diseases. Will this rational concept move them to action or is it better to use the concept of "a responsible mother takes children to vaccination three times because that is what doctors recommend." Which concept will move mothers more? This situation is when focus groups give you the best indication of what message will be best suited to achieve the desired response form a particular audience.

2. **Selecting the pretest focus group participants you will need**

Clear definition of their characteristics. This process has to be as carefully done as the selection of your sample for the individual pretest interviews. The most important criteria is to select your participants in the focus group from among your target audience, keeping in mind the criteria you have defined for that audience. Only accept participants who match your audience criteria: age, sex, literacy level, number of children, neighborhood, type of work, knowledge of the health topic, and experience.

Screening questionnaire. The screening questionnaire is a simple instrument that allows you to find out if the person you are inviting to the focus group session qualifies. For example, if the target audience is mothers with children under five years old that have tried mixing the ORS solution, then your questions will be directed to finding this vital piece of information when you screen your potential invitee.

The screening questionnaire can look something like the following. Use it to design your own questionnaire when you have to select people for your pretest focus group.

3. **Preparing the discussion guide**

This guide will help you maintain focus on the objectives of the focus group session and the material or concept to be pretested. It should address the main variables mentioned at the initiation of this question (comprehension, attraction, acceptance, involvement, inducement to action).

A discussion guide for the pretesting of a radio-TV spot could look like this:

Sample Pretest Guide (Nonprint Material)

Introduction

- Greetings
- Presentation of participants and team
- Give objective of pretest
- Thank them in advance for their invaluable assistance. Remind them that there are no right or wrong answers and that opinions of each participant counts; participation of all is most desired.

View or listen to the video or spot (twice minimum)

Distribute the individual pretest questionnaire with comprehension questions. Have each one respond individually. If there are illiterate participants write answers for them.

After the individual questionnaire is completed, proceed with your focus group session using a guide similar to the following general guide.

Comprehension and cultural appropriateness.

1. In your opinion, what is the message of the spot? What makes you think that?
2. Were any words difficult to understand? Which ones? Were any parts of spot not clear?
3. Could you explain this message to someone else? Please do so. What would be difficult about explaining the message?
4. In your opinion, does this spot reflect your situation? What about it does/does not?

   5.Does it reflect the reality truthfully? Tactfully? Appropriately?

Attractiveness

6. Is there something about the spot you like the most? What?
7. Was there anything you did not like in the spot? What part? For what reasons? How would you change that?
8. Is there anything in the spot that other people like yourselves will not like? For what reasons?

Acceptance

9. Is there any idea that is not acceptable? What reasons make it unacceptable?
10. Is there any word, phrase, sound, or image that may be rejected by others like yourselves? For what reasons?
11. Is there any idea, image, or word that is not believable? Can you explain the reasons why they are not believable?

Involvement/Inducement to Action

12. Does this spot show people like yourselves?
13. Are they in a real-life situation?
14. Do you think the spot asks you to take action? What action?
15. Would you consider taking that action? What would be different about that?
16. How would you explain this message and its action to a friend? Would you encourage them to take action?

Suggestions for changes

Explain the desired message and ask—

17. What can we do to improve the spot, make it more understandable, more pleasing, more realistic? How? What would be better about that?

Carrying out the focus group session. A full detailed description of how a focus group session is carried out can be found in the manual, Getting It In Focus: A Learner's Kit for Focus Group Research. (See Section III for information on ordering a copy of the kit.)

Organize the sitting arrangement. It is recommended that the participants be seated in such a way so they can see the TV monitor, hear the audio-tape, or see the print material with no problem. A semicircle around these instruments normally allows for most of them to see or hear with no problem. Be sure there is no major interruption while the session is going on. Consider the following two examples for room arrangement.

Print materials

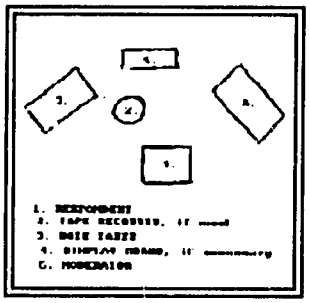


Figure 1

Nonprint materials

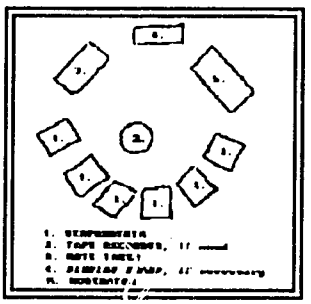


Figure 2

Have the participants hear or view the material to be pretested. If you are pretesting a television or radio spot, you will play the draft spot. If it is print material, such as a poster, show the actual size of the draft prepared; but if it is a pamphlet, a booklet, or a brochure, carry enough photocopies of it so that each participant can see one and read it at his or her own pace and leisure.

Distribute the individual questionnaire. It is very easy to come to a general consensus about the ideas the materials intend to communicate, especially when there are one or two outspoken individuals in the group. They tend to quickly polarize and manipulate the group. If they give their ideas of what they consider the main ideas of the material, the rest will follow and acknowledge simply what these leaders affirmed.

When this happens, it is easy to loose the true level of comprehension each individual originally had of the main ideas proposed by the material. It is

therefore recommended that you prepare a questionnaire for each participant in which the questions about comprehension and the call to action (if there is one) are asked individually. The discrepancies will show you how strong and influential was the opinion of the group leader versus the responses given in the individual questionnaires.

Conclude session

- Make a summary of each section to verify the group's position on each variable. Be careful to summarize all diverging opinions.
- Emphasize that all answers are valid.
- Thank everyone. Let them know their opinions may be recognized by them in the final product.
- Give them the incentive decided for their participation.

Complete Worksheet 18-1, Before the Pretest

Exercise 7. How To Interpret the Data of the Pretest and Apply it to Changes of the Material

Materials

Copies of Interpreting

Instructions

Have one of your team members read this section aloud.
Ask the rest to comment on any of the criteria.
Read the critique again to amplify it, or to demand a greater in-depth explanation of what is being read.

Interpreting

1. Changes in materials

The changes most commonly suggested by the pretest have to deal with changes or modifications of either the form or the content.

Form

- Music: make rhythm, tempo in accordance with content
- Color: improve combination, tone, intended impact, intensity
- Tone of the message: place more or less emphasis on emotional content
- Typeface used: make darker, bolder, bigger, higher or lower in contrast

- Eliminate distracting attention overload
- Make more accurate representation of persons or things (proportion and perspective)
- Rearrange text and visual distribution of elements
- Change names, roles, or personalities of characters

Content

- Change words that cannot be understood
- Give greater clarity to what the user is supposed to do
- Express a single idea and eliminate superfluous information
- Avoid using abstract concepts or figures that the user may not relate to the message
- Make the benefit stand out clearly
- Change technical terms that are obscure, confusing, unnecessary
- Clarify concepts that were thought to be clear
- Make the behavior easier to grasp, simpler to understand, more appealing to try

2. How to interpret and combine use of percentages from individual interviews

Percentage of acceptable material: It is an accepted standard that if 70 percent to 80 percent of your audience understands the message, would consider taking the action you recommend, and finds your materials attractive, acceptable, and believable, then your materials are successful. Monitoring will confirm that your materials have been successful after they have been used in the field for a while.

Combining low/high percentages: If your material is understood or accepted by less than 70 percent, how do you determine if you need to re-do the material, or if you should use it regardless of that low percentage?

There is no absolute rule for this. It is the combination of your results with your objectives that suggests a decision. The following examples illustrate the point. Suppose you have more than 80 percent for comprehension and 85 percent acceptance, but attraction was a low 45 percent and involvement and inducement to action were a low 40 percent. Your objective for the material was obtaining greater awareness. The decision to use the material with the appropriate changes suggested by the pretest, regardless of these low percentages, is justified by the fact that your objective and message are not intended to cause adoption of a new behavior.

Another example: Your results on a radio spot are high in comprehension (88 percent), involvement (83 percent), and inducement to action (85 percent), but are medium-low in attraction (57 percent) and acceptance (60 percent). This is not a usual combination, but it is not impossible. Since you are looking for inducement to action and com-

prehension and both are satisfactory, then the radio spot does not need to be rejected. It is clear that you need to look into your data to find out what suggestions may enhance your message's attraction and acceptance. Any clue in this respect will become very important.

Still one more example: You have made a flashy, attractive TV spot intended to persuade viewers to try out a specific behavior, but your comprehension is low (42 percent) and inducement to action is even lower (33 percent). You know you have to redraft your material. Flashiness can easily block comprehension and hide inducement to action.

There are no absolute guidelines. You have to look for the point of equilibrium among all the criteria used to measure the effectiveness of your material. That point of equilibrium is the one that will best guide your interpretation of your data.

Mistrust a Pretest that Suggests There Are No Changes To Be Made!

3. There is no such thing as a perfect material

Some changes may be minor and unimportant. You may well decide they do not merit the trouble (high expense, too much time, or any other additional reason required to make changes).

But a pretest that suggests no changes was (1) either poorly designed or badly implemented, (2) the answers the interviewer wanted to hear were induced, (3) results were not well analyzed, or (4) the process was manipulated along the way.

It is common for any material to be perceived by the target audience as needing changes. What is less common is an open attitude of the creators in accepting significant suggest changes. This openness is a virtue that must be prepared for in advance. It is recommended that you present your results and recommendations in a way that will make it easy for your artist to make the changes.

4. Number of pretests

There is no set rule for the number of pretests per material. As you become more familiar with pretesting dynamics, you will develop your own criteria that will be far more helpful than any recipe given here.

The number of sessions per material is dictated by the nature of the materials to be pretested and by how well the first draft answered the pretest variables as perceived by the target audience.

By the second focus group, or in the case of doing individual pretesting when the first round of 10 people are interviewed, you should stop and collect the overall information thus far gathered and ask the following questions:

- Is there a clear rejection of the material? If so, why?
- Is there a general consensus that the material is ugly, culturally insensitive? If so, why?
- Is there a gross incomprehension of words, of a specific drawing, symbol? Which ones? Why? If so, which can be changed according to the suggestions given, so that you can continue with further pretesting interviews or focus groups?

If you find no gross evident error in any of the variables that must be corrected immediately so that the rest of the pretest can be done with these corrections made, you should continue with the rest of the programmed number of individual interviews or focus groups.

Again, the number of focus groups or individual interviews should be decided on the basis of your budget and previous definition. Normally, by the third to fourth focus group with any audience segment or material, the pattern and trends of the answers are already well established and you may need to do more focus group research. Similarly by the 25th-30th individual interview, you will have a pattern and answers that follow a trend.

NOTE OF CAUTION. If your material is to be used on a national scale, then it is wise to increase the number of individual interviews and focus group discussions so that your sample has the best chance of representing most of the nation's cultural and ethnic diversity. National products are the most delicate ones, so be certain to have a good representation of your entire target audience.

Synthesis

1. Effective communication material should accomplish the following:

   - Establish a personality
   - Position itself correctly
   - Feature the most compelling benefit
   - Break the pattern

- Generate trust
- Make an appeal to both heart and head
- Respond to communication strategy

2. Pretesting materials should include the following:

   - Definition of pretesting
   - The need to do pretesting
   - The audience with whom to do the pretesting
   - The variables pretested, which include—
     Comprehension
     Attractiveness
     Acceptance
     Involvement
     Inducement to action

3. Steps required to carry out the pretesting include the following:

   - Check the objective and content of each material
   - Write or have the draft script written
   - Have the technical team review the draft to ensure correctness of the technical message
   - Be sure preproduction steps are carried out: sound effects, music, pictures, photographs, actors, artists, briefs ready
   - Produce the draft materials
   - Pretest the first draft with close-by persons of the institution(s) who belong to the target audience
   - Redesign or modify the materials based on the results of the in-house pretest, if necessary
   - Prepare the draft script, art, or video for the field pretest
   - File and conserve all original material for future reference
   - Determine the sample for those population segments with whom the material is to be pretested
   - Select the techniques to be used in the pretest
   - Design the pretest guidelines and instruments for each techniques
   - Select interviewers
   - Train interviewers
   - Test the pretest guidelines and instruments
   - Make the necessary logistical arrangements

4. Conducting for the individual pretest interview includes the following:

   - Explain reason for visit
   - Determine if the individual is willing to be interviewed
   - Begin the pretest process
   - Complete the pretest process

5. Pretesting with focus groups includes the following:

   - Decide when to use focus groups
   - Screen participants
   - Develop guide
   - Carry out the session

6. Interpreting the data includes the following:

   - Analyze data
   - Determine acceptable percentages
   - Combine low/high percentages

Application

1. Complete Worksheet 18, Before the Pretest.

Worksheet 18-1

Before the Pretest

ORGANIZATION	TO BE COMPLETED BY	COMPLETED
1. Design/pretest guides/questionnaires according to technique		
2. Determine samples of pretest		
3. Prepare field logistics: - obtain clearances - arrange participants - organize logistics		
4. Select and train interviewers		
5. Prepare materials: - make sufficient copies of questionnaires and materials to be pretested - obtain and check equipment to be used		
6. Distribute all pretest materials and forms to teams		
7. Do the pretesting		

Question 19

How Are Draft Print Materials Designed and Pretested?

This question reviews the overall criteria used to prepare and design your print material and discusses the guiding principles for producing and pretesting the material.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Applied the 19 principles of effective print materials and completed an exercise to design a draft print material
2. Prepared a draft of the print materials you have decided to produce
3. Described how to pretest draft print materials
4. Drafted the questionnaire for pretesting your draft print material

Exercise 1. Designing Your Print Materials

Materials

Paper and pencils
Copies of 19 Basic Principles for Designing Print Materials

Instructions

Ask your team members to write down the following four titles with the numbers included.
Instruct them to fill in after each number a basic rule related to each of these categories that they should have in mind when preparing print materials.
Ask them to compare their list with the 10 Basic Principles for Designing Print Materials.

Design/Layout:
1.
2.

3.
4.
5.
6.

Illustrations:
7.
8.
9.
10.
11.
12.
13.
14.

Text:
15.
16.
17.
18.

Supervision:
19.

19 Basic Principles for Designing Print Materials

Note: The principles marked with an (*) are particularly important when producing print material for nonliterate rural audiences.

Design/Layout

*1. Present only one message per illustration, especially on posters, counseling cards, and handouts.
2. Limit the number of concepts and pages on materials.
*3. Make the materials interactive whenever possible.
*4. Leave plenty of white space. Balance text, illustrations, and white space.
*5. Arrange messages in the sequence that is most logical to the audience.
*6. Use illustrations to help explain the text. In some materials, especially for nonliterate viewers, illustrations carry most of the weight.

Illustrations

*7. Use appropriate styles: (1) photographs without unnecessary detail, (2) complete drawings of figures when possible, and (3) line drawings. There is no need for elaborate decoration or excess in shadows.

*8. Use simple illustrations. Unnecessary detail can distract the viewer from the central message.

9. Use familiar images that represent objects and situations to which the audience can relate.

*10. Use realistic illustrations. Often symbols are too abstract.

*11. Illustrate objects in scale (especially correct anatomical proportions using a projected slide to facilitate accuracy) and in context whenever possible.

12. If symbols are used, pretest them with members of your audience.

13. Use appropriate colors. In most cultures, colors have special meaning. For example, red is associated with alertness, danger, and life support. Color is best for posters, although full-color separation is not needed (screens will do fine). Be careful with color registration for clear printing.

Text

14. Use a positive approach. Negative approaches are very limited in impact, tend to turn off the target audience, and will not sustain an impact over time.

15. Use the same language and vocabulary as your audience, as found in formative research. Limit the number of languages (for example, Spanish and two local languages) in the same material.

16. Repeat the basic message at least twice in each page of messages.

17. Select a type style and size that are easy to read. Italic and sans serif typefaces are more difficult to read. Use a 14 point font for text, 18 point for subtitles, and 24 point, for titles.

18. Use upper and lower case letters. Text presented only in upper case letters is more difficult to read.

Supervision

19. Without careful supervision, it is very easy to receive materials with wrong colors, incorrect alignment, or careless print jobs. It is best to have an experienced member of your team providing close supervision.

Background Information

Print Materials for Low-Literate Populations

When preparing material for low-literate people, extra care must be taken. Their lack of formal education limits them in the interpretation of material if they are not famil-

iar with the visual cues used in the material. Simple everyday codes of the visually literate urban resident such as a stop sign or traffic light may have absolutely no meaning to a rural person who has never seen traffic signs.

In rural settings, literacy rates are often low. Designing materials that convey messages effectively without words is the principle challenge of working with rural populations. Often a well-designed material for a rural audience is also the most effective manner of reaching urban populations with higher literacy rates. Developing materials for low-literate, rural populations requires stricter adherence to basic design principles than developing materials that communicate through text as well as images.

Although it is still possible to find population groups that have had no contact with visual images, they are increasingly rare. Even people who have seen very few images will learn to read the visual cues of illustrations and photographs surprisingly quickly.

Since carrying out a new health behavior in a rural area often means breaking away from an established tradition, individual community members need to be assured they are not being asked to act alone but rather as part of a group. Print materials can effectively provide a model of how others (neighbors and friends) have already adopted a new health action.

Noninteractive materials simply are not appropriate for rural populations. The most common noninteractive print material is the poster. A poster is often the first idea that pops into the minds of design teams when they think of communication materials for a health intervention. Unfortunately posters are rarely effective for rural, low-literate groups because they usually rely on the written word.

An interactive material is one that encourages exchange between the health worker (or facilitator) and members of the target audience. These materials are hand-held practical tools. They not only improve the quality of communication but also the likelihood that an exchange of information will occur. A good action-oriented tool illustrates and clarifies the message. The two interactive tools most frequently used are counseling cards and flip charts.

Counseling cards are a basic communication building block in rural settings because they are-

- Simple. Conceptually and graphically they represent the simplest, most straightforward way to communicate a message.
- Interactive and action oriented.
- Low cost. There is no quicker, less expensive way to get messages in the hands of a large number of interpersonal communicators.

- Flexible. Counseling cards can be used equally well by all community development agents: teachers, agricultural agents and health workers, and grass-roots educators.

Have your team see the following examples of these basic principles to appreciate how they were translated to actual print materials. Study them in a group and decide in what manner each of the principles was taken into account by the design teams.

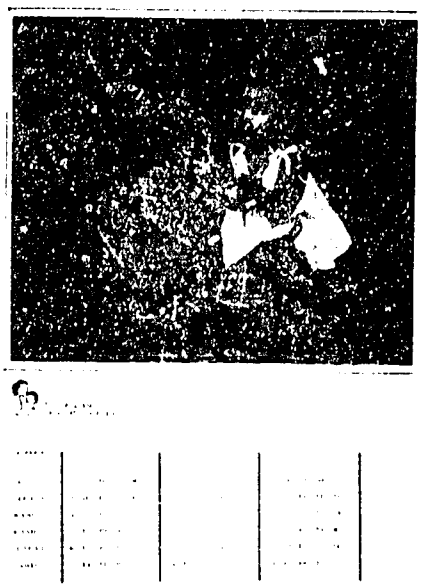
Examples of the Use of the Principles for Designing Print Materials

HEALTHCOM Materials	
Material	**Description**
	One message. This illustration is one page from a 37-page flip chart for dehydration and ORS preparation in Ecuador.
	Appropriate use of photographs to support text. Flyer for pharmacies in Indonesia focusing on use of Oralite for children's diarrhea.

Interactive materials. The next two examples come from a radio course in Ecuador. The mothers received the booklets (left) which corresponded to 37 radio broadcasts of the program "For Healthy Children We Work."

This bag, which looks a bit like a brief case, has the logo, "For Healthy Children We Work" written on it. The bag contained PREMI materials. It was given to each mother participating in the radio program.

Interactive material. Mothers that graduated received a card citing them as Health Promoter Volunteers. Another card with numbers allowed them to participate in a lottery awarding scholarships for their children.



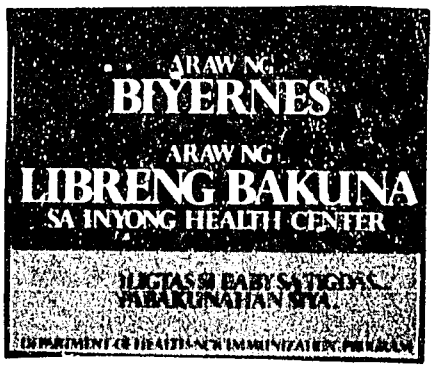
Interactive material. This calendar has a pocket which contains CDD counseling cards for *kader* (community health workers). It was produced in Indonesia.

Text and illustrations in balance. This is a flyer which replicates a poster developed for use by community health volunteers and pharmacists in Indonesia.

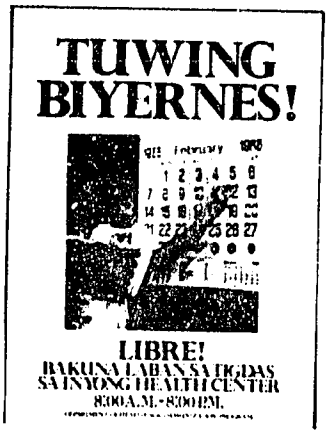
	Appropriate use of symbols. This tee-shirt promotes a symbol for the ORS packet which was widely understood and accepted in Uruguay.
	This poster from Senegal respects cultural norms regarding appropriate colors.
	Positive Reinforcement. Once a child completed the first year vaccination series, this sticker was placed on his or her Vaccination Brochure which was designed to be placed in the standard vaccination card in Burkina Faso.

Use of audiences' vocabulary. "Obradera" is the common word used by Honduran mothers when referring to diarrhea.

Repeat the message at least twice. This poster from Paraguay reiterates a breast-feeding message twice.

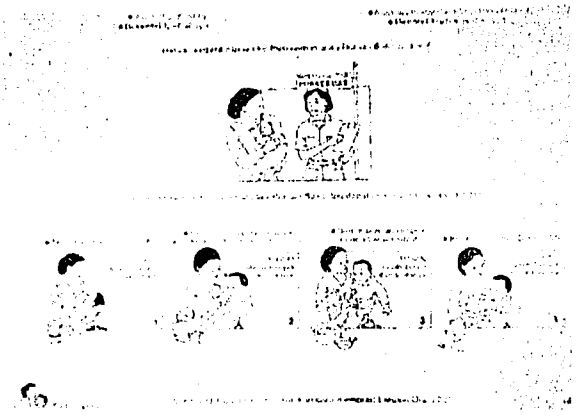


Use upper and lower case letters to highlight most important part of the text. This is a sticker from the Philippines to remind mothers that Friday is the day for free measles vaccinations.



Select the type style which is readable from at least two meters. This example from the Philippines shows a good type size for reading from a distance.

Plenty of white space so reading and visuals are not crowded. This calendar from Honduras makes liberal use of open space to help focus the message.



Most logical sequence. This diarrhea treatment card from Indonesia is color coded so that when the flow chart is complete, you are at the square that tells you the diagnosis.

Familiar images. The objects in this poster from Zaire represent a mother's reality.

Realistic illustrations.
This Guatemalan vaccination poster shows realistic illustrations of children.

Simple illustrations. This counseling card from Mali demonstrates good pre-natal nutrition.

Pretesting Print Materials

Introductory Note

The way you pretest your print materials will vary with the type of material. A poster does not have the same size or function as a brochure, counseling card, or flip chart. Each has its own internal structure and requires that the pretest procedure be somewhat different.

Here are descriptions of the pretesting procedures for the most frequently produced print materials: posters, brochures and pamphlets, flip charts, and photonovels and comics. These, by their very nature, demand that those interviewed are literate.

Exercise 2. Pretesting Posters

Materials

Copies of Pretesting Posters

Instructions

Ask team members to draw up a generic questionnaire using the ideas proposed in the introductory note and in the explanation of pretest variables in Question 18. Have them compare their questionnaires with the one provided in Pretesting Posters. Be sure their questionnaires reflect all of the steps that should be included in the pretest. For example, in pretesting a visual, one first pretests the image by itself (drawing, photograph, etc.), then the accompanying text by itself, and finally the two together.

Pretesting Posters

Pretesting Drawings and Illustrations

Start pretesting the picture in the poster, alone, without the text, to evaluate the ability of the image to transmit the message by itself. Generic questions about the drawing or picture might be:

Comprehension

1. Describe what you see in this picture (photograph or illustration).

2. What do you think is happening here? What do you think the person(s) is (are) doing?

Attractiveness

3. Do you believe that this picture (photograph or illustration) is
   - Very pretty
   - Pretty

- Fair
- Not pretty

4. What do you like most and what do you like least about this picture (photograph or illustration)?

Acceptance

5. Is there something in the picture that you definitely don't like? What is it that you don't like and why don't you like it?

6. Is there something about what is shown here or about what the person(s) is (are) doing that might upset or not seem right to some people? What about it?

Involvement

7. Where do you think the people and things shown here are from?
   - The country
   - The city
   - The neighborhood
   - Some other place (please indicate)

8. Why do you think these people are from (indicate the place mentioned in the previous response)?

9. Do these people appear to be like the people from your community? How are they alike and how are they different?

Inducement to Action

10. What do you think this picture is suggesting that you do? What do you think about that?

General Comments

11. Describe in your own words what this drawing suggests to you.

The Text

After the picture has been pretested, it should be covered up to proceed to analyze the text. First ask the person being interviewed to read the text. Take note of the degree of ease or difficulty that he or she has in reading it. Underline in your text those words that the respondent has difficulty understanding or has trouble reading. Then proceed to ask questions involving the components of effectiveness.

Comprehension

12. Tell me in your own words what this message is attempting to say. What is the idea you understand?

13. Are there any words that seem difficult to you or whose meaning you do not understand?

14. Does the size and type of letters used seem to you to be easy or difficult to read? Ask the member of the target audience to tell you what he or she prefers and to write it on the back of the pretest instrument.

Acceptance

15. Do you think this message might upset or offend anyone? If the answer is yes: What about it do you think might upset someone? In what other way would you phrase the message so that it would not upset anyone?

Involvement

Ask the person being interviewed to read the text again out loud.

16. Is the way that things are expressed in the message the same way that people around here express them? If the answer is no: How would the same thing be expressed in your area?

Inducement to Action

17. Would you be willing to follow the advice given? Would the text encourage (dis courage) your following the advice?

Pretesting text and illustration together

Now show the respondent the entire poster with both the illustration and text visible at the same time. Ask the following questions:

18. Now that you know what this poster is about, please tell me: Do you think the picture (photograph or illustration) is appropriate for the message that is being transmitted? If the answer is no: What about it is not appropriate? What other picture (photograph or illustration) would be better?

General Comments

19. How could this poster be improved?

A word of caution! As mentioned in Question 18, it is very important that you do not forget:

- *Every material has a particular role in your communication strategy. Your pretest should assure you that it fulfills that role.*
- *Every material also has its own personality, be it a poster, pamphlet, comic book, or radio or TV spot.*
- *Study each material carefully. Take a good long look at what you have before you pretest.*
- *As you study your material, you will become aware of the special nuances that make it different from other materials even if it deals with the same theme.*

Pretest questions will have to be adapted to your material to explore specific aspects of that material that generic questions will not cover. For example, does the material present the image of a 'loving mother' as called for in your strategy? Or, what do you see the mother is holding in her hand? (It is supposed to represent an ORS packet). What were the background noises in this radio spot? Do they correspond to...(a street market?)

Pretesting two versions of the same poster

Note: When audiences are shy or hesitant to express negative opinions, asking them to compare two versions can encourage a more frank discussion.

If two or more versions of the poster are being pretested, conduct the pretest first for each poster separately. After information has been gathered for each version, show the respondent the two complete versions together and ask the following comparative questions:

Comparative Questions

20. Which of these posters do you think best gets the message across? (Tell the person being interviewed which message you want to get across so he or she can compare correctly.)

21. Which of the posters do you think is most appealing?

22. If you had to choose the best of the two, which would you choose? What about it influenced your choice?

23. If you could make a poster by taking the best elements from each of these two, which elements would you choose?

Exercise 3. Pretesting Brochures and Pamphlets

Materials

Copies of the section on Pretesting Brochures and Pamphlets

Instructions

Have one member of the team make a presentation on the theme after reading the section. The others will fill in what he or she misses.
Be sure you have read the material and fill in whatever concept was still left out.

Pretesting Brochures and Pamphlets

A word about this material

Brochures, pamphlets, and other printed materials provide more detailed information about a subject than posters or flyers. They generally are used to train users in a given behavior or to reinforce the knowledge that will induce users to adopt a particular behavior. It is important that their messages be understood.

Whereas a poster or radio spot may be considered to be a communicative stimulus for motivating the viewer or listener to take action, brochures and pamphlets are used to explain that action and ensure that it will be put into practice correctly. Brochures and pamphlets have an additional advantage over posters and radio spots because their use can be controlled by the user; i.e., the user can consult them whenever he or she requires information and has the time necessary to review the information contained in the brochure or pamphlet.

For this reason, the pretest of the brochure or pamphlet is not an evaluation of the ability of the person being interviewed to recall content of the material but rather of the ability of the brochure or pamphlet to provide the information in a comprehensible way.

Pretesting Brochure Components

The above-mentioned characteristics establish the two most important components of the brochure (or pamphlet), both of which need to be evaluated:

1. Comprehension and simplicity in the presentation of messages
2. Presentation of the content of the brochure in such a way that the user will be able to easily find the information that he or she requires; for example, make sure text and headings are in a large-enough type size

Other characteristics include the usefulness of the content and its manageability (the ease with which the brochure can be saved or carried by the user).

During the pretest exercise, the brochure should be as close to the final design as possible. Photocopies should be made. If the final brochure will have colors, it is advisable that the copies be colored with colored markers so the illustration will be as close as possible in appearance to the final product.

Conducting the pretest

There are many ways to conduct a pretest of a brochure (or pamphlet). Here are some easy and accessible suggestions.

Make several photocopies of the material. Select a sample that represents members of your target audience. Distribute one copy of the piece to each individual. Explain that you want him or her to read and analyze it and that on the following day you will return to ask some questions about it. It will not be necessary to ask at this time whether the individual knows how to read. What is important is that he or she be given the brochure and allowed to determine whether it is useful to him or her; i.e., whether there is anybody in the house that could read and explain it. If you cannot go back on the next day, then be sure you allow sufficient time for the persons interviewed (they must be literate) to study the pamphlet before asking the questionnaire questions. In this case, they should be literate.

On the following day, conduct the pretest interview. The content of the brochure should be pretested first, followed by the cover. During the interview, the person may have the brochure with him or her and consult it if he or she wishes.

Asking Questions about the Text

The sequence of questions to be asked might be as follows:

1. Did you read the material, or did someone read it to you?
2. What words in any of the paragraphs of the first page did you not understand?

Tell the respondent the exact meaning that we wish to convey with the particular word(s) and ask the following question: What word do you use to refer to this?

3. Are there any other words in any of the other pages of the material whose meaning you do not know? If the response is yes: Please indicate which words.

At this point, the interviewer should ask specific questions about each message contained in the brochure or pamphlet.

For example, suppose that the brochure deals with the prevention and treatment of cholera and one of the subjects is the symptoms of this disease. When referring to this point, the following question might be asked:

4. How does the brochure say that we can recognize cholera? What symptoms does the brochure say are present in someone who has cholera?

If the person being interviewed does not recall the exact response, ask him or her to look for this information in the brochure and read it aloud to you. Analyze the person's ease or difficulty in reading and understanding the material. You may be able to determine by the tone of voice whether the message is understood or not. Ask specific questions for evaluating the degree of comprehension. Repeat the process for each message or subject covered in the pamphlet.

Proceed to Pretest the Illustrations

For this purpose, the illustrations should be numbered and the pretest instrument should contain the questions to be asked for each illustration. These questions should be asked in the manner of someone commenting on the illustration. The following should be evaluated:

Whether the person being interviewed -

- Is able to describe the picture and what he or she sees in it.
  (What things do you see in this picture?)
- Is able to understand what the picture is attempting to describe.
  (What do you think is happening? What scene does the picture represent?)
- Thinks that the picture is appropriate for illustrating that particular message.
  (Do you think this picture illustrates this idea clearly? Why?)
- Feels aspects of the message would be better understood if illustrated with a picture.
  (Do you feel that some ideas should be illustrated? Which ones? Why?)

Finally, ask the person to indicate any part of the material he or she did not like, found offensive, or thought was impossible to carry out as a behavior.

Note all responses in your instrument. Thank the person you interviewed and go on to the next. If you are doing the pretest in a group session, ask comprehension questions first individually, then have the group reflect on the other aspects.

Exercise 4. Pretesting Flip Charts and Photonovels or Comic Books

Materials

Copies of the sections, Pretesting Flip Charts and Pretesting Photonovels or Comic Books

Instructions

Give copies to two team members.
Ask one to prepare and make a presentation on pretesting flip charts and the other to present pretesting the photonovel or comic book. Make sure all points included in these sections are covered.

Pretesting Flip Charts

About Flip Charts

Flip charts are materials that are generally used for instructional support in group talks. Accordingly, pretesting can be conducted in a group setting with between eight and twelve representatives of the target population. The technique for selecting the participants and managing the group is the same one used for formative research. Guidelines containing the pretest questions to be posed to the members of the group by the facilitator will need to be prepared (see Question 18).

A flip chart is composed of a series of sequential pages, each of which provides visual support to the oral communication being provided by the person giving the talk. In other words, it illustrates the messages that someone is transmitting orally. It helps a facilitator to encourage participation in the discussion by asking questions regarding the illustrations on each flip chart page. These questions usually are written on the back of the previous page so the facilitator can lead them easily.

To pretest a flip chart, it will first be necessary to evaluate the pages individually and then, after all of them have been pretested, to pretest the flipchart as a whole. An attempt should be made to evaluate its usefulness in providing support for the messages it is designed to transmit and for the facilitator who uses it.

The mechanics for pretesting a flip chart are as follows:

- The group should be arranged in a semicircle in such a way that everyone will have an opportunity to see the pages of the flip chart clearly.
- The facilitator will explain that the reason for the meeting is to conduct a joint analysis of a particular piece of educational material. He or she should not say anything about the nature of the material to avoid influencing the opinions of the group members.
- The first page is then shown to the group. The same questions are asked for

each page with primary emphasis on the comprehension, involvement, and acceptance of the material.
The group is allowed a few seconds to analyze the page, after which the facilitator will begin to ask the questions:

Questions about Comprehension

(The first question attempts to assess whether the viewers are able to identify everything that is present in the illustration.)

What do you see here? (The facilitator should write down all of the various items mentioned, in the order in which they are mentioned.)

(The second question attempts to determine whether the group understands the situation represented by the illustration.)

What do you think is happening in this scene?

Questions about Involvement

To evaluate involvement, the questions should refer specifically to what is being represented by the illustration. For example, if the page shows a woman preparing food for her child and if the illustration contains a woman, a stove, a table, and other kitchen utensils, the questions would be:

Does the kitchen shown here look like the kitchen in your home?

If the response is NO, the facilitator should ask:

How is it different? (What is missing or what does not belong?)
What would need to be added or removed so that it would look like the kitchens around here?

Is the stove shown here like the ones usually used around here?

If the answer is NO, the facilitator should ask:

What do the stoves used around here look like?

Are the kitchen utensils shown in the picture like the ones used around here?
Which utensils are missing and which do not belong?
Does the woman shown in the picture look like the mothers from this community? How could she be shown better?

Questions about Acceptance

Is there anything in the drawing that you do not like or that you think should not be shown the way it is?

If the answer is YES, the facilitator should ask:

What do not you like or what do you think should not be shown in this way?

After all of those present have been encouraged to participate, the facilitator should show the next page and once again proceed to ask all of the questions pertaining to it.

When all of the pages have been analyzed, there will be a general discussion on the flip chart as a whole. The group will be asked to offer suggestions about how it could be improved. The facilitator will again show each page in sequence and explain the message that the designers are attempting to communicate with each one. He or she will then ask for suggestions about how to improve them so that each can provide greater support to the explanation of the message.

Pretesting Photonovels or Comic Books

Preparing the Material

The process of pretesting a photonovel or comic book should be similar to the process described for pretesting brochures. The photonovel is distributed among a sample of individuals from the community and a time is set for a meeting to be held on the following day.

In the case of the photonovel, it will be necessary to have available photocopies of the final layout, which will be joined together to look like a photonovel. In the case of comic books, pretesting should be conducted using photocopies of the draft design. During interviews, participants may have the materials with them and consult them when asked to provide answers.

Unlike the brochure, the photonovel and the comic book develop a subject through the dramatization of a situation. The photonovel represents this dramatization through a sequence of photographs, whereas the comic book does so with a sequence of illustrations. This means that in addition to the questions related to the comprehension of the messages, it will be necessary to ask questions about the other components of effectiveness.

The sequence of questions for pretesting a photonovel or comic book might be as follows:

Comprehension

Tell me in your own words what the photonovel (or comic book) is about. (Try to get the respondent to explain the story represented by the material.)

Proceed to ask specific questions about the key message or messages you want to be sure were understood by asking the respondent to indicate where in the material the message is located.

Acceptance

Is there anything inappropriate in the story being told or in the way that it is being told that you believe might upset someone?

> If the answer is yes: What thing in particular would upset someone? What about it might be upsetting?

Do the photographs show anything inappropriate or not in good taste? Do they contain something that should not be shown at all? If yes, ask what in particular? For what other things should it be substituted?

Involvement

Are the characters in the story like the people they should represent (dress, haircut, context)?

> If the answer is that they appear to be different, ask: In what ways do the characters or setting appear different to you?

Do the characters in the story express themselves in a way similar to the people from around here?

> If the response is in the no: What things do the characters say differently from the way people say things around here? How are those things said around here?

Inducement to Action

What do you think this story is trying to get people to do? Are you willing to do what this photonovel suggests?

> If the response is no: What in the story would make you unwilling?

General Questions

Do you know of any case similar to the case presented in the story? Could you tell it to me?

Synthesis

1. The principles for producing effective materials include one message per illustration; limited number of messages that are presented sequentially in an interactive format, whenever possible; and liberal use of white space and appropriate/simple illustrations, with familiar and realistic images in scale. Symbols should be pretested and colors appropriate. The text should be positive and in the same language as the target audience. The basic message should be repeated at least twice. Type style and size should be easy to read with both uppercase and lowercase letters used. Production of the material requires careful supervision.
2. Special consideration needs to be given to developing materials for low-literate audiences.
3. Pretest variables (comprehension, acceptance, attractiveness, involvement, and inducement to action) should be applied to various types of print material (posters, brochures and pamphlets, flip charts, photonovels and comic books.)

Application

To help assimilate all the concepts seen thus far in this question, here are several suggestions of things you can do.

1. Make or have made a draft of any print material you have decided to produce.
2. Do an 'in house' pretest of the material so that gross errors and technical aspects are reviewed by your technical team.
3. After that is done and corrections of gross errors are made, use the guide that suits the print material draft you have and prepare a pretest questionnaire draft.
4. Be sure your team members have seen the pretest questionnaire draft and have reviewed it using the corresponding pretest questionnaire guide studied in this question.

Question 20

How Are Good Pilot Radio Spots Made and Prestested?

In Question 19 you reviewed the basic rules for producing and pretesting effective print material. Now you will see how to use guidelines for producing and pretesting radio spots. The spots use the feasible behaviors, communication objectives, messages, and creative briefs you developed in Question 17.

Skills/Knowledge

By the end of the question, you will have accomplished the following:

1. Listed the nine rules for the production of good radio spots
2. Reviewed examples of radio spot scripts
3. Discussed strengths and weaknesses of the Caribbean radio spots
4. Written a draft radio spot (Worksheet 20)
5. Drafted your pretest questionnaire for the radio spot

Exercise 1. Designing Radio Spots

Materials

Copies of Guidelines for Designing Radio Spots

Instructions

Ask team members to read the guidelines in small working groups and discuss their content.

Guidelines for Designing Radio Spots

If you have to design radio spots or judge the quality of the drafts presented to you, the following guidelines will be useful.

1. **Present one idea.** Each radio spot should have one main message, which should be repeated several times within the material. Even a short radio spot can and should repeat the main message at least twice.

2. **Use a credible source.** Feature a source of information that is suggested by the audience as appropriate (e.g., doctors, other health workers, or community opinion leader).

3. **Break the mold.** Try innovative ideas and formats; e.g. using testimonials from the audience. If you do not have much experience, start out with microdrama format or one narrator with appropriate background music and/or a few musical notes to separate text.

4. **Touch the heart as well as the mind of the listener.** Make the listener feel something after hearing the spot or programhappy, confident that they can do something but make them feel.

5. **Stretch the listener's imagination.** The voices, music, and sound effects can and should evoke pictures and create images in the listener's mind. TV limits the watcher to a small screen and print material to its own size. Radio sets no limits at all. With radio, listeners are invited to use their imaginations to see health problems in new ways and feel and imagine health behaviors from different perspectives.

6. **Write for the ear.** Radio should have the same natural, spontaneous sound as conversation. Read your spot or program to yourself aloud several times to really hear how it will sound over the air. Radio creates images through sound. Sound becomes part of the message. Think in terms of sound effects, musical notes, and words to evoke images.

7. **Write to the individual.** Imagine the face of a person within your target audience and write for that person.

8. **Ask listeners to take action.** Be explicit about what the listeners should do to resolve their problem. Too frequently radio materials simply raise awareness of problems without offering concrete solutions.

9. **Provide consistency.** Develop a similarity of sound in all of your radio materials. This can be provided by a unique voice, song, sound effect, or jingle that is incorporated into all of the radio materials produced (and other materials produced as well). This sound provides continuity to the radio materials.

Now let us analyze some of the elements involved in a radio spot.

Exercise 2.Writing a Radio Script

Materials

Copies of Example 1, Radio Script
Copies of Questionnaire on Writing a Radio Script
Copies of a Radio Script

Instructions

Have team members read aloud the example of the radio script.
Ask them to answer the questions in the questionnaire on organizing a radio script.
Hand out the information on organizing a radio script.

Example 1. Radio Script

THERE IS NOTHING AS HEALTHY AS A LAUGHING BABY

OPERATOR:	LAUGHTER OF A BABY
MOTHER:	(TENDERLY) There is nothing as healthy and beautiful as the smile of a happy baby.
OPERATOR:	CRYING OF A BABY
MOTHER:	Nor as sad and painful as his tears.
OPERATOR:	RAPID MUSICAL FLOURISH
ANNOUNCER 1:	(SOFTLY AND CONVINCINGLY) Mother, the laughter and the tears of your child depend on you. Give your child more attention when he most needs it.
ANNOUNCER 2:	(SOFTLY AND CONVINCINGLY) A child less than two years old is more delicate. He needs more attention.
ANNOUNCER 1:	(SOFTLY AND CONVINCINGLY) Your infant is delicate; give him special attention.
OPERATOR:	HAPPY MUSIC. LAUGHTER OF THE MOTHER AND CHILD
ANNOUNCER 2:	And enjoy his laughter (PAUSE) together.
OPERATOR:	THE MINISTRY OF HEALTH SLOGAN

Questionnaire on Writing a Radio Script

1. How many columns is the radio script divided into?
2. The left column has three functions. Can you identify them?
3. What does the right column show? Can you identify three functions of this column?

4. What is in capital letters? Why do you think it is done that way? What do the capitals indicate?
5. How long do you think this spot will be when it is produced?
6. How long will a spot be if the text is one page long? What is the normal length of a radio spot in your location?
7. What do you notice has been done with the message in this spot? What has been the treatment?
8. What do you think is the communication objective of this spot? Can you pick out the communication strategy behind this spot? At what point in a communication intervention do you think the spot would be used?

Writing a Radio Script

Ask team members to compare their answers to the following text.

- The radio script is divided into two columns. The left column indicates to the director or the producer who speaks, at what moment, and in what sequence. It also gives instructions to the person in charge of the production.
- The right column tells the production staff the sound effect you want to be heard or the inflection, modulation, or feeling you desire from the actor. It also includes the pauses and sounds you want from the actor.
- The instructions for the production staff are in capital letters. When they call for a sound effect, they also are underlined.
- The script has a communication objective which, in this case, is to touch the mother's feelings about how delicate the-under-two-year-old child is.
- The strategy behind this spot is obvious: to get mothers to pay more attention to their children under two years because this age group is most vulnerable to whatever disease the spot is addressing.

Exercise 3. Writing a Radio Spot

Materials

Copies of the Creative Brief
Copies of the Caribbean Script and four Caribbean radio spots
Worksheet 20-1, Create a Radio Spot

Instructions

Have each working group draw up a radio spot script using the Creative Brief prepared by the Caribbean team and Worksheet 20.
After they have written the scripts and presented them to the other team members, read to them the actual radio spot produced in the Caribbean intervention.
Have your team members read the other four examples of the Caribbean radio spots and comment on their appropriateness; i.e., how they meet the criteria of a good radio spot script.

Creative Brief
Media
Radio

Format
Five 30-second spots

Message
Make Measles History - tactical/informational

Audience
Parents

Communication Objective
Create doubt to combat complacency

Obstacles
- Think children have had measles; why need a shot
- Do not believe measles is a problem

Support Points
- Measles still exist; last year there were more than 4,000 cases
- Measles biggest killer
- Many diseases look like measles; cannot be sure your child has had it
- Never need another measles shot

Tone
Authoritative, dramatic, convincing

Creative Considerations
Portray voice of health specialist; mention MOH; must use "Make Measles History" at least once in every spot.

After writing a radio spot with the above information as if you were writing it for the Caribbean program, compare your script with any of the one done by the Caribbean team.

Make Measles History

Measles Elimination Month
"Myths about Measles"
RADIO (:30)

SPOT

OPERATOR:	CAMPAIGN THEME
Announcer:	(DEEP VOICE) Myths about measles. Myth Number One:
OPERATOR:	TRANSITIONAL BREAK
Woman:	(DISDAIN) Measles is nothing! It comes and it goes!
OPERATOR:	SOUND EFFECT
Announcer:	(DEEP VOICE): Now the truth:
Woman 2:	(CONCERN) Measles comes...and can take your child with it. (GRAVELY) Forever!
Announcer:	(INVITINGLY) If your child is between nine months and fifteen years of age, ask your health authority about Measles Elimination Month. (TRIUMPHANTLY) And make measles...history.
OPERATOR:	CLOSING THEME

Study the following four Caribbean radio spots and apply criteria of a good radio spot script.

SPOT I

OPERATOR:	CAMPAIGN THEME
Announcer:	(DEEP VOICE) Myths about measles. Myth Number Two:
OPERATOR:	TRANSITIONAL BREAK
Woman:	(LIGHTLY) So if my child gets measles, so I lose a couple of days of work. That's not so bad.
OPERATOR:	SOUND EFFECT
Announcer:	(GRAVELY) Reality: If your child gets measles, he could lose... his eyesight. If your child is between nine months and fifteen years of age, ask your health authority about Measles Elimination Month. (TRIUMPHANTlY) And make measles...history.
OPERATOR:	CLOSING THEME

SPOT 2

OPERATOR:	CAMPAIGN THEME
Announcer:	(GRAVELY) Myths about measles. Myth Number Three:
OPERATOR:	SOUND EFFECT
Woman:	(LIGHTLY) Measles is a household word...No big deal.
OPERATOR:	SOUND EFFECT
Announcer:	(CHALLENGING) The truth? Measles is a very complicated disease...that could take your child to the hospital with pneumonia, heart disease, or even brain damage. (INVITINGLY) If your child is between nine months and fifteen years of age, ask your health authority about Measles Elimination Month. (TRIUMPHANTLY) And make measles...history.
OPERATOR:	CLOSING THEME

SPOT 3

OPERATOR:	CAMPAIGN THEME
Announcer:	(GRAVELY) Myths about measles. Myth Number Four:
OPERATOR:	SOUND EFFECT
Woman:	(DEFENSIVELY) My child has already had measles. He couldn't get it again. Why does he need a shot?
OPERATOR:	SOUND EFFECT
Announcer:	(ASSERTIVELY) The fact is: Many diseases LOOK like measles. (PERSUASIVELY) You can never be sure. (ASSERTIVELY) If your child is between nine months and fifteen years of age, ask your health authority about Measles Elimination Month. (TRIUMPHANTLY) And make measles...history.
OPERATOR:	CLOSING THEME

SPOT 4

OPERATOR:	CAMPAIGN THEME
Announcer:	(GRAVELY) Myths about measles. Myth Number Five:
OPERATOR:	SOUND EFFECT
Woman:	(DEFENSIVELY) My child's had her measles shot already. (DEFENSIVELY) Why does she need another one? And won't there be any side effects?
Announcer:	(PERSUASIVELY) Another shot can only reinforce and boost your child's immunity. (CATEGORICALLY) There IS no danger of side effects. (INVITINGLY) If your child is between nine months and fifteen years of age, ask your health authority about Measles Elimination Month. (TRIUMPHANTLY) And make measles...history.
OPERATOR:	CLOSING THEME

Exercise 4. Writing Your Own Radio Spot

Materials

Use a copy of the same Worksheet 20-1 as you did for the Caribbean example. You also need the following:

- Your communication objectives
- The messages (feasible behaviors) you selected for the radio channel
- Your creative brief for the radio productions
- Your enthusiasm and creativity to translate into radio language (sound) what you want to accomplish by using this channel of communication

Write a draft of a radio spot for your intervention. Present each spot to the other team members and together choose the best one. Check the script with a radio producer for technical improvements.

Note: Do not attempt to do anything more complex with radio if you do not have expertise. Full half-hour radio programs, interview type programs, dramas, and interactive programs need and require professional expertise. If you want to do anything

more ambitious than spots, hire someone already working in the medium. This person should have enough expertise to translate the content of your messages into the radio format so that it achieves your objectives.

Exercise 5. Pretesting Radio Spots

Materials

Copies of Pretesting Radio Spots

Instructions

Ask a team member to study this section and make a presentation to the rest of the team.
Keep a copy of this exercise at hand during the presentation to make sure the following key points are covered:

1. Preparing the pretest
   - Preparing the pretest material
   - Playing the tape
   - Identifying the tape in questionnaire
2. Doing the interview
   - Asking the question variables
3. Asking the comparison question

Pretesting Radio Spots

Preparing the Pretest Material

For purposes of pretesting, a radio spot is defined as a short announcement with a particular message. If there are several announcements for a single message, they will be referred to as versions of the same spot.

The radio spot should be recorded with all of the characteristics of a final production; i.e., complete with sound, special effects, and music. If there are no professional announcers in the office, staff members of the health communication office itself can, with proper guidance, record a spot with acceptable quality for pretesting purposes. In this way, you can avoid payments to professional actors or announcers for a spot that will probably be modified after the pretest.

If only one version is being pretested, it should be recorded two times in succession with a small pause between recordings. In this manner the respondent can hear the spot twice without having to turn off the tape recorder.

If there are two versions of the same spot, the cassette should be identified with the letters A and B to indicate two versions. Version A is recorded twice with a small pause between each taping, followed by a long pause. Then Version B is recorded two times in succession, followed by another long pause. Finally, the two versions are recorded in A-B order, followed by a long pause.

For the next interview, version B will first be recorded two times in succession, followed by a long pause. Then version A will be recorded two times, followed by a pause. And finally, both versions will be recorded in B-A order. At this point the recording stops.

If you are pretesting two different radio spots, record spot 1 first twice with a small pause in between, followed by a long pause. Then record spot 2 twice with a small pause between each. After a long pause record spot 2 twice, long pause, spot 1 twice.

Playing the Tape

If one radio spot is being pretested:

Play the audio tape which should have the spot repeated two times with a small interruption between each repetition.

If two versions of the same spot are being pretested:

The first interviewee will hear:
Version A (twice), short pause, Version B (twice) then A, B.
The second interviewee will hear:
Version B (twice), short pause, Version A (twice) then B, A.
After the second interview, the tape is rewound so that interviewee three will hear the same version as the first interviewee, and so on.

The order of the spot is alternated to ensure that no version is heard first by all the respondents.

If two different spots are pretested, play recording for first interviewee so he or she hears twice, spot 1 first then spot 2. The second respondent will hear the two different spots in reverse order, spot 2, then spot 1.

Identifying the Tape in Questionnaire

In the pretest questionnaire, a title is given to each radio spot version, so that there will be no confusion about which responses pertain to which version. This is necessary because versions will be alternated in successive interviews.

The Interview

Following your presentation and general questions, tell the person being interviewed that you are going to ask him or her to listen to a radio spot and to pay close attention.

Play the first recording. After it has finished playing, let the tape continue to run and ask him or her to listen to it one more time. Then, turn off the audio cassette tape player and proceed to ask the pretest questions.

Comprehension

1. Tell me, in your own words, what did the announcement (message) that you just heard say. (Be insistent.) What was the message transmitted by the announcement?
2. Are there any words in the announcement (message) whose meanings you do not understand?
   If the response is yes, identify the word and ask: What do you think that word (mention the word) might mean? Which word do you think should be used instead?

Acceptance

3. Is there anything said in the announcement (message) that you think is not true?
   If the answer is yes: What do you think is not true? What about it do you think it is not true?
4. Did the announcement (message) say anything that might upset or offend people from around here?
   If the answer is yes: What might upset them? What is offensive?

Attractiveness

5. What did you like most about the announcement (message) or what do you think others would like most?
6. Is there anything in the announcement (music, speech, persons talking, sounds) that you did not like or that you think others might not like? If the answer is yes: What did you not like? How would you say it so that you would like it?

Inducement to Action

7. What do you think this announcement (message) is asking you to do?
8. Are you willing to follow the advice being given? What would cause you to be willing to follow the advice or what would discourage you?

Involvement

9. To whom do you think the announcement (message) is directed? What about it makes you think that?
10. (In the case of a dramatization), do the people who speak in the announcement (message) talk the way people from here talk? Is the form of speech used in the announcement like the form of speech used here?

11. Is there anything in the announcement said in a different way here? If the answer is yes: What thing? How is that said around here?

If you are pretesting one spot, return to the beginning and play the recording again and allow the person being interviewed to listen to the version one more time.

Then ask,

General Opinion Question

12. In your opinion, what could be done to improve this announcement?

Two versions being pretested: Inform the person being interviewed that you want him or her to listen to another spot. Turn the tape player on again and have him or her listen to the second version twice. Turn off the tape player and ask the pretest questions. After the questions for the second version have been asked, tell the person that you now want him or her to listen to the two announcements together and to compare them. Play the two versions and then ask the following questions.

Comparison Questions

13. Which of the two announcements do you like best? Identify in the survey instrument the announcement the respondent selects, by its title, to avoid confusion when the two versions are played in reverse order.) Why do you like that announcement best?
14. If you had to prepare an announcement containing the best parts of each version, what parts would you choose from each?

Say good-bye to the person interviewed as indicated in the Mechanics for Individual Interviews. At the conclusion of the second interview, rewind the tape back to the beginning for the subsequent interview.

Exercise 6. Pretesting Radio Programs

Materials

Copies of Pretesting Radio Programs

Instructions

Ask team members to study the material in small groups.
Have teams point out the differences of radio-program pretesting versus radio-spot pretesting.

Pretesting Radio Programs

Even though it is suggested that you not attempt to create radio programs unless you

have the needed expertise, but instead contract them out with professionals, this does not mean you cannot pretest a radio program that has been produced. The following information will describe how to conduct such a pretest.
To pretest radio programs, it is necessary to know the following:

- Whether the radio program will be a one-time broadcast; i.e., whether it will be an individual broadcast and not part of a series of regularly scheduled radio programs
- Whether the program will be part of a regularly broadcast series of prerecorded programs on a number of different topics
- Whether the program will be part of a short series of programs prepared on a single topic, which will later be used as a series for training and dissemination purposes once production has been completed; for example, a series of four radio programs to be used together on how to nourish a child by means of exclusive breast-feeding during the first six months.
- Whether this will be a series of programs regularly broadcast live in the studio

In the first two cases, the pretesting of each individual radio program should follow the steps given for pretesting any type of educational communication material and evaluated in terms of the various pretest criteria.

For the two remaining cases, bear in mind that it is costly to pretest all of the radio programs in a series and that the task is virtually impossible if the programs are broadcast on a daily basis, even if they are prerecorded. Accordingly, what should be pretest in these latter two cases is not so much the comprehension of the message that a particular program transmits, but whether its format and structure are the most appropriate for transmitting an educational message in a comprehensible and convincing way.

The most appropriate technique for pretesting a radio program is to organize a focus group discussion. The rules and implementation of this technique are modified only slightly when pretesting radio programs. Questions on comprehension, attractiveness, acceptance, involvement, and inducement to action are similar to examples given in Question 19.

Specific considerations for pretesting radio programs with focus groups are as follows:

- Some of the questions in the pretest guidelines are related to the general pretest criteria. Others refer to specific aspects of the program (for example, format, dialogue, presentation, dramatization, or informational) or to specific aspects of the characters involved and of the individual messages being transmitted.
- If the program deals with several different messages, the facilitator should encourage the participants to name as many messages as possible and take note of the order in which the messages or topics are mentioned.

It is very important to take note of those messages that are least remembered or those that are not remembered at all. For example, if the program deals with the steps to be taken in the case of a child with an acute respiratory infection, the questions of comprehension might be as follows:

- What did the program say are the symptoms of an acute respiratory infection? (Write down the symptoms mentioned in the order that they are given.)
- What did the program say it is necessary to do when a child shows signs of having a respiratory infection? (Write down the responses mentioned in the order that they are given.)

If the program is a dramatization in which characters are used, it will be necessary to ask about the individual characters.

- Who do you think (mention each character) is? If the character is a representation of an average individual from the target population, it will be necessary to ask:

- Do you think that (mention the name of the character) is like people from here and does he or she talk like people from here?
  If the answer is no: How is he or his speech different? How should he speak in order to become or sound like the people from here?

After all of the questions have been asked, the group should be asked to listen to the program one more time. If it is a half-hour program, choose the most critical session. The tape is played once again and a final general question is posed to the group.

- What part or section of this program would you improve so that it would be more convincing regarding the messages being proposed?

Synthesis

1. A good radio spot accomplishes the following:
   Presents one idea
   Uses credible sources
   Breaks the mold
   Touches the heart and mind of the listener
   Stretches the listener's imagination
   Writes for the ear
   Writes for the individual
   Asks the listener to take action
   Shows consistency with all radio other spots

2. The components of a radio spot are the following:
   Sound effects
   Music
   Actors
   Voice inflections
   Instructions to the producer on what you want him to do

3. Any radio production more complex than a radio spot, generally should be contracted from a professional source.

4. The steps of a radio spot pretest are as follows:
   Setting the mood
   Asking the questions about comprehension, attractiveness, acceptance, involvement and inducement to action
   When comparing two different spots, making sure the spots are recorded in alternate order, one-two then two-one

5. The steps of pretesting a radio program are as follows:
   Determining type of radio program
   Mechanics of pretesting in a focus group situation; guide with questions regarding pretest variables of comprehension, acceptance, attractiveness, involvement, and inducement to action.

Application

1. Using the radio spot developed in the first part of this question, draft your pretest questionnaire following the guidelines just analyzed.
2. Pretest your radio spot or program in the field.

Worksheet 20-1

Create a Radio Spot

Main Message: Date:

Format: [Dramatization, dialogue, presentation, informational]

Title:

Length: [Remember to account for your music time]

Description/Voices:

Text:

Question 21

How Do We Recognize An Effective Television Spot? How Do We Pretest It?

Question 20 discussed the elements involved in making an effective radio spot. This question presents the criteria to help you (1) produce the creative brief your producers need to make the rough-cut TV spot; and (2) judge a rough-cut television spot presented to you by the production firm.

Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Discussed the 11 guidelines for judging an effective television spot
2. Completed an exercise in writing a television creative brief and concept development document
3. Studied the elements of a television spot storyboard and its components
4. Designed and carried out the pretest of a rough-cut TV spot
5. Listed the elements that go into a TV spot questionnaire
6. Developed a practice TV spot questionnaire
7. Designed your pretest questionnaire if you have a TV spot draft to be pretested

Exercise 1. Recognizing the Elements that Make Up an Effective TV Spot

Materials

Copies of 11 Guidelines for Judging a Rough-Cut of a Television Spot

Instructions

Have the team members read the guidelines and discuss the content among themselves to determine a common criteria for judging a draft TV spot or a TV spot storyboard.

Eleven Guidelines for Judging a Rough-Cut of a Television Spot

If you have to judge the quality of a rough-cut TV spot or storyboard presented to you by a production company, these 11 guidelines will help you.

Concept

1. **Does the TV spot present ONE main idea?** Each TV spot should have only one main message. If at all possible the message should be repeated at least twice. Singlemindedness and repetition are two key factors of success.

2. **Is the message relevant?** If the message is important to the life of the viewer, it will probably be remembered.

3. **Is the message research driven?** Your formative research gave you the directions and parameters to design your communication strategy and its messages. These research results must be seen to be clearly incorporated in the rough-cut presented for your judgment.

4. **Does the spot follow the communication strategy?** The spot should not only be on track using the research results, but it should also be responding to the communication strategy and the creative briefs you developed in Questions 16 and 17.

5. **Does the message have real life?** Health messages need to touch human experience and talk concretely to people in your target audience. Make sure the presentation of the message refers to real-life situations.

6. **Does it ask viewers to feel, believe, or take action.** Be explicit about what your audience should feel or believe to resolve their problem. Too frequently materials simply raise awareness of problems without asking a reaction from the audience. The cost of TV spots is too high to miss asking the target audience to react.

Production

7. **Use a credible source.** Feature a source(s) of information (public figure, doctor, nurse or sportsman) identified as credible by the target audience and who is appropriate for them.

8. **Touch the heart as well as the mind of the viewer.** Make the viewer feel something after watching the spot or program, such as being happy, confident, glad, or enthusiastic that they can achieve something by adopting the proposed behavior. Make them feel the spot is addressing them individually.

9. **Capture the viewer's attention.** All components of the presentation should grab the viewer's attention as soon as they see the spot. Make them feel part of the problem and the solution. Involve them with your images.

10. **Be unexpected.** The message is considered creative when it is novel, fresh, unusual, and original. Because of the unexpected, the message can break through the clutter and be recognized. Do not substitute intricate visual production for clarity. A very intricate, new visual approach (such as music videos) may be too complicated for your audience to understand.

11. **Provide consistency.** Develop a recognizable, consistent sound or identifier to be used in all of your materials. This can be provided by a unique voice or face, song, visual effect, or jingle, which is incorporated in all the TV material produced. This identifier provides continuity for all your materials.

Steps and Elements in Creating a TV Spot

TV has the potential to use sound and images simultaneously. This is its magic. It transmits live images of whatever you want to communicate, but this transmittance limits viewers' imaginations. They see, perceive, and assimilate what they are shown.

The production of a TV spot requires first a creative brief, then a concept development, and afterwards a storyboard that describes for the client (you and your audience) the audio and video elements that will be heard and seen on the screen. It requires hardware that usually includes a video camera, lighting equipment, and video tapes. All of this material must be handled by specialized crews that know how to use the equipment. Any attempt to do it yourself without the necessary training is a loss of time, effort, and money.

Exercise 2. Creating a TV Spot

Materials

Copies of Creative Brief, Concept Development, and Storyboard

Instructions

Ask team members to read the materials in small groups and then make presentations of the content to each other.
A joint summary of the steps and elements presented should be made.

Creative Brief

The firm you will contract with to produce the television spot needs to receive a creative brief from you in order to produce a concept development and then translate it into a storyboard.

Review the elements of a creative brief so you will remember the work done in Question 17.

Example 1. Measles Elimination in the Caribbean

Here is an example of the creative brief proposed by the communication team of the measles intervention.

The Creative Brief	
1.	**Target Audience(s)** • Parents of 9-month olds to 15-year-olds • Teenagers 12 to 15 years old • Health workers
2.	**Message** - Make measles history
3.	**Objectives** • To convince parents to have their children immunized against measles, regardless of previous vaccination status or previous history of measles • To convince teenagers to get immunized • To obtain health workers' support for this effort
4.	**Obstacles** • Parents think measles are not important/dangerous • Teenagers do not feel at danger, much less in need of a vaccine "for kids" • Health workers believe their credibility will be damaged if a new measles campaign is undertaken because it will make their previous effort seem inefficient • Health workers do not understand why a new measles campaign is necessary
5.	**Key Promise** - The Caribbean will be the first region in the world to be measles free.
6.	**Support Statements/Reasons Why** • Many diseases look like measles. You cannot always be sure that your child has had the disease. • This is the last shot your child will ever need against measles. • Measles is still around in the Caribbean. Just last year, there were more than 4,000 cases. • Of all preventable diseases, measles is the biggest killer.
7.	**Tone** • Challenging • Triumphant • Reassuring
8.	**Media/Format** • TV • Radio
9.	**Creative Considerations** • Parents are responsible for their children's health. This is their chance for protecting them. • Teenagers' participation in the campaign makes a difference to its success. • Teenagers' can also make history by providing role models for their younger siblings. • Health workers care for people. They play a key role in the nation's health.

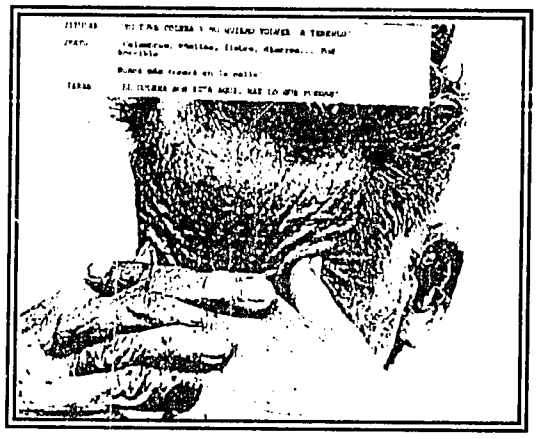
Concept Development

The creative brief gives the television production firm the essential information it needs to proceed with a concept development.

The concept development is basically a picture (drawing or illustration from a magazine fitting the purpose, or a photograph) with the potential text ideas the spot will include. It is presented to you for approval as the first step toward developing the spot. If the concept development meets all the requirements you have included in the creative brief, then the firm proceeds to make the storyboard, which will show the essential elements (audio and visual) of the television spot.

Concept development is very important because it shows you immediately how well the firm has understood the essential information, including the research results and the communication strategy (and objectives) you have given it. At this point it is easy to correct misunderstandings.

Ask for the Concept Development before the Storyboard is Made



Here are two examples of concept developments made by an advertising firm in Ecuador for a Cholera campaign. Study them and make an analysis to see if, by looking at both examples, you can find all the elements presented to the firm during their creative brief meeting. They are:

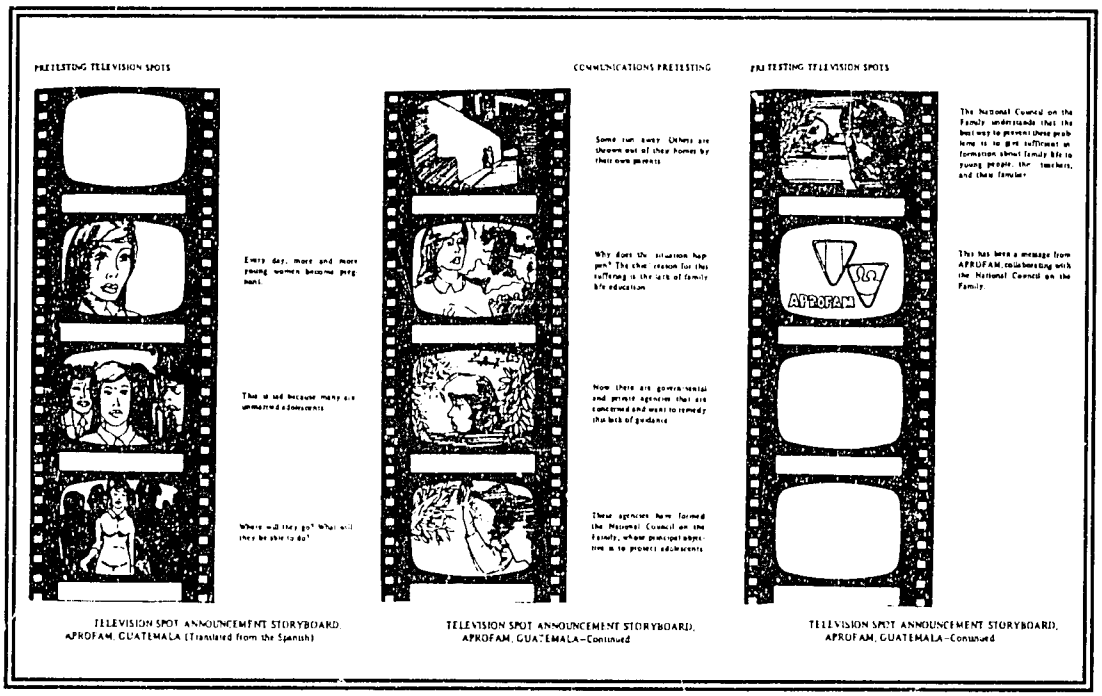
- Media/format
- Message
- Target audience
- Objectives

- Obstacles
- Key benefit
- Support statement/reasons why
- Tone
- Creative considerations

Storyboard

The creative brief and concept development are normally turned into a storyboard that is presented to you. The storyboard has the text of the spot accompanied by the key images or scenes of the spot as one would see it on the television screen. There will be sufficient number of these drawings to match the lines said by the actors or the voiceover, as well as an adequate number of squares to give a full idea of the sequence of the visual images.

Here is an example of a storyboard. Be sure to ask your production firm for one similar to this one. You will then be able to judge how well the firm has translated your research findings, communication objectives, creative brief, and concept development.



TELEVISION SPOT ANNOUNCEMENT STORYBOARD. APROFAM, GUATEMALA (Translated from the Spanish)

TELEVISION SPOT ANNOUNCEMENT STORYBOARD. APROFAM, GUATEMALA—Continued

TELEVISION SPOT ANNOUNCEMENT STORYBOARD. APROFAM, GUATEMALA—Continued

With your storyboard you are ready to do your TV spot pretest

Pretesting a Television Spot

You are now aware of the steps necessary to produce an effective TV spot. The next step is to pretest the spot with members of the target audience.

Exercise 3. Preparing Your Pretest TV Spot

Materials

Copies of the Pretest Formats

Instructions

Read each of the following points about prestst formats in a group setting.
Stop and comment on each step to make sure the main concepts have been understood by team members. Take as much time as needed.
If everyone is not clear, read the text again and discuss it.
If help is needed, you may invite an expert in pretesting TV spots from an advertising agency to join you. He or she may have a slightly different approach than the one explained here, but the process will be similar.

Pretest Formats

The TV spot you wish to pretest can be shown to your target audience in different formats. You will select those that are easiest and most economical for you. The pretest format options you have:

- **Storyboard plus tape.** The basic way of preparing a TV spot for pretest purposes is to have an artist make a storyboard of the main scenes of the spot. The storyboard is accompanied by an audio-cassette of the suggested text with the recording of the voices of the people appearing in the drawings or just a voice-over for the corresponding drawing. A different voice should be matched to each character. The taping does not need to be a finished studio production. It can be done by team members or others that you know.

- **Animation of the storyboard.** This is done by videotaping each drawing of the storyboard in such a way that it gives the impression of movement. The producers make use of all the technical possibilities available to them: close-ups, zoom outs, camera left or right pans, fades in or out, vertical pans, full shots of the squares, or super closeups of fine details. These camera movements provide a visual sensation of movement, very much like the limited animated cartoons so common in television. The videotape will have the sound track with voice over images of the text to be heard as it was on the air.

NOTE: Which format alternative is best for pretesting? There is no right answer. It will depend on your available resources, time, and the circumstances in which the pretesting will be conducted. You will have to weigh these factors and make your choice.

Setting up the pretest session

- **Site.** A TV spot pretest is best done within a focus group discussion because you must get people to come to where the TV monitor and VCR are. When a VCR is not available, then the storyboard plus an audiotape of the text will have to substitute for it. It is very important that the audiotape be used with every audience. The moderator should not explain the storyboard. The audiotape does it. In this manner, subjective explanations are avoided.

  Select a place where the people attending the session will not be bothered by surrounding noises that will interfere with the audio of the spot.

- **Time.** Be sure to select an hour when most people can come to the session. Usually this will have to be done in the evening when most people are free from work and household chores. Be sure to confirm it.

- **Electricity.** There are places where a sustained electrical power is not guaranteed, although most people in the vicinity can see television when there is electricity. If this is a problem, be sure to bring along a power unit source to avoid having to cancel or stop the session because of a lack of electricity.

- **Selection of participants.** Remember to apply to your participants the selection criteria presented in Question 19. The people attending the focus group should be representative of the target audience to which you are directing your spot. The characteristics of that audience have been well defined in your communication objectives and channel of communication selection. Use the same criteria to choose your pretest audience. The number that will work well in this type of session is from eight to twelve participants. Remember to invite more than this number because, as a general rule, three to five of those invited will not show up. Three to five focus groups for each segment of your audience should give you enough information to see a pattern and think that you understand the target audience's reactions.

Conducting the pretest session

- **Seating arrangement.** The best seating arrangement for this type of session is a semicircle around the TV monitor or the person showing the storyboard.

Make sure in advance that all participants can hear and see well from where they are sitting.

- Setting the mood. Welcome all participants. Tell them briefly why they have been invited; e.g., to help the Ministry of Health determine if a rough-cut of a television spot that has been prepared is clear enough for people like them to understand without any difficulty; if it is culturally appropriate; if it tells people clearly what to do; and if it is unoffensive to everybody. Follow the rules of focus group sessions.

- Playing the videotape play-back of rough-cut TV spot. Make sure your videotape has the spot taped two times with a short interval between each taping. It is best that you show them the spot more than once (at least twice), so they can answer the individual questionnaire on comprehension with sufficient recall of the spot and its details.

  Some theoreticians suggest that to test recall, it is best that your spot be presented with other typical commercial spots from the time slot in which yours will be aired. This approach will enable you to see how much your spot captures the attention of the viewer when it is competing with other commercial spots.

  If you want to use this approach to test recall, have the producers tape your spot with real-life actors as it would appear on the TV screen. Otherwise an animated spot among true commercials will either stand out too much by contrast or it will not have an equal chance for competition because it lacks the professional finish quality of the others.

- Applying the questionnaire. Even if you are pretesting your TV spot with a focus group discussion, you want to make sure you capture the individual's comprehension and acceptance levels before the group discussion takes place. In this way, you can prevent confusing the group consensus with what people understood individually from your spot.

  After the spot has been played, distribute your individual questionnaire with the questions that test levels of comprehension and acceptance of the spot. The questionnaires can be self-administered, and the person presenting the spot can individually help those that may have questions regarding how to answer any given question. This, of course, requires a literate audience. If you need to test with a nonliterate audience, enough helpers should be present to help administer the questionnaire individually.

Example 2. Pretest TV Spot Questionnaire with Core Questions

Case Number _____
TV Spot (identification): _____

1. Please tell me in your own words what the spot said
   (What was the message of the spot?)

_____
_____

2. Did you feel that the spot was asking you to do something in particular?

   1. _____Yes
   2. _____No
   9. _____Don't know

   2a. IF YES, what?

_____

3. Did the spot say anything you do not believe to be true? Or unacceptable?

   1. _____Yes
   2. _____No
   9. _____Don't know

3a. What was not true? Unacceptable?

4. Did the spot say anything that might bother or offend people who live in (name of community)?

   1. _____Yes
   2. _____No
   9. _____Don't know

4a. IF YES: What? _____
_____
_____

5. Was there anything about the spot that you particularly liked?

   1. _____Yes
   2. _____No
   9. _____Don't know

5a. IF YES: What? _____
_____
_____

6. Was there anything about the spot that you particularly disliked?

1. _____Yes
2. _____No
9. _____Don't know

6a. IF YES: What? _____
_____
_____

7. What could be done to make this a better spot?
_____
_____
_____
_____

Comparative Questions (if it applies)

8. You have just seen the two TV spots again. Of the two, which did you like best?

1. _____Title 1
2. _____Title 2
9. _____Don't know, indifferent, liked them both

9. Why did you like this spot better than the other? (VERBATIM)
_____
_____
_____

- **Carrying out the group session.** After the individual questionnaires are completed and collected, the facilitator will carry out the focus group using a discussion guide that will help keep him or her focused on the major issues to be pretested.

What does such a discussion guide look like? Here is an example.

Example 3. TV Spot Pretest Discussion Guide

Introduction

You have just seen the spot and have answered an individual questionnaire that will let us know what each one of you thinks of the TV spot and what it tried to say.

We would like now to spend some time with you discussing other aspects of the TV spot that are very important for us to be sure we have your opinions.

Comprehension

We will start by finding out what group members think was the main message or idea the spot wanted to communicate.

If there are discrepancies in the opinions, try to find out the reason for the differences with questions like these:

- Mr... says that the spot wanted to say...., but Ms... thinks the spot really was trying to say the following....
- Is there anyone else that has a similar or different opinion? Is there anyone who would like to add to what has been said?
- Is there any image or symbol that you think is not clear. What about it is not clear?

After you have established the two or three most common ideas as the position of the group, go on to the next section.

Acceptance

The objective is to identify the kind and importance of rejection felt by group members toward any aspect of the spot. The following types of questions will help:

- Is there anything shown in the spot that may offend anyone seeing it on television?
- Is there any word or expression that may be offensive or not correctly said? If so, how can we change it (them) so it (they(will not be offensive?
- Is there any object, or person in the spot that is not believable; that needs to be changed to make it easier to accept?
- If you had the opportunity to change any character or speech to make it more acceptable, what would you change and for what reason?

Attraction

The objective is to find out if anything in the spot repels the target audience visually or audibly. The following type of questions will help accomplish the goal:

- We would now like to find out if there is anything that you did like about the television spot. What did you like about it?

(Be sure to stimulate as many of the participants as possible to answer this and the other questions.)

- Was there anything you did not like in the spot, such as the characters, tone of the speech, dresses, hairdos, situation depicted, props, colors, music, or the way the sequence is put together? (Ask as many of these individually as you can.)

Inducement to Action

The objective of this section is to decide if the spot suggests clearly the action or behavior you wish the target audience to adopt. The following types of questions will elicit that information:

- Does the spot say that you must do something? If so, what precisely is the spot asking you to do? If nobody has a clear opinion, probe to find out why they feel there is no clear indication of what it wants them to do.
- Is it because the language is not clear, or the sequence of the images too fast or too complicated?
- What would you change to make the message more clear about what you should do after seeing the spot?

Remember, try to probe as much as possible for the reasons why the participants do not accept or understand the behavior suggested. These are key findings to show how the spot can be improved.

Summarize and thank participants

To make sure all ideas are clear and in accordance with the participants', opinions, prepare a summary of their major suggestions following the above sequence. In this way, you are sure you have understood the group's opinion on all of the issues discussed.

Thank them for their cooperation and bid them good bye. Sit down immediately with the observer or assistant and make a summary of the major findings, agreements, and disagreements for each major point so that the most salient aspects are captured freshly with the audience's own expressions and words.

Synthesis

1. The guidelines of an effective television spot are as follows:

   - Present one main idea
   - Make sure messages are relevant, be research-driven, be based on the communication strategy, and feature real-life situations
   - Ask viewers to take action whenever possible
   - Use a credible voice/person(s)
   - Touch the heart as well as the mind of the viewer
   - Capture the viewers imagination
   - Be unexpected
   - Provide consistency

2. The steps and elements of creating a TV spot: creative brief, concept development, and storyboard

3. The pretest of a TV spot requires the following:

   - Preparation of the TV spot either by storyboard and audiotape or by videotaping the storyboard
   - Individual pretest questionnaire for comprehension and inducement to action
   - Focus group:
     Screening
     Setting, hour, conditions for showing spot
     Conducting correctly the session
     Setting the mood
     Presenting the spot, repeating two times
     Giving out the individual questionnaire
     Making the group discuss questions of attraction and acceptance
     Summarizing the session at the conclusion of the discussion
     Thanking them
     Making a summary, with assistant, of the most relevant findings

Application

1. If you have already decided on a TV spot for your intervention, prepare a creative brief for the advertising agency.
2. Have your team do an exercise drawing up the pretest questionnaire of one of the television spots of the Ministry of Health that has been aired recently. Get a copy of it so that you can see it as many times as necessary to determine what specific questions must be asked of that particular spot to find out the variables of pretesting.

3. If you already have a storyboard being done for you by the organization that will produce the TV spot, do the pretest questionnaire for that storyboard. Be sure to check the questionnaire with the pretest variables that have been studied in this question.

Step 4

Deliver

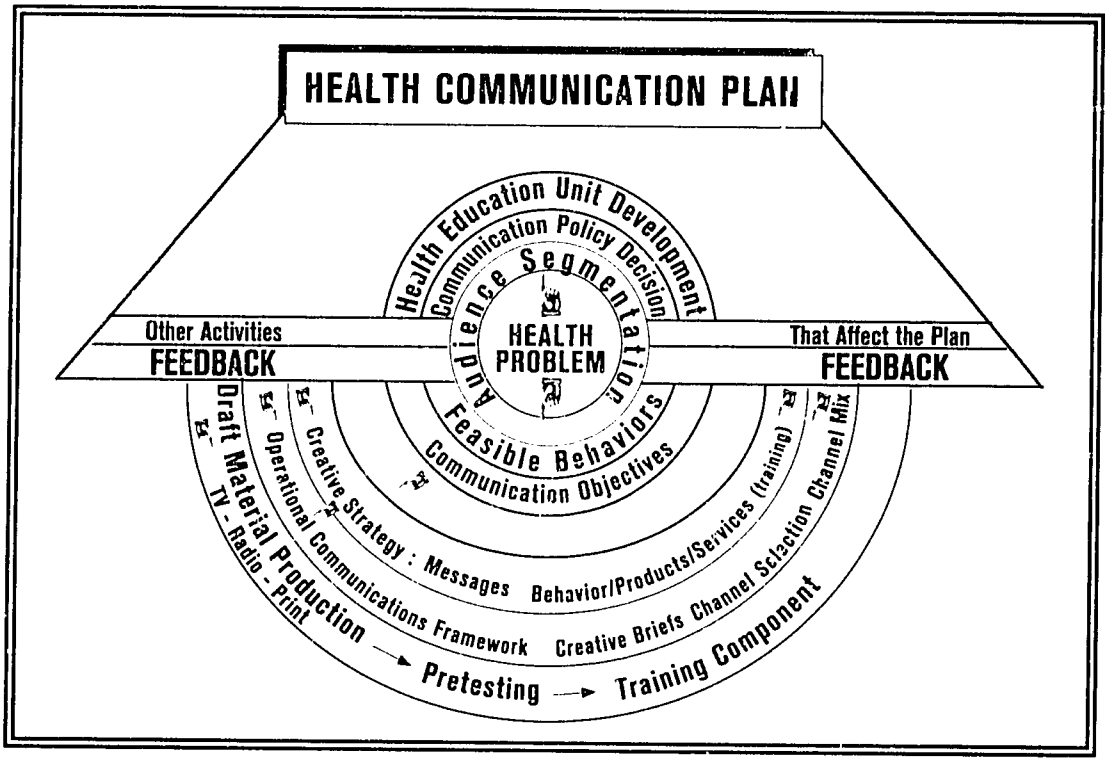
Questions 22 - 23

Question 22

How Do We Make Sure Our Training Reflects Our Health Communication Plan?

Questions 18-21 dealt in depth with the steps involved in designing your pilot materials and pretesting them before the final professional production stage. This question examines the elements needed to design and carry out the training of those individuals (health workers or volunteers) who will act as personal channels with the target audience, either by delivering services or by acting as agents of promotion and behavior change.

The training of this personal channel is often a key component in the implementation phase. It follows pretesting because the materials and messages you have produced are used as part of the training. Participants learn the skills and attitudes they need to play the role called for in your health communication plan. Training appears in the graphic in the following position:



Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Explained the link between training and communication messages and materials thus far produced
2. Listed the steps involved in designing an effective training session for health workers, taking into account adult learning criteria
3. Described the similarity between behavior change in training and in your intervention
4. Written a training organization plan (Worksheet 22)

Introductory Note

Training is a major step in the implementation of your communication activities. It is the opportunity to make the best use of one of the most effective channels for promoting and supporting behavior change: interpersonal or face-to-face communication. Few communication plans are complete without an interpersonal communication channel. It is key for reinforcing the massive reach of the media and adds the element of personal contact. HEALTHCOM has confirmed that while mass media reaches more people, interpersonal communication is much more persuasive on an individual basis. Elements of trust and concern, as well as the opportunity to raise doubts and seek information, contribute to the power of this interaction.

Interpersonal communication allows for dialogue with the target audience. Other channels (mass media, print) function on the premise that the target audience is for the most part a receiver and not a sender of messages.

The training session provides an opportunity for trainers to model the interaction they hope the health workers (or others being trained to communicate with clients) will establish with their audiences. Trainers listen carefully to participants, responding to their questions, objections, and reservations, and to the constraints the participants see to the new program, behaviors, and messages. The trainers can detect tensions, discomfort, and confusion and can work to negotiate behaviors that are acceptable and comfortable for the participants so they can adopt and sustain them in the field situation. Feedback from the participants can clarify questions about the work situation and the group norms of the participants and thus provide valuable information to program staff. This respectful dialogue is a compelling model for participants to use in their own interactions with their clients and should be discussed explicitly as a model for communication during training.

Background Information

Defining the audience for training is similar to finding the target audience for the health problem and the formative research. Who, then, is the target audience of the training?

There are many potential target audiences for training. You want to choose those who can be most helpful, credible, and influential, and who can be in direct contact with the target audience of your intervention.

These individuals are those who will do the following:

- Eventually use your communication materials
- Deliver the services being promoted through the communication messages/materials
- Be in charge of reinforcing the messages transmitted by other communication materials/channels

These people are generally health workers. They also can be pharmacists, traditional healers, teachers, or respected mothers in the community. These individuals are those people whom your audience trusts to provide credible information.

For this question, training for health workers has been selected because they provide direct service to the target audience. They are the target audience for the training sessions, and their interaction with mothers is the focus of training.

The design and atmosphere you provide in your training is critical to creating an environment in which health workers feel comfortable enough to learn and try out new ways of thinking and behaving. Health workers will tend to treat target audiences in the same way that they are treated during training sessions. It is therefore critical that you design your training so that the way participants are treated models the way you wish the health workers to behave with mothers.

Training Content

Training for the communication portion of an intervention is not the usual technical training about the composition of vaccines, temperature standards of cold chains, or storage quality control for ORS. Instead it deals with the following:

- Understanding feasible behaviors, using the steps identified in Question 15
- Communication objectives

It is common to find that most training participants do not understand why mothers

behave the way they do, think the way they do, believe what they believe, or feel as they feel. They have not had the time to gain an understanding of mothers' behaviors nor seen the importance.

By sharing the results of your formative research in training, participants will gain new understanding of the actual behaviors and the reasons mothers choose them. Training is the best setting to share this new knowledge with participants, so they understand the context in which the communication plan was developed, including identification of feasible behaviors. Then they will be able to understand their role in influencing the target audience in adopting these behaviors.

In Honduras, for example, formative research uncovered the belief of some mothers that their children are born with worms. They believe these worms stay in a sack inside the stomach and are quite content there until the child eats dirt, when they become excited and wander out of the sack into the body. When this happens, the mothers say, the child has a specific type of diarrhea that has its own particular treatment and is not subject to diarrhea medicine. All health workers should learn to listen for similar ideas, so they can discuss them without offending or confusing the target audience.

It is crucial that your participants are familiar with the communication materials and understand the strategic and communication objectives each piece is designed to achieve. They also must understand how each piece fits into the overall strategy and how it is linked to the other materials.

The communication channel mix gives the overall strategy its strength. The entire package must be understood by the participants, including how the messages contribute to achieving behavior changes; e.g., the radio explains the signs of dehydration, a counseling card with the same diagram as a poster that hangs in the health center is used by health workers when explaining signs of dehydration to waiting mothers, and, finally, the mothers find the same signs of dehydration in a replication of the poster on the brochure they take home after their child is treated for diarrhea at the center.

Your communication messages are at the core of the training content because they are the product of your formative research, communication objectives, and pretest results.

Training should feature the actual materials the communication intervention will be using. If these are not available, drafts can be used. If at all possible, these drafts should be pretested with the participants, because they will have to feel confident that

they can use them. They should see the materials as an aid in their work rather than an additional burden. The training has to teach participants the correct use of these materials, why they have been designed the way they have, and what they are expected to achieve.

Health workers are the secondary audience for the material. Their confidence in the material, how easy they find it to use, and their expectation that its use will have positive outcomes will determine whether they will actually use the materials effectively in their work or at all. This is especially pertinent when the materials are designed to interact with other communication activities, such as radio programming, loudspeaker messages, and in-school activities.

The health worker role can be seen in relation to all other materials in the following chart:

Item	Use/Action	Reason
Radio Message: A baby with signs of dehydration is in danger of dying	Endorse, repeat at the health center	Mothers know signs of dehydration but do not associate them with death
Material: Counseling cards for ORS packet mix	Use them with mothers to teach correct mixture of ORS	Mothers have exact concept of a liter, but are not familiar with ORS packets

The following exercise should be done with all messages and materials so that it is clear to trainers what must be covered during the training.

Exercise 1. Understanding Different Training Styles

Materials

Paper and pencils
Copies of Example 1, Training Styles
Descriptions of Training Styles

Instructions

In small groups, read this material.
Give each style example a name and write out a brief description of that kind of training.
Compare what you have written with the descriptions of training styles and answer the questions in the example for each type of training.

Example 1. Training Styles

Style 1. You walk in and find a group of health workers in a room that very much resembles a classroom. There is a table at the front with the trainer seated behind it. Health workers sit in a classroom format; i.e., chairs are in a single row.

The trainer stands behind his table, walks to the front of the group, and reads from a training manual. The participants busily write what he is dictating. During the first hour, the trainer reads technical reasons for immunizing a child five times during his or her first year.

At one point, he stops to go to a blackboard and jots down three technical terms he thinks the participants are not familiar with: hemoglobin levels, plasma density, and sero-active reagents. He reads the terms while looking at the board. One of the participants raises his hand to ask clarification of the words he has written. Even though it is clear that the trainer has seen the hand, he continues with his reading.

When he finishes the text, he says, "Our time for this session is finished. If there are any questions please try to remember them for the next session, which will start in five minutes. You may now stand up, but please do not leave the room since we will continue as soon as the five minute break is over."

- What is a name for this type of training?
- What are its characteristics?
- Is this typical of training sessions you have participated in or observed?
- How did you feel in such training sessions?

Style 2. You walk into a training session The participants sit in a semicircle and the trainer stands to one side where there is a flip chart with an outline of points to be covered.

The trainer has given out a summary of the main concepts she wishes to cover. She organizes the participants into small working groups and asks each to prepare a section of the content during the next half hour. Each group presents what it has prepared to the other groups.

After each group presents their portion of the summary, the trainer asks if there are any points they feel have been overlooked. In this manner she assures herself that everyone has a chance to discuss what he or she has prepared. If there are any further points missing, the trainer will add them. If during the presentation the group has not used a flip chart page to illustrate their points, she uses one to do a visual summary.

- How does this session differ from the previous type of training?
- What is the main difference?
- What is a name for this kind of training?
- Is this typical of training sessions you have participated in or observed?
- How did you feel in such training sessions?

Style 3. You walk into the training room and find the participants sitting in a semicircle. The trainer gives the following instructions:

> We will try to understand the problem we are dealing with based on your previous experience. Please divide yourselves into working groups and within each group list the different ways each of you has experienced the problem of dropout in immunization coverage. Group all the points that are common and organize them according to the frequency of occurrence. Put the most frequent problem at the top of the list.

Each group then presents to the other groups their findings and how they have ordered the problems.

After that is done, the trainer asks participants to return to their groups and for a half hour find solutions to the problems presented. At the end of the half hour, he asks one of the groups to present to the others how far it has advanced in finding solutions. He invites anyone from the other groups to offer solutions they have found to complement what has been presented.

The trainer then gives each group a list of solutions (some technical, some logistical, some involving training, others service quality, and still others involving the mothers's point of view). He asks the groups to choose from that list those solutions that would complement those offered by the presenting group.

At the end of another half hour he asks a second group to present the original solutions it proposed to the problems and the ones they chose as complementary.
He concludes the session by making a comprehensive list of all the major problems determined by the groups and in a second column the major solutions they agreed on.

- How does this session differ from the previous types of training?
- What seems to be the key difference between this and the second example?
- Have you participated in or observed a training session similar to this?
- How did you feel in such training sessions?

Descriptions of Training Styles

The following names are given to each of the training styles, along with the description of the characteristics that define each style. Compare these names and descriptions to your answers to the questions at the end of each example.

Classroom Format - Style 1. This typical situation, in which the teacher is the owner of the knowledge to be imparted and the student is a passive recipient who dares not ask questions for the risk of been ridiculed, sanctioned, or seeming incompetent,

is based on the traditional classroom model. The main actor is the teacher, not the students, and he or she directs and controls the learning process. Students are asked to open their minds to the voice of the teacher and receive the content the teacher wants to impart during the session.

Participatory Training - Style 2. In this type of training the roles of training and participant are more equal. The trainer is no longer the main actor. The participants take an equally active role and involve themselves deeply in the process of learning by multiple forms of participation. They learn actively, not passively. They are encouraged to ask questions, try new approaches, send immediate feedback to the trainer, and apply what they have learned.

In this form of training the trainer is a facilitator. He or she is no longer the possessor of knowledge nor the sole depository of a particular technical content. Instead, the trainer facilitates the learning process for participants, conscious that even though there may be technical content the participants do not know, his or her commitment is to help them learn in an interactive manner.

Experiential Adult Learning - Style 3. This type of training builds on the participatory model by adding an important factor. It acknowledges (and accepts with all its consequences) the fact that those coming to be trained are not children. They are adults and must be treated as such. They have a life of experience, including work experience, which enables them to add reality to theory.

Several principles of the adult learning process which you will learn in the next exercise, must be taken into consideration when designing a training session. Some have been researched by adult educators such as Jane Vella (*Learning to Listen, Learning to Teach,* 1994, pp. 3-22).

Exercise 2. Principles of Adult Learning

Materials

Paper and pencils
Copies of Ten Principles of Adult Learning

Instructions

Have team members list the ten principles and ask them to describe what each is about.
The titles of the principles are as follows:

1. Adults already know many things
2. Learning adults need a safety zone

3. Behavior change must be sequential and reinforced
4. Practice should be followed by reflection
5. Ideas, feelings, and actions contribute to learning
6. Sound relationships and clear roles need to be established
7. Teamwork in small groups works best
8. Participants need to be actively engaged
9. Honest dialogue among participants must take place
10. Accountability must be included

After they complete this task ask them to compare their comments on each of the principles with the following descriptions.

Ten Principles of Adult Learning

1. Adults already know many things

Before designing your training, find out what the participants already know about your topic and what they will need to know to adopt the behaviors that will support your intervention. Participants can help you decide what they realistically can do, would be willing to do, and what makes sense for them to do in their situation.

2. Learning adults need a safety zone

A safe environment in training allows and encourages participants to express themselves honestly and comfortably when they are ready. To ask questions and share doubts, disagreements, or items that they do not know but wish to learn requires participants to feel comfortable. The trainer has to think ahead and plan to create a safe environment. Often, when participants perceive that they are different in status or in place within a hierarchy, they find it difficult to disagree or state their opinions openly. Nurses in discussions with doctors, for example, may find it difficult to speak openly unless the trainer has created a situation in which they feel their comments are welcome.

3. Behavior change must be sequential and reinforced

Adults prefer to learn new ideas and behaviors following a logical sequence, from simpler to more complex, from slow to fast, and from practice supported by the group during training to practice alone on the job. Adopting the new behavior should be reinforced positively at each step. A health worker, for example, needs to have supervised practice with supportive feedback so she understands how to correctly mix oral rehydration solution and teach mothers in the same way she was taught.

4. Practice should be followed by reflection

Adults learn from doing. Training should give people the opportunity to practice new skills or apply new concepts and to reflect on the experience immediately. Considering what was done, why it was done, how it was done, and what the consequences were of

doing it that way helps learners to understand the practice or concept and to think of ways to use them in other situations or in different ways. Practice with reflection helps learners internalize the new learning. New concepts or skills by themselves have little or no value for a learner unless they are related to a problem that he or she recognizes or a behavior that he or she finds useful and that provides positive reinforcement and motivation when practiced. Concepts applied and reflected upon can become action guidelines. They can become meaningful and useful tools for their work rather than additional burdens.

5. Ideas, feelings, and actions contribute to learning

Learners retain 20 percent of what they hear, 40 percent of what they hear and see, and 80 percent of what they hear, see, and do. Integrated adult learning must involve the learner in as many ways as possible in thinking, feeling and doing. Telling mothers about Vitamin-A-rich food is less meaningful than involving them in preparing the food and enjoying it. Training is effective to the extent that it involves more than the intellectual aspects of a new concept or practice.

6. Sound relationships and clear roles need to be established

Adults learn best in a climate of mutual respect and trust. Everyone needs to know what is expected of trainers, participants, and the training. Each participant needs to know what he or she is expected to contribute and to gain from the training. Participative training should not be confusion or chaos. All members of the group need to feel they are important, taken seriously, and have important ideas and knowledge to share. Relationships are not those of teacher/student, nor child/parent. Group members are professionals among professionals learning together with an active voice in the process of learning.

7. Teamwork in small groups works best

Adult training provides participants with opportunities to practice communication and team-building skills in small groups. While carrying out training activities, participants learn how to use and accept principles of giving and receiving feedback and providing and accepting supportive reinforcement for new practices. The result of this interaction is improved ways of learning.

8. Participants need to be actively engaged

People learn more if they are involved in learning and applying what they are learning than when they merely listen to someone talk about a subject. The level of engagement of learners in discussions and dialogue is not only an indication of their learning, it is how they learn. Open questions put to members of small groups who are given the materials and resources they need to respond put participants in a position to react effectively. When the groups begin to work on the problems in this way, engagement is taking place.

9. Honest dialogue among participants must take place

In adult learning, the facilitator learns from the participants when there is open dialogue in which honest sharing is taking place. This open dialogue, where the facilitator is learning and the participants are opening up, becomes the training content.

Open dialogue is the only way either party can accept any type of risk (criticism by the group, acknowledging ignorance, or being laughed at). Without risking these outcomes, the true interchange needed for learning does not occur.

10. Accountability must be included

Adults need the reinforcing factor of knowing what learning they will be accountable for when the training is finished. The trainer is responsible for working with the participants to translate what will be learned into specific knowledge and behavior objectives. After this is done, tasks and evaluation indicators can be developed. The trainer is accountable to the learner to do everything needed to make training effective. The participant is accountable for taking the responsibility to learn and apply this learning.

Training Is Behavior Change

Training is one of the most powerful tools for behavior change. To assure that participants not only leave training able to carry out the new practices but continue to use them in field situations, you will need to use the same tools of behavior analysis that you would use to encourage and sustain behavior change in any audience. You can use audience research, in this case with the health worker or other potential participants as your audience, to help identify a realistic behavioral objective for your training. Here are some questions to consider.

- What behaviors would health workers find feasible and sensible, given the competing demands on their time and energy?
- How can this new behavior be planned to fit smoothly into their daily schedule?
- What job aides and reminders could help them apply the new skills more easily and effectively so they will continue to use them?
- What are the barriers to and benefits of the new behavior?
- Why would they want to do it?
- What can be done to decrease the barriers and increase the benefits?
- How can we ensure positive outcomes of the new behavior?
- How can we reward and reinforce the new behavior?

Often the behaviors needed to improve services or communication are relatively simple: delivering priority information, treating clients with respect, or listening to their questions. The problem is often not that participants do not know how to perform the behavior, but that they choose not to because of competing demands on their time and energy or they lack the time or self-confidence. Perhaps they doubt the behavior will

pay off in ways they value. In other words, the same barriers and benefits that are considered for other audiences must be considered when designing training.

Reflecting on Field Experience

Example 2. Health Worker Training

In a West African country, researchers found mothers were not completing their children's vaccination series. Mothers said they did not like to visit health centers for vaccinations, because health workers treated them badly and did not talk to them, making the experience unpleasant and confusing.

What was happening? The health workers were concerned about falling coverage and completion rates, but could see no way other than scolding the mothers to encourage them to change their behavior. Mothers resented the scolding and reacted by staying away from the centers. In addition, mothers often did not know how many vaccinations their children needed or when they were scheduled to return to the center. Health workers were not providing this information.

Health education team members decided that workers were aware that a problem of coverage existed, but did not know an effective solution. They did not feel comfortable or skilled in talking to mothers and did not expect a positive outcome from the investment of time and energy in doing so. Training content, therefore, focussed on developing an understanding of the mothers' perspective.

Health workers discussed the mothers' perceptions that health workers treated them poorly and the negative impact these perceptions had on mothers' return rates. They discussed ways they could provide a more positive experience. In addition, they practiced feasible ways to provide the needed information to mothers in the very limited time they had available. Practice during training helped them feel confident that they could talk with mothers without risking looking foolish or losing control of the interaction.

Three to seven months after the training, observation of health worker-mother interaction in the field showed that those who had participated in the training continued to perform consistently and significantly better in all categories than untrained workers in similar situations.

What motivated this improvement and sustained it? Health workers who were trained differed from untrained workers by having more confidence that their behavior affected mothers' behavior. Health workers who expected their interaction with mothers to have positive outcomes were more likely than those who did not to practice the desired behaviors of treating mothers well and providing the information mothers needed.

Understanding what the research told them about how much impact their behavior had on mothers helped to motivate workers to adopt and maintain the new behaviors despite the additional time they required. Because the training addressed such behavioral issues as expected outcomes, skills, and self-efficacy, it was able to have greater impact on health worker behavior.

Example 3. Practicing New Behaviors in Training

In another West African country, observation showed that the contact between health workers and mothers during a busy vaccination session averaged around 30 seconds. The standard set of messages a vaccinator was asked to deliver during this interaction required two minutes. Clearly this was not feasible, and therefore the vaccinators did not attempt the behavior. When the messages were narrowed to a priority two or three (based on what mothers said were key for them), and trainers and health workers came up with a way of delivering them in less than a minute, the practices improved. Vaccinators practiced the behavior in training so that they were certain they could talk to mothers without compromising their commitment to delivering the vaccinations with safety and care.

Exercise 3. Steps to Effective Training

Materials

Copies of the Guide to Organizing a Training Session

Instructions

Ask members of your team to study the guide and discuss among themselves if there is anything missing. If so, add these missing elements and use the guide to design your training session.

Guide to Organizing a Training Session

1. Determine the content of the training
2. Determine what audience needs what training
3. Why is the audience not performing the desired behavior now?
   - If they cannot do it, train them to understand and perform it
   - If they will not do it, provide motivation for them to change their attitude
4. Determine the benefits of and barriers to adopting the new behavior
5. Decide what behavior is feasible
6. Determine what would reinforce the behavior when adopted
7. Establish measurable training objectives
8. Define very clearly the content to be learned
9. Organize content for logical learning
10. Determine and develop learning materials
11. Develop materials presentations

12. Develop and organize administrative procedures
13. Analyze tasks and define the kinds of skills to be acquired or practiced: reaction skills, perception skills, conceptual skills, application skills
14. Determine the learning process to be used: visual, auditory, physical, emotional, conceptual, practical, individual, group
15. Determine how participants will process and use new learning
16. Determine the most appropriate training media
17. Design evaluation criteria and instruments for the training
18. Organize the training by activity, days, and hours

> ***NOTE: There is more than one way to organize a training session. This guide is just one of many forms. The training experience of everyone on the training team will contribute to a final outline everyone is comfortable with.***

Example 4. Organizing the Training Plan

When all the above steps have been taken into consideration and completed, you can organize your training into a matrix like the one in Content of ORS Management Training.

Content of ORS Management Training		
Theme/Topic	**Methodology**	**Communication Materials**
Feasible Behavior: Mothers will procure and mix one ORS packet in one liter of clean water	Group reading of research results General discussion	Radio spots: awareness of packets—one liter/one packet
Correct mixture of ORS packet in liter of water	Trainer demonstrates Participant repeats	Community ORS flipchart
Administer ORS with spoon or cup	Small groups: all practice	Bag with mixing instructions

Synthesis

Training those individuals who will carry out the face-to-face communication for the intervention is very important to the overall effort. Careful planning needs to go into designing this training. It is best to include the actual communication materials in the training and their communication objectives.

The skills learned to change behavior should be applied to training. What are the barriers and benefits and what can be done to affect them?

Feasible behavior for trainers needs to be identified. Results of formative research will help identify these behaviors. Participating training techniques will encourage vibrant sharing of knowledge and techniques among the trainers and participants. It is important to allow adequate time for participants to practice what they are learning. In the end, participants should feel confident that they will be able to accomplish this important interpersonal channel of communication.

Application

1. Using Worksheet 22, Training Plan, have team members fill out a training plan using the above matrix with changes that are appropriate to your intervention.

Worksheet 22-1

Training Plan

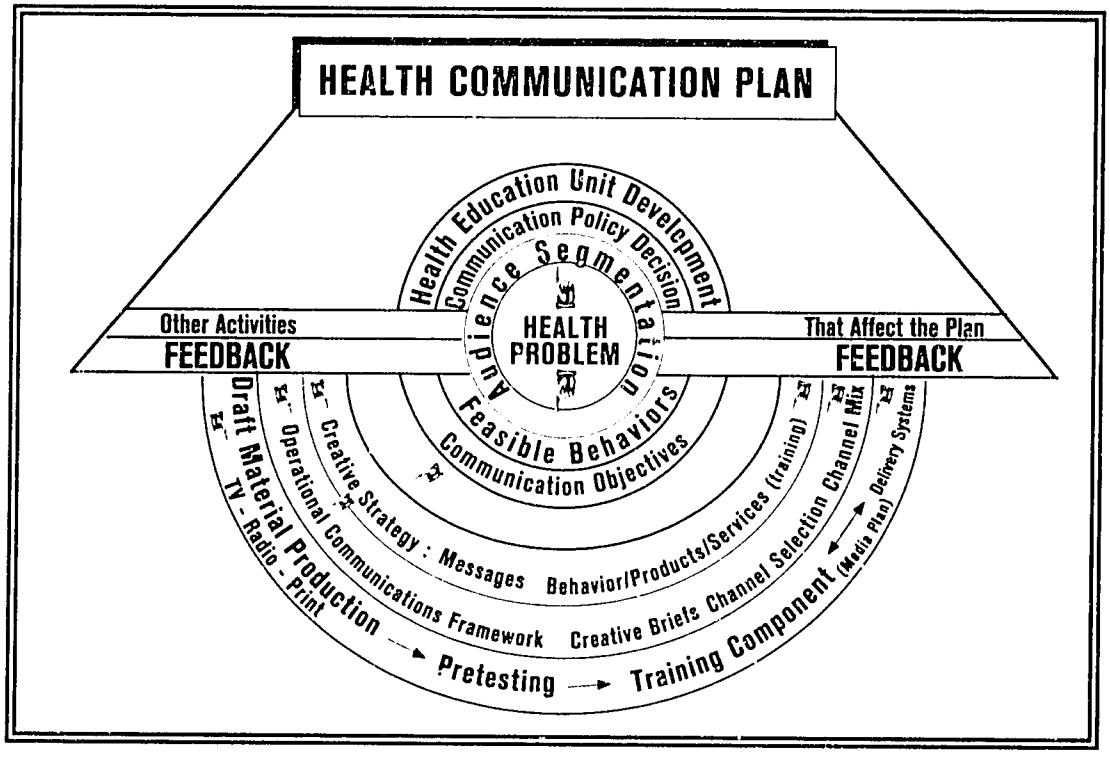
Theme Topic	Training Methodology	Communication Materials
Feasible Behavior:		

Question 23

What Needs to Be In Place For Us To Deliver Our Intervention?

This question will review all the components that make up the delivery system and how these are linked to the communication materials thus far produced.

This step in the overall Communication Intervention Plan is found in the following position:



Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Organized your activity's launch including communication materials (supervising production), the media plan, products and supplies, and logistics (distribution outlets) (Worksheets 23-2 and 23-4)

2. Listed the steps involved in gaining support for your launch and the audience you need to support it (Worksheet 23-3)
3. Discussed criteria for deciding what to do when things go wrong (Worksheet 23-1)

Introductory Note

Expect the unexpected. Project launch is an exciting and often chaotic time. Few communication interventions start without difficulties, setbacks, last-minute modifications, or emergency decisions, no matter how efficiently the advance planning has been done.

As the intervention moves forward, alarming and unexpected complications appear at just the wrong moment, involving the wrong people just when all the other components are ready to go!

Often a major crisis will take much of your staff time and energy and can seem to threaten your schedule if not your intervention itself. The list of problems encountered in various HEALTHCOM project activities is a long one. One country ran out of the paper needed to print the flip charts that were key to the communication plan and could not import more in time. In another program a gas cap rusted shut on the only vehicle available to get into the field. In still another incident, the Minister of Health appeared before national television to launch the vaccination campaign only to find that there was no vaccine in the health center chosen for the broadcast. In a more dramatic example, a coup d'etat pre-empted all of the mass media for months just as a launch was scheduled to begin.

The fact that the unexpected will happen makes it even more important to think ahead about the components of the system that will deliver your communication intervention and how it will be orchestrated to make the launch of your intervention a realistic, manageable event. You may want to plan to have extra hands to help you meet unexpected demands during your launch.

As you will see in this question, the intervention delivery is an integrated system.

Exercise 1. The Delivery System

Materials

Copies of Components of the Delivery System

Instructions

Read the information on the components in a group and have group members summa-

rize the points they believe are needed for their communication intervention.
Components of the Delivery System
The delivery system is made up of the following components:

Communication Materials Production

Your planning has provided you with a series of communication materials and the channels you will use to deliver them. These materials, which may include diverse communication materials such as the posters, pamphlets, brochures, comic books, photonovels, radio spots, press releases, television spots, or health worker counseling cards, must be integrated to provide consistent and focused messages and contribute to your strategy.

To produce these materials on time, without errors and with the quality and appearance you want, a competent person from your team will need to understand and supervise all of the production steps.

Example 1. The process in Nepal

The members of a communication unit of the MOH had developed and pretested their program interventions - a flip chart and two radio spots - to promote a newly available contraceptive injectable, Depo Provera. After they finalized the flip chart text and illustrations, as well as the radio text and music, team members visited the chosen printing company and radio production firm.

One team member dealt with the printing firm. He met with them before printing started to get to know them and establish a working relationship and to agree on contractual issues, such as price and deadlines, and print concerns, such as paper, format, and color. Furthermore, he took the printers step-by-step through the flip chart so they would understand how it was to fit together and would be able to notice errors if they occurred.

Another team member met with the radio spot production firm before beginning the actual taping of the spots. They discussed the creative brief, the voices to use, tone to convey in the spots, and all the necessary contractual issues. Since members of the communication team had already developed, pretested, and revised the spots using staff voices and local music, the production firm's responsibility was to put the spots into a professional format that easily could be used by the local radio station. It was not the production firm's job to change text, write new music, or in any way adapt the content of spots that had already been pretested and finalized. The communication team member worked closely with the firm to assure that no changes were made to the spots.

Production Supervision

Supervising production firms can be demanding. The following guidelines will help you keep the process under control.

1. Assure that the final draft versions are correct before giving them to the producers.
2. Meet with the person(s) handling your job and 'walk' through every aspect of your material—page by page, illustration by illustration, spot by spot, scene by scene.
3. Clearly explain that these materials have already been pretested and approved by the audiences involved and that the producers' responsibility is to produce the materials, not change or adapt them.
4. Prepare an agreement that indicates the following:
   - Number of copies to produce
   - Price for the work
   - Payment terms
   - Production schedule and completion date
   - Price for corrections that are not the fault of the firm
   - any special work that the firm will provide; e.g.,a radio production firm might also handle having the spots aired or a printing company might be able to arrange additional distribution
5. Ask to see/hear their final version (camera-ready copy or demo copy) before they begin production/copying.
6. Arrange to be at the printers for the first printing run and check that (1) colors are correct, (2) pages are in the proper order, (3) fonts/type set is as agreed upon, (4) text and illustrations/photographs are clear, and (5) paper is the quality and color agreed upon.
7. Arrange to be at the studio for the first copy or first spot taping to ensure that (1) music and voices are clear and (2) tapes are of agreed-upon quality, length, and content.
8. Determine in advance the quantity of each material to be produced. Base the estimate on actual planned use; for example, numbers of health workers who will be using it, health centers displaying it, mothers receiving copies, or institutions requesting samples.
9. Add to the number you will be distributing 50-100 copies for your files. You will find that throughout and following the intervention you will receive requests for samples of the material. Requests will come from within your organization and also from donors, evaluators, trainers, and representatives of other institutions.

Example 2. The Media Plan

After the communication materials are produced, your intervention needs to have a plan for using the materials. A media plan will organize the use of the materials and provide an overview of how many, where, and with what broadcast intensity. This is how the Caribbean team designed their media plan for the measles initiative.

A. Media Priorities and Rationale
   1. TV, because it has the largest reach, appropriateness, credibility
   2. Radio, because it also has a large reach, but cannot communicate image messages well
   3. Print, because it has a limited reach, but is the only way to communicate some of the tactical messages

B. Media Budget
   1. 60% of budget for TV
   2. 30% of budget for radio
   3. 10% of budget for print

C. Production
   1. TV
      - Three 30-second TV spots
      - One 30-minute TV special
   2. Radio
      - Five 30-second radio spots
   3. Print
      - Information kit - 500
      - One poster - 100
      - One poster - 100
      - One brochure - 1000
      - One button - 10,000
      - One fact sheet - 10,000

D. Timing
   1. Length of time

To Air:	Radio, TV	9/94 to 12/95
To Distribute:	Print	9/94 to 12/94

   2. Frequency

TV	-	Twice weekly on channel 7 at 6:30 and 7:30 pm
	-	Special twice in October and November
Radio	-	Twice weekly on WRFT (FM) at 10:00 p.m. Tuesday and WHI (FM) at 10:30 p.m. Friday

3. Distribution Channels	Print	- Information kits once at press conference, 9/94 - Buttons once at launching, 9/94 - 10 posters once to 10 vaccination centers, 9/94 - Fact sheets once at launching, 9/94 - Brochure throughout, 9/94-12/94
4. Storage		- Materials in place and in storage by 9/94

Distribution Channels and Outlets. Channels and outlets for distribution include the MOH supplies delivery system (truck, supervisory visits, messengers), mail, and private companies (delivery vehicles, buses, messengers). These channels must be explored before the products or communication materials are ordered. If the program can not get the product to the target audience, why bother to produce it?

Example 3. How the Honduras Team Tested the Delivery Channels

The Honduras team tested delivery channels using traveling merchants who deliver small goods to the villages (canned goods, cigarettes, aspirin, etc.) to help deliver the ORS packet materials. They found the merchants were useful in more remote areas. The team also needed inexpensive, reliable ways to check delivery on a regular basis. They tested writing letters from the central offices in the capital to the provincial health centers and sending notes from the health center level to the capital when they were on field trips. The majority of the mail in both directions was safely delivered.

Volunteers, community organizations, and small vendors can be incorporated into the distribution system as immediate outlets for the product so that the target audience can have a wider range of options to acquire the product. If there is only one outlet, it will not be feasible to ask your audience to acquire the product.

The delivery channels also include those needed for your mass media products to get on the air. The following questions will help you be aware of the needed activities:

- Who will make the necessary audiotapes for all the contracted radio sections?
- Who will pick them up and distribute them to the individual radio stations?
- Who will make the videotape copies for the TV stations and distribute them with an instructional note?
- Who will pack the predefined number of print materials and take them to the appropriate transportation channel?
- Who will write the instructional letter for the materials?

Other parallel audiences, which your communication plan should always keep in mind, especially as you near your launch, include the public image creators, molders of public opinion, accepted specialists, and communicators in the field. These are the audiences behind the target audience that you can enlist during the launch phase of the intervention.

Who are these people in your area, what can they do for your project, and what can your program offer them that will result in their help and support?

Exercise 2. Reaching the Audiences Behind the Audience

Materials

Copies of Example 4, Marketing a Launch and Delivery

Instructions

Have one of your team members read this example and make a presentation to the rest of the group.

Example 4. Marketing a Launch and Delivery

In Jordan, the Noor al Hussein Foundation staff launched a breast-feeding TV and radio program. They highlighted the newsworthy character of their intervention by having staff work with media personnel, using several techniques common to the world of marketing.

- **A press information kit**
  The staff prepared a kit of ready-to-publish information about breast-feeding, statistics, data, and program research results. They included policy papers from WHO and UNICEF, journal articles, prepared press releases, photographs, graphics, video and radio clips, and video advertisements that would provide credibility to their materials and give the larger public and medical community correct information about the technical aspects of their intervention.

- **Press briefings**
  They brought together journalists; producers of TV and radio health shows, religious programs, and family shows; and academics from the field of nutrition. At these briefings they presented the press information kit, explained what was in it and highlighted goals of the campaign. They plan to use these briefing materials for slide presentations in research, strategy, objectives, and the scientific basis for their intervention.

- **Creating a Technical Committee**
  They created a program advisory committee of MOH physicians, nurses, and academic and clinical specialists in the field of pediatrics and nutrition. They

provided credibility to the intervention and felt ownership of the strategy. Each time the committee met, they made news!

HEALTHCOM experience shows that intervention launch is an exciting and often chaotic time. At least one major crisis will take much of your staff time to overcome, because it will threaten your program. At this point, you have to ask yourself what component can you sacrifice if parts of your plan fall behind or fail?

Exercise 3. What To Do When Things Go Wrong

Materials

Copies of Example 5, Launch Flexibility
Copies of the Criteria for Flexible Decisions

Instructions

In small groups, have team members read the Example and the Criteria for Flexible Decisions and decide on a course of action.
Share with the others the course of action decided upon and its justification.

Example 5. Launch Flexibility

In a West African country, MOH project staff planned carefully integrated media support for their newly trained vaccination teams. This support included radio shows, songs, and flip charts for use in village education events. The chart told the story of a village mother named Awa, who with the help of family and friends overcame all obstacles to complete her child's vaccinations.

The MOH team printed flyers, which fit into the vaccination cards of each mother, filled with picture messages that reminded them about coming back for the second round of vaccinations. When the flip charts were delivered, the MOH team discovered they had been badly misprinted and there was no paper available to do a second, revised printing. Project staff knew these flip charts to be used in conjunction with village education events would be essential to remind mothers of the second vaccination. They also knew that postponement of the launch date was dangerous as the rainy season was about to begin and the enthusiasm of the health workers around the country would be discouraged by waiting.

A decision had to be made:

A. Postpone the launch of the program until paper could be found.
B. Start on time, leaving the village health workers without a role.

Criteria for Flexible Decisions

Launch time may require tough decisions. These criteria may help you make them.

1. **The audience must be able to complete the promoted behavior.** For example, if ORS packets are not available then it is useless or counterproductive to create a demand for them.

2. **The product must be as promised in the media.** If training has not been completed and the health workers are not going to perform as promised, then beginning a program dependent on training can damage your credibility and lose the audiences' good will.

3. **The communication strategy must be intact.** If certain media are being counted on to counter misinformation, others to motivate, and still others to reward new behavior and one of these is missing, a decision will have to be made about whether losing one piece leaves enough of the strategy in place to achieve the desired audience behavior change.

4. **Results must be on time.** Sometimes a funding cycle determines when a job must get done. A second program that is beginning may depend on the completion of the first one.

5. **Delay can affect credibility.** Delay or postponement may cause key decision-makers or the target audience to take the program or the unit less seriously. Timeliness may be more important than having all components in place.

Using the above criteria, decide what you would have done with the launch for the vaccination intervention. Give reasons for your choice. The following communication intervention, which was done in Manila, the Philippines, demonstrates how all the elements of the delivery system work together. It will give you an overview of the whole process.

The following communication intervention done in the Philippines demonstrates how all the elements of the delivery system work together. It will give you an overview of the whole process.

Exercise 4. Putting It All Together

Materials

Copy of Example 6, Putting It All Together

Instructions

Have team members read the example in small groups.
Ask each team member to present the delivery system components implied in the vaccination program.
Ask the other group to present what they think were the distribution channels used and the audiences behind the audience.
One group should assess how they handled the crisis situation and share their assessment with the team members.

Example 6. Putting It All Together

The Metro Manila Measles Vaccination Program tested the feasibility of using an integrated communication approach to assist the Department of Health (DOH) in increasing the rate of full immunization among children less than one year old. The Philippine DOH sought to raise national levels of fully immunized children under the age of one from 70 percent in 1988 to 90 percent by 1993. It aimed to achieve this through its health delivery system.

Under this new mandate to design, implement, and evaluate a program that would promote the acceptance of vaccination among mothers and support the activities at the health centers, communication team members carried out a countrywide KAP study, urban-based focus group research, and observations of and interviews with health workers in the health center setting.

Key research findings included the following:

Mothers

- Perceived government health centers as a credible source of vaccination services
- Recognized measles as a common childhood disease
- Recognized vaccination as a means of protecting the child against that disease
- Saw measles as natural for children, not a real health threat
- Considered health centers accessible, involving short travel times, and vaccines and supplies as adequate

Health workers

- Believed they could not vaccinate a sick child
- Thought they could not give more than one vaccination per visit
- Had no way to tell if a child had been immunized if the mother did not bring in the vaccination card

Using this information, team members designed a communication strategy for (1) mothers with children aged 9 to 12 months residing in Manila and (2) health workers providing immunization services. Their main message, to protect your

child from the complication of measles, immunize, was to be communicated through integrated face-to-face, TV (five spots and a miniseries), radio (two spots), and print materials (6,000 posters, 150,000 flyers, 150 flip charts, 500 sets of counseling cards, and 20,000 vaccination cards). Their communication objectives included the following:

1. Have children less than two years of age fully immunized in order to capture those between one and two years of age who had missed previous vaccination efforts.
2. Encourage mothers to bring their children to the health center on Friday for a measles vaccination.

Their program was to include the following:
For Mothers

1. A focus on measles because it was the last vaccination needed to complete the series and it had the highest dropout rate (Measles was a disease that mothers readily recognized and to which they believed their child was susceptible.)

2. A designated single day of the week as measles vaccination day to encourage mothers to take timely action and not postpone measles vaccination

3. Highlighting the value of vaccinations to protect their children against the often fatal complications due to measles though the distribution of the flyers and radio spots

4. Providing mothers with a vaccination card for every vaccinated child

For Health Workers

1. Updated information to explain they could give vaccinations when a child was sick and they could give a child multiple vaccinations (Poster for health centers will summarize this information)

2. A system to set up a health center register that listed all neighborhood children and their immunization records

3. Training in interpersonal communication

4. Tee shirts, banners for clinics, and other MOH national material

Program delivery included:

Logistics. They carried out pre-campaign activities of producing audiovisual materials, printing and delivering print materials, and preparing materials for their press conference.

Training and Orientation. Health workers from 331 participating health centers were invited to participate in kick-off orientation sessions. To optimize the effectiveness of the materials and their impact, health workers were briefed on how to use and display the materials. The briefing was carried out for both the print and broadcast media materials. A one-page document containing guidelines for use and installation of the print or 'point-of-purchase' materials was distributed to each of the health center staff attending the briefing. They also reviewed the monitoring scheme to be used in tracking the effects of the campaign.

Launching. The day before the mass media messages were broadcast, the Secretary of the Department of Health invited representatives of the major papers and broadcast media to a one-and-a-half-hour press conference. This activity provided the initial momentum for the campaign and inspired everyone to pursue a common goal.

Crisis Situation. The launching date set by the Secretary of the Department of Health was advanced three weeks of its original date.

This meant that only half the staff of the 331 participating health centers would be trained by the new date. The team got together and reviewed the situation using the Criteria for Flexible Decisions and decided that none were substantially overburdened by the new, early launching date.

Moreover, they could minimize the potential impact by sending a lengthy explanation to the nontrained staff of the health centers letting them know the context in which the launching of the campaign fitted and the communication strategy elements that accompany it.

This explanatory letter was sent and arrived at 80 percent of the nontrained health centers before launching date.

Synthesis

1. The delivery system is made up of the following components: communication material production, production supervision, media plan, and distribution channels.

2. Material production includes supervising the production process, which must be known by the supervisor. This will avoid mistakes at key moments, such as contractual issues; deadlines; and production concerns on format, color, editing, first version, order of pages, fonts/types, and number of copies.

3. Media plan includes rationale, budget, format, length, number, timing, frequency, broadcast, and distribution channels.

4. Audiences behind the audience are public image creators, molders of public opinion, specialists, and communicators for whom special material and events may be organized. The materials include press information kits and press briefings, and special events include the creation technical committees.

5. Criteria for flexible decisions when something goes wrong include the following:

   - Audience must be able to complete the promoted behavior
   - Product must be as promised in the media
   - Communication strategy must be intact
   - Results must be on time
   - Delay can affect credibility

Application

1. Worksheet 23-1, How Flexible Can You Be? can be used when necessary to help you make tough program delivery decisions.
2. Worksheet 23-2, Production Checklist, will help ensure timely and efficient production of your materials.
3. Worksheet 23-3, Audiences Behind the Audience, will guide you in determining your additional sources and how to use them.
4. Worksheet 23-4, Media Implementation Plan, will help you identify the activities involved in launching your program interventions.

Worksheet 23-1

How Flexible Can You Be?

Use this form when you need to make tough program delivery decisions!

What is your CHALLENGE?	HOW DOES IT IMPACT YOUR PROGRAM?			ACTION to take:
	1. Will the audience be able to complete the promoted behavior?	YES	NO	
	2. Will the product be as promised in the media?	YES	NO	
	3. Has the communication strategy remained intact?	YES	NO	
	4. Is the timeliness critical?	YES	NO	
	5. Will the results be known in time?	YES	NO	

Worksheet 23-2

Production Checklist

WE HAVE—

_____1. Assured that the final versions ARE CORRECT before giving them to the producers.

_____2. Met with the person(s) handling the job and walked through with him or her every aspect of the material, page by page, illustration by illustration, spot by spot, scene by scene.

_____3. Clearly explained that these materials have ALREADY BEEN PRETESTED AND APPROVED by the audience involved and that their responsibility is to produce the materials, not change or adapt them.

_____4. Prepared an agreement that indicates the following:
_____Number of copies to produce
_____Price for the work
_____Payment terms
_____Production schedule and completion date
_____Price for corrections that are not the fault of the firm
_____Any special work that the firm will provide

_____5. Asked to see/hear their final version (camera-ready copy or demo copy) BEFORE they begin production/copying.

_____6. Seen or heard the final version.

GRAPHICS/PRINT ONLY

_____7. Arranged to be at the printers for the printing run and to check that (1) colors are correct, (2) pages are in the proper order, (3) fonts/type set is as agreed upon, (4) text and illustrations/photographs are clear, and (5) paper is the quality and color agreed upon.

_____8. Been to the printers and checked.

MASS MEDIA ONLY

_____9. Arranged to be at the studio for the first copy or first spot taping to ensure that (1) music and voices are clear and (2) tapes are of agreed-upon quality, length, and content.

_____10. Been to the studio and checked.

Worksheet 23-3

Audiences Behind the Scenes

Group similar audiences, where possible. Add additional rows as necessary.

WHO/AUDIENCE	WHAT CAN THEY DO TO HELP?	WHAT DO WE NEED TO PROVIDE THEM WITH?

Worksheet 23-4

Media Implementation Plan

Add additional categories as necessary for your situation. List specific activities under each category. Remember the considerations listed in the Synthesis of Question 23 to help identify the activities necessary to effectively implement this plan.

ACTIVITIES	DATES TO ACCOMPLISH	NECESSARY ACTIVITIES	PERSON(S) RESPONSIBLE
LOGISTICS			
1. Production of: • Videotapes • Radio tapes • Printed materials			
2. Distribution • TV • Radio • Print material			
MEDIA			
3. Airing • TV • Radio			
4. Audiences behind the audience • Press kits for media			
SUPPLIES			

WORKSHEET 23-4

Media Implementation Plan

Add additional categories as necessary for your situation. List specific activities under each category. Remember the considerations listed in the Synthesis of Question 23 to help identify the activities necessary to effectively implement this plan.

ACTIVITIES DATES TO ACCOMPLISH NECESSARY ACTIVITIES PERSON(S) RESPONSIBLE

LOGISTICS

1.Production of:

- Videotapes
- Radio tapes
- Printed materials

2.Distribution

- TV
- Radio
- Print material

MEDIA

3.Airing

- TV
- Radio

4.Audiences behind the audience

- Press kits for media

SUPPLIES

Step 5

Monitor/Evaluate

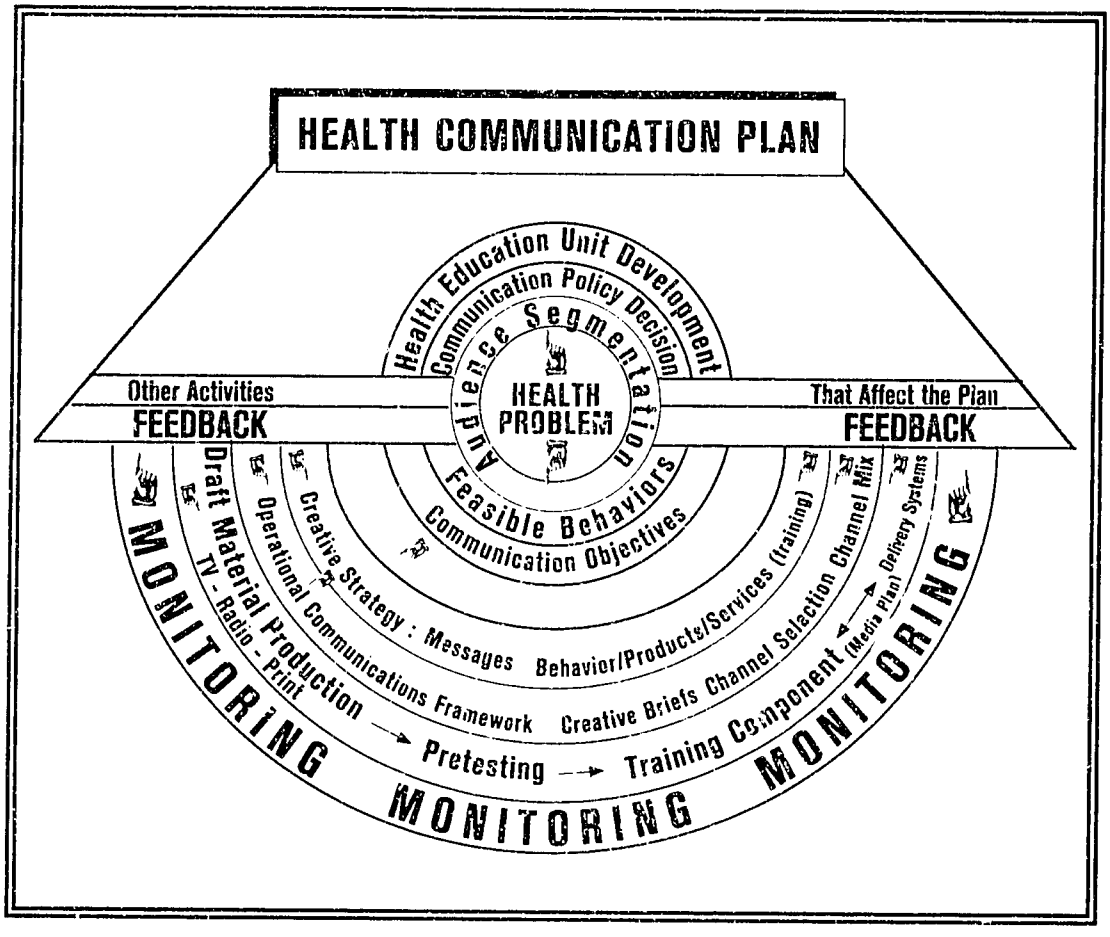
Questions 24 - 25

Question 24

How Can We Ensure Our Communication Strategy Is On Track?

In Question 23 you identified those elements that go into a delivery system to launch your communication intervention, making sure that distribution channels, products, materials, and supplies are in the places needed for the target audience to have access to them. In this question you will study the elements that make up the monitoring system. This system will help you keep track of what is happening to your intervention; that is, how it is operating and what is not working.

Monitoring is found in the communications plan in the following position:



Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Described the purpose of monitoring
2. Listed the elements of a monitoring system
3. Decided what you will monitor (Worksheet 24-1)
4. Planned how to do your monitoring (Worksheet 24-2)
5. Planned how to use your monitoring results

Reflecting on Field Experience

Exercise 1. What is Monitoring?

Materials

Copies of Example 1, A Typical Reality!

Instructions

Have a team member read the example aloud.
Answer the questions that follow in a group.

Example 1. A Typical Reality!

The health education team conducted its formative research. It identified an audience and feasible behaviors, asking the audience of first-time periurban mothers to start breast-feeding in the first hour after the children's birth and continue exclusive breast-feeding on demand without supplementary liquids or solids for six months. The team defined the barriers and benefits for this behavior for this audience and also developed a strategy and sequence of messages that presents first-time mothers as modern, caring, and up-to-the-minute women who give the important colostrum to their beloved babies and feed them on demand.

The communication package for the intervention included posters to be placed in birthing clinics and a brochure on the benefits of colostrum, what to expect in the first days of breast-feeding, and how to manage problems. It also included a set of counseling cards for nurses in birthing centers and midwives who attend home births. Radio spots promoting the good a mother does when she breast-feeds her child were prepared.

After three weeks, the project director asked team members if anyone had verified that the posters were up as planned, and that brochures had reached first-time mothers who had delivered in that time. No one knew the answers to these questions. He also asked if the counseling cards had been delivered to the nurses and midwives who had been trained to use them. The team did not know.

He asked if anyone had verified that the radio spots were on the air as planned. No one could even verify if the tapes of the spots had been delivered to the station or who at the station had received the letter giving the schedule for the broadcast of the spots. No one knew who at the station was responsible for assuring the schedule was met.

What went wrong? What had the team neglected to do? What are the possible consequences for your intervention in not knowing what is happening in implementation?

Background Information

It often happens that all of the effort, creativity, careful planning and execution, and expense invested in a communication program are wasted because key elements of the plan did not occur, or did not occur as planned. It will not matter how well you have researched, conceived, and produced your materials if they do not reach your audience in the way you decided. The most creative strategy can have an impact only if it reaches its target.

Discovery of problems and flaws in your intervention is an indication of the vitality of your program, because it provides the opportunity to correct problems in time to avoid serious damage. One of the most important characteristics of the educational communication process is that it is dynamic: Monitoring allows you not only to correct problems, but to constantly adapt to changing situations and the emerging needs of the target audiences.

A definition of monitoring. Monitoring refers to the continuing review and supervision of activities and the use of the findings to improve implementation. Its purpose is to provide a tool to identify and correct program problems, direction, and priorities early enough to make changes and maximize the impact of programming efforts.

What does monitoring do for you?

- It lets you know what in your strategy is not working as expected.
- It shows you what links in the delivery system are not functioning as expected.
- It reveals if the materials have been delivered in time, to the correct people, at the correct place.
- It permits you to take steps to ensure that activities and strategies occur as planned.
- It lets you correct the plan when you find it is in error or inadequate.
- It enables you to assure that activities and materials are consistent with your strategy.
- It lets you redirect your strategy as new barriers, audiences, and stages of behavior adoption emerge or are created by the program itself.
- It allows ongoing review of project inputs and outcomes to provide feedback to

the people and delivery systems of your program for the purpose of reinforcing, rewarding, refining, and correcting practices.

Monitoring establishes an immediate feedback loop to your intervention. It will give you the necessary information at the right time to make timely, mid-course corrections. Monitoring is not an outsider's test of the implementer's performance. It is a tool used by program implementers to reveal new facts, situations, and constraints that were not foreseen and that require corrective actions.

Concrete benefits include the following:

- Changing the sites where the graphic material is displayed
- Redistributing materials; changing those responsible for its management
- Broadcasting in other media and/or at more appropriate times
- Delaying the broadcast launch if a product has not been produced, has not been delivered, or is not available in all the promised sites
- Reshaping training sessions
- Changing product prices
- Improving distribution systems
- Changing elements of message strategy
- Making midcourse corrections of the implementation
- Shifting internal workloads or responsibilities

Monitoring helps you recognize the deficits in your system. It will give you indications of what is not working and what needs to be corrected or changed while you have time to do something about it, rather than at the end of your intervention when there is no possibility of making changes.

Monitoring and evaluation are frequently confused. The boundaries seem to overlap and many activities are both monitored and evaluated. The major differences between monitoring and evaluation are that they answer different questions and have different purposes. Each is implemented in a different time schedule. Please study the following comparative table.

Monitoring and Evaluation Differences	
Monitoring	**Evaluation**
Answers these questions: What is happening to the delivery system/training?	Answers these questions: What happened as a result of the intervention?
Why is it happening? (flaws, gaps)	What behavior changes took place?
What are the interim effects? (in the target audience, in health workers, in the service)	What portion of the target audience adopted the new behavior?
How can it be fixed, corrected, redesigned?	Why did they adopt it?
	What was the health impact on target audience?
Purposes: To correct, reorient, or redesign delivery systems	Purposes: To demonstrate the impact of health communication
To readjust communication strategy and messages	To determine the level of behavior adoption
	To determine program impact on health status

In terms of the timeline and staff responsibilities in charge, there are noticeable differences between monitoring and evaluation as the following table indicates.

Time and Staff Responsibilities of Monitoring and Evaluation	
Monitoring	**Evaluation**
Monitoring begins as soon as possible when a communication strategy is implemented and continues through the intervention. Data are collected periodically, and frequently, at preset intervals or when the occasion permits it. Monitoring is customarily done by the same people implementing the communication activities. Data are analyzed as needed and used immediately for program correction.	Data are generally collected at different points that permit a comparison; for example: - Before the communication strategy begins to establish a baseline - After a longer period (frequently more than a year or two) to make the post intervention comparison Data collection is planned to allow sufficient time for intervention impact to take place. Research is most often conducted by internal researchers not directly involved in the health communication activities. Data are analyzed and used at a central level after program completion.

Each of the four stages in monitoring provides more useful information and requires more resources and time. Think about your needs and resources and begin to plan which stages of monitoring makes sense for your project.

Stages of Monitoring			
What?	**Type**	**When**	**Why/Reactions**
1. Logistics (product/media and materials; product/supplies)	Inputs	*e, c	Correct errors, flaws in implementation
2. Interim effects	Outputs	p	Correct plan
3. Target behavior	Outputs	p	Reinforce practices; redirect strategy; identify new barriers, audiences, stages possibly due to intervention
4. Health improvements (clinic, health stats)	Outputs	p	Report, reinforce, set new directions

*e = early, as soon as implementation starts
c = continuing
p = periodic, at intervals as information is needed

The monitoring stages are as follows:

- **Chronological.** Each stage takes place before the subsequent one; that is, you deliver your intervention before you expect interim effects, and expect interim effects before target behavior change, and behavior change before changes in health conditions.
- **Sequential (incremental).** Each stage follows and builds upon the previous stage.
- **Increasing in complexity.** Each stage requires more time and elements to be monitored than the previous one and provides more information.

Each stage provides the basis for corrective actions that also are chronological and sequential; that is, information collected at each stage permits corrections that are necessary before moving to understanding the next stage. Each stage should be in place and functioning well before monitoring a sequential stage that depends on it. For example, if the spots were not aired at the frequency and time you planned, you cannot expect mothers to have heard them and, therefore, they cannot recall them.

Strategic Use of Monitoring

Findings from any of these stages can be used to modify your program, as noted. They also can be used to inform decision-makers about positive outcomes and trends within your project. Illustrative anecdotes and incidents can complement the data of what your project is doing.

Exercise 2. What Is Monitored

Materials

Copies of What to Monitor

Instructions

Ask team members to divide into two groups and have each group study a section of What to Monitor and make a presentation of its content to the other group. Discuss the content presented and make sure there is common understanding of what is to be monitored.

What to Monitor

Logistics

Is your program being implemented as planned? Are the program components such as print materials and supplies being delivered on time, in the right place, by the right people, to the right audience? This is the minimum level of monitoring required to ensure that efforts and moneys you have already expended are reaching the people and places at the times and with the quality your plans require.

Findings from monitoring should be used immediately to correct problems in implementing your plan. The following are examples of the things to monitor for the logistics, so that everything is in place as planned.

- **Distribution of print materials.** Are posters up, but not where your audience can see them? Have your flip charts reached the health centers where the health workers have been trained in their use?

  These types of questions can help you find out if materials are reaching the target audience in a timely and effective manner. The team may want to test several distribution systems and, based on the results of the monitoring system, select those that are most effective.

- **Mass media broadcasts.** Because radio and television programs have been scheduled during the time when the target audience is currently listening, it is important to be sure that they are actually broadcast on those days and at those

times with the frequency and in the order agreed upon. To monitor mass media, specified people should listen to the radio stations or watch television during the time slots contracted to determine whether the materials are being broadcast as scheduled. A printed schedule will help with this. If the schedule is not being followed, the team can meet with the responsible person to request better compliance.

- **Exposure.** Your strategy called for 50 percent of mothers to hear your radio spots. Are that many mothers listening to your messages? If not and the reason is the radio station's poor coverage, you may ask the station to air them at different times or use a different radio station.

- **Distribution of supplies/products.** You want to make sure that the products you are promoting, for example ORS packets or vaccines, are in fact where you say they will be when you ask the audience to request them.

- **Training plan.** Is the training on schedule, delivered as designed, and for the right personnel? Training is consuming and expensive, so it must be done correctly (see Question 22).

The function of logistics monitoring is to give you a second chance to get it right.

Interim Effects

Once you are assured that your logistics are working as planned, you can begin to look at the interim effects of your intervention: knowledge, reaction and target behavior.

- **Knowledge.** You want 40 percent of mothers to recall the key radio messages. Do that many mothers recall the messages? If not, you may need to have the messages broadcast more often, on other stations, or at a more appropriate time. Those factors must be reviewed and tested.

- **Reaction.** Is there evidence that the target audience is reacting negatively to the messages or the behavior promoted? Is there evidence of early message fatigue. If so, you may want to change certain factors in your messages, or in your broadcast schedule.

  Example: In a Latin American nation a campaign was designed to meet the threat of a cholera epidemic already raging in neighboring countries. The cam-

paign opened strongly with frequent and urgent calls for changes in behavior. The epidemic did not arrive as soon as expected, however, and before long the messages lost their credibility with the target audience. When the epidemic did arrive, the messages were rebroadcast but had little effect.

- **Target Behavior.** Once you are assured that the interim effects are in place, you may begin to look at changes in behavior for your target audience. Findings about behavior changes can help you change or adapt your strategy. The reporting of target behavior is included in the monitoring section because the purpose of the monitoring at this moment is to provide timely feedback to your project, as well as to the practitioners of the new behavior.

  Monitoring does not involve techniques or designs that will enable you to demonstrate statistically that the behavior you are recording has in fact changed or that the change is the result of your intervention. These findings require a different evaluation approach (see Question 25). You monitor simply to determine if the behavior is present or not, and if present, to what degree, in what audiences, how often, and for how long a period it is practiced. Another purpose of monitoring is to provide feedback to those adopting the behavior to reinforce, adapt, or refine the behaviors.

  The advantage of periodic monitoring of behavior is that you may find that you may have accomplished a project objective, allowing you to adapt your strategy to the next stage. For example, your initial objective was to develop awareness of the dangers of dehydration. Your monitoring will tell you when the planned proportion of your audience can recall this information. You may then decide to move to the next stage to teach the skills needed for correct use of ORS. Or you may find that your original target group, the most responsive, has adopted the behavior, and you can turn your attention to harder-to-reach members of your community.

There are several ways you can target behavior in order to monitor it. Here are some helpful criteria:

- **Selecting the behavior.** To decide what behaviors to monitor, review the target behaviors you selected in the planning stage. Which communication activities have been tried and what behaviors were expected following these activities? For example, a target behavior for a control program might be for mothers to mix and use ORS in their homes. The strategy called for training health workers, making packets available, and broadcasting radio messages to reinforce regular ORS use.

To monitor these changes, individual health workers mixing ORS and demonstrating to the mothers could be measured and then mothers' skills in mixing ORS at home could be measured. You will need to know that the packets were available and the audience was exposed to messages as planned. This should have been accomplished as part of the logistics monitoring done early in the intervention.

- **Looking at the behavior.** By looking at behavior, you have a measurement of what is happening. If monitoring shows less-than- expected progress, the program strategy, channels, and/or messages may need to be changed. If, on the other hand, adequate progress has been made, those responsible for the intervention may negotiate with decision-makers on how to reinforce and maintain the behaviors and possibly establish new objectives for future activities.

- **Getting feedback on performance.** This can serve as a positive consequence and reinforce behaviors being performed. Monitoring results themselves, if presented as feedback in a constructive and simple form, can help strengthen the very behaviors being measured. This feedback can be informal, as in the case of a health worker pointing out to the mother what she did correctly to treat her child's dehydration. It also can be formal, as in the case of a trainer graphing four essential communication skills that trainees were practicing in a workshop so that the trainees could see from the graphs where their own performance needed extra work or was satisfactory.

  In another example, if part of your strategy was to improve health workers' performance in treating mothers better and passing on key messages, the use of an observation form will help you see if trained workers are using their new skills to counsel mothers. Exit interviews with mothers will tell you if they understand the key messages and feel the encounter has been a positive one. If this is done early enough with a small number of health workers, you can take steps to improve the training design if necessary.

- **Developing self-monitoring.** Working with health workers to develop a self-monitoring form measuring the behaviors you are promoting can provide you with information and the worker with feedback and reinforcement on the new practices.

  Any health worker or supervisor working with children might find self-monitoring a useful tool. With this technique, individuals select behaviors of their own to observe, record their occurrence, and graph the results. Reading the graph itself gives them feedback. For example, in an urban clinic in Morocco and in a village health center in Senegal, nurses made and displayed graphs that

reflected the number of prenatal exams they gave or immunizations they administered on a monthly basis. Clinic staff in Ecuador used pins stuck in maps to show which village households had fully immunized children and, implicitly, where more work was needed.

The records kept during self-monitoring need to be graphed, updated, and displayed so that the trends in behavior can be appreciated visually. The graphs can remain private or can be shared with an appropriate group such as colleagues or the community. As with other monitoring activities, the data collected by self-monitoring can function as powerful reinforcers of the behaviors being observed. Moreover, the graphs can be used to highlight the program's accomplishments to funders and other decision-makers who will decide to extend or disseminate the communication approach.

- **Identifying new, unexpected barriers.** Your monitoring may reveal that there are new or unexpected barriers to adoption that you did not identify in your earlier strategy. For example, in Egypt a health team found that pharmacists were recommending ORS. As the treatment gained visibility, however, suspicions voiced by physicians who had not been involved in the program were damaging its credibility and discouraging continued use. The team developed new educational materials for physicians.

- **Identifying need for additional information.** When you examine your monitoring data you may find you need additional information to adapt or expand your program. For example, routine service statistics show that since your program began, more mothers are returning with their children for the second vaccination, a first step in your objective of having them complete the series. Do you need to know which segment of mothers is not yet changing their behavior? Do you need to know what was the key element in influencing the behavior of the mothers who changed? Could this information help you decide which elements of the program to replicate in other areas?

  Monitoring at this stage enables you to adapt your strategy to respond to new problems and to new barriers, audiences, or stages in behavior adoption that you were not previously aware of, or that have emerged as important, possibly as a result of the intervention itself.

- **Counting numbers.** It is easier to count numbers of mothers attending a prenatal clinic or a vaccination session than it is to measure the attitudes or knowledge clients have about these services. It is easier to count packets of ORS distributed than to carry out in-home observations of mothers' ORS use. Using existing reports to help measure progress toward your objectives is an excellent, cost-effective option.

Exercise 3. How Is Monitoring Done?

Materials

Copies of Monitoring Methods

Instructions

Have team members study this information and ask them to extract the elements involved in each monitoring form.
Use these elements to design your own monitoring forms according to your communication implementation activities.

Monitoring Methods

Monitoring is done in many ways using multiple forms of follow-up. Among the most common methods are the following:

- Regular audits of materials at representative distribution points
- Li[illegible]ng to broadcasts to ensure media messages are aired at the contracted hours
- Central location intercepts to ask for the perception of tag lines or program slogans
- Regular field trips to distribution sites to check on availability of products or supplies
- Observations at service delivery points or training sessions using monitoring guides
- Focus group discussions to investigate the impact of promotional messages and to detect possible confusion

Ongoing monitoring of behaviors need not exhaust resources if you plan carefully. For example, you may want to have supervisors, while on their regular site visits, check to be sure the health workers are still making presentations in villages with the new flip charts or that pharmacists are still recommending ORS for dehydration and showing mothers how to mix it. An assessment of your own resources will tell you how often you can afford to do this regular follow-up. A monitoring schedule can help you get needed information at the times that you need it to best manage your program. The frequency of your monitoring will depend on your resources, where you might expect problems, and when you can reasonably make program changes in response to findings.

The easiest way to monitor delivery is by site visits with a monitoring form. such as the one in the following example.

Distribution of Print Material								
Material	Date Produced	Date for Delivery	Date Delivered	Number and State of Material				Received by
Dehydration Posters	3/5/95	3/10/95	3/20/95	300	150	50	500	Jose Guerra

The team member in charge of this activity should come by weekly to see the schedule filled in by the person listening. Disabled persons may be a good choice for this work since they often are forced to stay at home and normally can be close to a radio or TV set.

Radio Monitoring

A recording instrument for radio broadcast monitoring can look like this.

Monitoring of Radio Spots

Monitor:_____ Site:_____

Spot Name	Station	Date	Hour	No. of times spot was heard per day
Mixing ORS	Liberty	5/8/95	10:00 12:00 2:00 3:00 5:00	

Radio Exposure

An instrument to verify if members of the target audience have been exposed to the radio spots will be different. It can look something like this.

Monitoring Exposure to Radio Spot Listening

Monitor:_____ Date:_____

Site:_____

Listener: male____ female _____ age_____

Radio Station Heard:_____

Name of Spot Heard	Hour(s)	No. of times heard
Litrosol is for	12:00	per day: _____
dehydration	3:00	per hour: _____
		per week: _____

_____

_____

Opinion Letters. Through the radio, request target audience or health providers to write or call into the radio station with comments on any components of the intervention. Read newspaper articles by opinion leaders to detect any type of negative comments regarding the intervention. These are very powerful and can neutralize all efforts. Similar monitoring should be done with television/radio news. Your program may be discussed with positive or negative consequences.

Training

Monitoring of training has two purposes: (1) to assure that the trainers/training covered the content and skills you had planned and (2) to assure that the trainees can practice the new behaviors. Monitoring the behavior of participants being trained should be done early in each training session to assure the training is effective in transferring the skills.

Monitoring should also be done on the job to assure that the training is realistic, practical, and motivating enough to produce workers who use the skills in the job situation. If you find participants are not using these skills, you will have time to adapt your training or even your behavioral objectives.

Monitoring Training Sessions

Date:_____ Observer:_____

Site:_____

CONTENT

Trainer covered the following points:

Mothers' beliefs regarding when not to breast-feed child:

Y N Mothers' belief that food will do harm to child with diarrhea.
Y N Mothers' belief that sunken fontanelle is sign of diarrhea.

ORS use:

Y N ORS packets contain the right amount of sugar, salt, and potassium a child needs to recuperate during diarrhea.
Y N The most common liter measure found in households is .

Mixing instructions:

Y N One liter of boiled water, if possible; if not, the cleanest water available.
Y N Open the ORS packet and place ALL the salts into the liter of water. Stir. Do not add anything; no sugar and no salt.

Administration:

Y N Give the ORS solution to the child after each bout of diarrhea and whenev er he or she feels thirsty.
Y N Use a cup and a spoon; give as much as the child will take. If he or she refuses, continue offering.
Y N If diarrhea is mild make sure the child drinks at least two cups a day.

Feeding:

Y N Child loses appetite while having diarrhea. Offer him breast milk on the usual schedule.
Y N If he or she is eating foods, offer smaller quantities of the usual foods but offer more frequently.

Practice:

The trainer showed trainees how to mix:

Y N He measured the liter of water.
Y N He showed how to open the packet.
Y N He poured all the salts into the liter.
Y N He mixed the solution.

The trainer showed participants how to administer:

Y N Using a live child or doll, he asked one of the trainees to replicate the mixing and administration process.

Interim Effects

This stage can require many forms of monitoring because it covers a wide array of activities and responses. Here are different monitoring techniques to gather information on interim effects.

- **Intercept interviews.** Mothers can be met in markets and other meeting places to ask about recall of messages from spots and posters.

- **Exit interviews.** As soon as a member of the target audience leaves the encounter or service, a short interview can be carried out to find out, for example, the messages given by a service provider, what he did during the encounter, what he gave the patient, what instructions he gave her about the product.

- **Sites visits.** These visits can be made for many purposes, such as to see mothers respond to service delivery in actual health centers, observe health providers' performance after training, or observe target audience's reactions to material to which they are exposed.

- **Individual Interviews.** These are done where the target audience can easily be found. Using a very short questionnaire, specific questions regarding message content, obstacles to behavior adoption, aspects of product presentation, and availability are asked to find possible causes for early product rejection.

Observation of the Behavior

An observation form is developed for all of the behaviors that the health worker is expected to perform at the end of training. Participants should be monitored during training to be sure they can perform all the essential behaviors before completing training. They should also be monitored for performance of these same behaviors on the job. These observation forms permit you to correct your training and to provide supportive feedback and reinforcement to the participant during training and the worker in the field after training.

Example 2. Giving Immediate Feedback on Performance

The following checklist is similar to that used to evaluate health workers in a project in West Java, Indonesia. Those health workers were given diarrhea-counseling cards and brief instructions in how to use them. One card showed the diagnostic algorithm for

diarrhea; four color-coded cards described the appropriate, recommended treatment for the mother to follow. The health workers then used the diagnostic card and one of the four treatment cards (depending on the severity of the diarrhea of the child whose mother they were counseling) in a role-play situation. Observers rated the performance of three health workers, using the checklist. They gave these data to the trainers so they could determine what additional training needed to be conducted.

The data presented below show that the counseling cards worked well. The health workers made the right diagnoses and selected the corresponding treatment cards.

Skill	Health Worker I		Health Worker II		Health Worker III	
	Yes	No	Yes	No	Yes	No
Listened to mother without interrupting	x		x			x
Asked questions from diagnosis card	x		x		x	
Made correct diagnosis	x		x		x	
Selected correct counseling card	x		x		x	
Read directions	x		x		x	
Showed mother how to mix ORS		x	x			x
Showed mother how to administer ORS		x	x		x	
Had mother practice these two steps	x		x			x
Gave praise as was appropriate		x		x		x

But health workers still needed more training in how to demonstrate mixing and give mothers praise. The trainers had the health workers practice these skills in their follow-up sessions. Two weeks later they evaluated the health workers again. This time the role plays proceeded virtually flawlessly, indicating that the health workers not only knew how to use the counseling cards but also know how to demonstrate mixing and reinforce mothers' behavior in trying out the skill.

Synthesis

What monitoring does:

- Examines the intervention's strategy, delivery systems, training, messages impact, behavior, and reaction
- Assures activities are consistent with plan, strategy
- Corrects errors of distribution sites, broadcast hours, stations
- Assists in confirming launching of campaign when products are in place
- Reshapes training sessions
- Changes message strategy
- Provides midcourse corrections of implementation

The stages of monitoring are logistics, interim effects, target behaviors, and health status improvements. These monitoring stages are chronological, sequential, and increasingly complex. The use of a monitoring guide and forms for components in each stage determines what elements of the intervention are being delivered as planned.

Application

1. Make a list of all the components you have in your intervention that you can monitor using Worksheet 24-1, What To Monitor.
2. Draw up a monitoring guide or form for each component so that you will be able to compare and analyze all observations and other data easily and systematically. Use Worksheet 24-2, Designing the Monitoring.

Worksheet 24-1

What to Monitor

A. Logistics
   1. Materials production and pretesting
   2. Distribution of systems
      Print Products:
      Audio
      Video

   3. Mass media broadcasts

      Radio
      TV

B. Mass media response

C. Interim effects

   1. Knowledge
   2. Practice
   3. Health improvements

Worksheet 24-2

Designing the Monitoring

Design your monitoring forms according to the list decided on Worksheet 24-1. Here is an example. You design one for each element to be monitored.

Distribution of print materials. Are posters up, but not where your audience can see them? Have your flip charts reached the health centers where the health workers have been trained in their use?

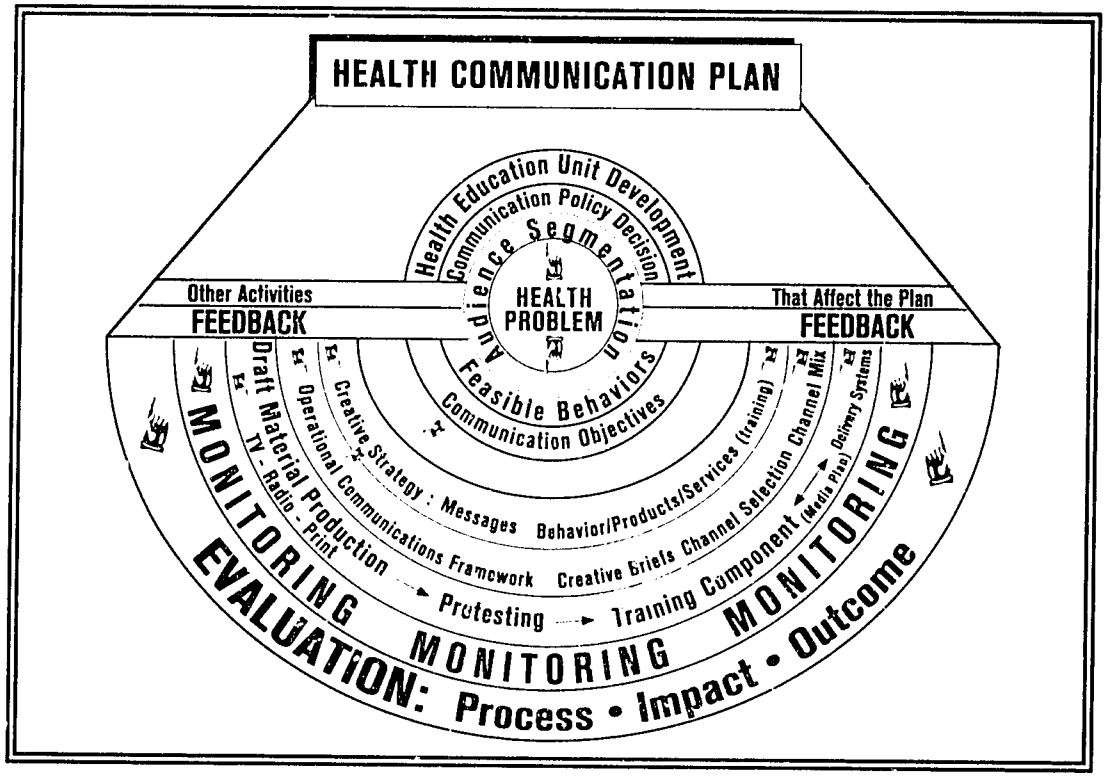
These types of questions can help you find out if materials are reaching the target audience in a timely and effective manner. The team may want to test several distribution systems and, based on the results of the monitoring system, select those that are the most effective.

Question 25

How Do We Evaluate Whether Our Communication Intervention Is Achieving Its Objectives? How Do We Know What Components Need To Be Corrected?

In the previous question you analyzed the elements that make up a monitoring system. In this final question you will focus on ways to carry out an evaluation. Several different evaluation designs and methods will be reviewed. The ones you choose will depend on your resources, as well as the kinds of information you have available and the use you want to make of the findings. Evaluation of your health communication intervention should build on data collected in monitoring which will enrich your understanding of your project for reporting purposes and eventual adaptation, revision, or expansion.

Evaluation is found in the following position on the chart.



Skills/Knowledge

By the end of this question, you will have accomplished the following:

1. Explained the advantages of evaluating your intervention
2. Distinguished among process, impact, and outcome evaluations
3. Applied criteria to choose the evaluation design that will be most useful to evaluate your communication intervention
4. Identified four steps in carrying out an evaluation plan: establishing evaluation objectives, determining evaluation research design, analyzing evaluation results, and making use of evaluation data (Worksheets 25-1 and 25-2)

Introductory Note

The purpose of evaluation is to determine to what extent your intervention has been effective. Evaluation findings provide credibility for the methodology, the health education unit, and/or strategy. Findings that demonstrate the success of your intervention help to justify the time and care invested in research and planning. All interventions teach something. Mistakes can be detected and should not be repeated. Successes can be shared with others and built upon. If the evaluation includes input/benefit ratios, funders learn how efficient the intervention was and whether it should be revised, expanded, or replicated. Demonstrated impact helps decision- makers allocate funds and resources rationally.

Questions that evaluations answer include the following:

- What change occurred?
- How, when, and with which audiences did the changes occur?
- What aspects of the intervention contributed to these changes?
- What aspects of the intervention should be changed to improve results/management?
- How cost-efficient was the intervention?
- How did the results of the intervention compare with results of other similar interventions?

Reflections on Field Experience

Exercise 1. The Importance of Evaluation

Materials

Copies of Example 1, Why Evaluate?

Instructions

Ask team members to read the example and, in small working groups, answer the questions at the end of the example.
Have the groups compare their answers and agree on a common understanding of the ideas addressed.

Example 1. Why Evaluate?

The Philippines measles team was aware that their communication strategy and implementation activities had a good chance of getting funded for another two years. The extension would enable them to (1) sustain the level of effort needed to maintain the vaccination coverage improvements that were the goal of the intervention; and (2) expand the pilot nationwide.

They also were aware that they could not submit a proposal for new funds unless they could show the donors how successful the pilot communication intervention had been. To demonstrate their success, the team decided to carry out an impact evaluation that would demonstrate statistically that changes in vaccination practices had occurred, and that the changes were the result of their intervention.

The results of the impact evaluation showed that numbers of vaccinations and of mothers attending special clinic days promoted by the program had increased significantly. Vaccination levels, however, had not risen consistently across clinics or to the expected levels. If the team wanted to expand the project nationally, they needed to know what was working and what needed to be corrected.

To answer these questions, the team needed an additional approach to evaluation, one that would let them look at what and how activities had occurred. They reviewed project records and found that they had collected descriptive data on what was happening throughout the intervention. Those data showed that while more mothers were coming to clinics for immunizations, some health workers in some clinics continued to refuse to vaccinate sick children and some mothers refused to permit it. This information about what was happening at the clinic level - a form of process evaluation - helped them to adapt the program before taking it nationwide.

What purposes were served by these two approaches to evaluation? Which purpose is more important to program managers? To donors? What other purposes can evaluations serve? What questions can evaluations answer? Ask your team for their ideas about these questions and compare their list of purposes and questions with those in the following discussion of types of evaluation.

Background Information

Types of Evaluation

Two useful approaches to evaluation work together to assist program managers and donors. Process and other descriptive evaluations document what and how events occurred. Comparative evaluations, such as impact and outcome evaluations, measure which changes occurred and the extent to which they can be attributed to an intervention. They rely on comparisons between those who benefited from the intervention and those who did not.

The table below shows these approaches, the questions they answer, and when in the intervention the data are best collected.

Type of Evaluation	Critical Questions	Phase/Timing
Process Evaluation	Is the management/system performing to expected standards?	Throughout/as needed
Comparative Evaluation: Impact	Are health behaviors changing? If so, how much?	At transition point (e.g., reapplying for funding) or at end of program; at convenient moments or times of program change
Comparative Evaluation: Outcome	Did the target population's health improve? What was the communication program/intervention efficacy?	At end of program or program activity

Process Evaluation - What It Is and What It Answers

Process evaluation is based on a description of how the implementation process is being carried out, and how it in turn is demonstrating the efficiency of your program intervention management. It answers the following questions:

- What happened during the implementation?
- How was each step carried out or not carried out?
- Were activities consistent with the plans and strategy?

Information is collected in a systematic way about activities and qualities of the intervention to provide decision-makers with a basis for improving effectiveness, reducing

uncertainties and unknowns, and making fact-based decisions for future programs. This information reflects the events and experiences of the specific program in the real-world environment of personalities, resources, cultures, and climate. This type of evaluation provides an ongoing description of how the implementation process is being carried out; how efficiently plans, activities, and decisions are managed; and the consistency between strategy and plans and actual events. Process evaluations describe (1) variations between sites and between program components, (2) consequences that were not intended, and (3) real-life reactions and experiences of program practitioners and recipients.

Process evaluations help program directors determine to what degree the original plans and strategies have been respected at each of the steps of the implementation process. They demonstrate the degree of discrepancy between actual activities (materials, training, messages) and their original purpose as well as how consistent the delivery system, training, media plan, and monitoring system were with the overall communication strategy.

Process evaluations differ from monitoring in two key ways. First, monitoring data are collected and used as the program is implemented. Second, data are used at all levels to improve performance. Process data are also collected throughout the program, but they usually are analyzed at the central level at the end of the program, often to explain and enrich findings of impact or outcome evaluations. As noted in Question 23, programs are rarely implemented exactly as planned. Understanding how the program differed from the plan helps you strengthen future communication activities.

How Process Evaluation Is Carried Out

Data collection techniques used in process evaluations include observations (staff and beneficiaries); open-ended questionnaires; and the review, analysis, and interpretation of records and documents. These documents include program plans, monitoring forms, memos, and program activities reports. All documentation that will provide evidence to determine whether programmed activities were in fact carried out according to plans and to program decisions should be considered.

These evaluations are enriched by interviewing those people who have the closest contact and knowledge about the implementation process. These key informants have usually devoted serious thought, not only to what happened, but to how staff and community felt about the process. They can offer good ideas about improvements and possible modifications.

Some Techniques for Doing Process Evaluation

- **Observation.** This technique can be applied to process evaluation in several different ways and for different purposes. Observations can be made of individual or group behavior or of incidents or activities.

- Individuals or groups: These observations are conducted as they are performing specified behaviors over a period of time and should be done using a prepared observation guide.
- Incidents or activities: These observations will include events significant to the implementation process, such as key staff meetings and decision-making meetings with local or MOH authorities.

Here is an example of an observation evaluation technique.

Observation Checklist for Policy/Issues Meetings
Meeting with the Minister of Health Date:_____

Issue: Availability of ORS packets for the launching of media campaign .

Observations:	(Check those that apply) Yes	No
• interest shown by minister		
• solution or alternative provided for lack of ORS packets in stock		
• date given for when packets will arrive		
• budget allocation mentioned		
• decision made on how the problem will be resolved		
• satisfactory plan approved		
• budget allocated		

- **Individual Interviews.** For process evaluations, individual interviews, using open-ended questions, can be tailored to key informants and constructed in such a way that the information yielded by the informants illuminates what is happening during implementation.

  The questionnaires should be designed to generate and stimulate ideas and thoughts as well as information from key informants to shed light on the complete process and detect flaws or gaps between what was planned and what has been executed. Questions also will be phrased to obtain plausible reasons from key informants for why events did or did not occur. Thought should be given to phrasing questions and conducting the interview in a manner that is collegial, nonblaming, or nonthreatening, so that informants feel comfortable enough to share their thoughts with the interviewer.

A descriptive, open-ended questionnaire will have questions such as the following:

- Which logistics were in place so that ORS packets would be available at the right time? Which logistics were not in place?
- If not, what do you think went wrong?
- What could have been done to obtain the packets on time?

- **Record Review, Interpretation, and Analysis.** There are multiple records that a program keeps as it is being planned and carried out: memos, meetings minutes, letters, implementation plans, epidemiological data, and systematic activities reports. All of these documents constitute the living history of the program and its implementation. The problem with these records is that while they are excellent pieces of information, they usually are collected and considered separately.

  These documents provide different pieces of information. The evaluation analysis should not only review them in the context of the original plan and strategy, but also review them as they relate to or conflicted with one another. This process of relating project documents to what was expected should be an ongoing and evolving process throughout the project.

  Adequate meeting minutes should allow the evaluator to verify if decisions were based on the strategy. Memos should include clear statements related to those strategy decisions, sustaining the strategy decisions rather than contradicting them. Implementation plans should make it clear from the start which activities will be based on which strategic premises. Analysis of such documents should be based on what they reveal about what happened. Activities reports (monthly, quarterly, or other) can be used to track how the implementation was carried out and with what type of activities. Those activities implemented should be compared to those called for by the strategy to see how the content and time line differ. Differences between the two will be noted as part of the descriptive process evaluation.

Exercise 2. Carrying Out a Process Evaluation

Materials

Copies of Example 2, Process Evaluation

Instructions

Ask your team members to study the problem faced by the team in the example below. After reading the example, ask them to list reasons found in process evaluation to account for the differences between the two interventions.

Example 2. Process Evaluation

In Peru the health education unit carried out family planning and immunization interventions, hoping to increase participation in both programs. Immunization rates increased significantly, however, rates of family planning acceptors did not. The team wanted to isolate those program components that had been effective for immunization and less effective for family planning. They considered three possible explanations for the differences: (1) the media development processes and media campaigns were of different quality; (2) the health practices addressed were not equally susceptible to short-term campaigns; and (3) the field support was different.

Data Collected in Process Evaluation

1) As far as media development was concerned, their records showed that more extensive research had been done for family planning than for immunization. They had conducted intercept interviews in clinics that told them that the family planning messages were more likely to be recalled than the immunization messages.

2) As for ease of promotion of the two interventions, focus group discussions during the intervention showed that couples continued to be more concerned about childhood illness than contraception.

3) As for field activities, the immunization strategy had included a communication role for vaccinators, and their monitoring showed vaccinators' communication skills had improved during the implementation. In addition, in some sites community mobilization for immunization had been carried out and in these sites immunization rates increased more than in other sites. Central managers made more vaccines available at clinics so that clients also had greater access during the intervention than they did before.

   In contrast, there were no new field activities or supplies as part of the family planning intervention, and communication activities and family planning services were out of phase at several points in the intervention with clinic staff unprepared for increasing demand or expectations.

They hypothesized that health worker-client interaction during family planning visits affected couples' decisions to contracept. They had not, unfortunately, collected information about this interaction and, therefore, could not draw useful conclusions. The team was able to conclude that there was no discernable quality difference in media production, and that childhood illness was more of a concern than family planning.

Family planning's failure to coordinate between communication and field activities, the greater complexity of the contraceptive issue, and probably the failure to involve

communities and health workers in the communication strategy contributed to the smaller impact of the program.

Background Information

Types of Evaluations (continued)

Impact Evaluation

Impact evaluation is research designed to identify whether and to what extent a program accomplished its stated goals. Usually, in the case of communication activities, impact evaluations focus on the behavioral changes defined in the communication objectives. Impact evaluation data will help you determine if and to what extent the target audience is assimilating the expected knowledge and attitude changes and their level of initial adoption of behavior; for example, increased use of bed-nets or vaccination services.

Outcome Evaluation

Outcome evaluation is research designed to account for program accomplishments and long-term effectiveness in health status changes achieved by the target audience. Data will demonstrate the level of impact the communication intervention had on the program goals in terms of health status indicators, as well as epidemiological statistics; for example, declines in the incidence of malaria or cases of measles.

What they answer

These two types (impact/outcome) of evaluation use many of the same designs and methods, but they provide answers to different questions. They usually will not describe what within your project did not work. That is the role of process evaluation.

Impact and outcome evaluations provide answers to the questions, "Was there a change?" and "Was that change caused by the intervention?" They are used to demonstrate statistically that changes are unlikely to have occurred have occurred randomly and to suggest a cause and effect relationship between the intervention and changes that occurred.

Usefulness of these evaluations

Impact and outcome evaluations enable program managers to continue, redirect, or intensify their efforts if they have not met their objectives. They also may choose new objectives; for example, sustaining the improvements or moving in new directions. They can demonstrate the success of a program, the credibility of its approach, and the competence of the health education unit. In addition, findings can be used to redesign future activities, strategies, materials, and messages.

How are impact and outcome evaluations done?

Impact and outcome evaluations are based on comparison of one group or system both before and after the intervention or of a behavior/group/system (A) that did not benefit from the program with a behavior/group/system (B) that did. These are known as A/B comparisons.

Another relatively simple way of carrying out comparisons is the use of time series charts, in which data over time for a given clinic, group, or individual are entered in a time chart. For example, numbers of weekly clinic visits over similar two-month periods (matched for seasons and schedules) can be charted before and after the intervention. These two designs are discussed further in the Appendix to Question 8, Section 1.

Selecting an Evaluation Design

To decide which evaluation design fits your purpose best, you have to first establish evaluation objectives linked to the communication objectives you defined in Question 15.

Research designs most commonly used to carry out program evaluations are:

- descriptive designs for process evaluation
- time series or A/B models which rely on comparison for outcome/impact evaluation.

Several common research techniques can be used to carry them out. Some of these techniques have been described in Question 9, and others are mentioned here. They are presented in full detail in the Appendix to Question 8. The table below presents a comparison of the three designs.

Evaluation Designs

Design	Research Techniques (common to all designs)
Descriptive Describes and explains why and how the program responded, worked, and was implemented according to strategy and plan	Direct observations (see Appendix to Question 8)
A/B comparisons Compares behaviors, groups, systems, or other sets of data; eg. pre-post, case-control comparisons	
Time series Tracks a behavior or set of data over time, usually comparing pre- and post-intervention.	

Which of the three designs is best for your evaluation purposes?

The answer to this question depends on what type of evaluation results you need. The following criteria will help you make the appropriate selection of the evaluation design needed:

- If you want to show results from the process point of view, then you want to use the descriptive design that is common to the process evaluation.

- If you want to show impact over time, then the most appropriate evaluation design will be the time series.

- If you want to show behavior or health status change at one point of time, then the comparative design will be best suited for this purpose.

Who Should Do the Evaluation?

The answer to this question will depend on your past expertise in performing evaluations, personnel available, the budget at your disposal, the necessity to present an outside evaluation versus one done by yourself, time constraints, and the urgency to show impact.

Regardless of these considerations, a few criteria may help you decide whether you should or can conduct the evaluation yourself.

- Process Evaluation. Since you are close to the recordkeeping, you know the system. You have greater accessibility to those written documents and participate in many of the activities that form part of the evaluation itself. As part of an ongoing process, you are probably well equipped to undertake this kind of evaluation.

- Impact and outcome evaluations. To decide if you will undertake one of these types of evaluations, several questions will help you make the decision.

  - Are you familiar with comparative A/B designs?
  - Have you ever applied this design and then made analysis with the results?
  - Do you have expertise in the time-series design? Have you done it before?
  - Do you have access to data base facilities? Can you handle the data design processing?
  - Have you practiced writing conclusions based on that design?

If the answer is NO to any of these questions, you are better off asking help from someone who has had the experience and is familiar with these evaluation designs. It is not advisable to improvise in this field when so much is at stake.

Exercise 3. Comparative Designs

Materials

Copies of Example 3, Times Series Applied
Copies of the table, Total New Acceptors

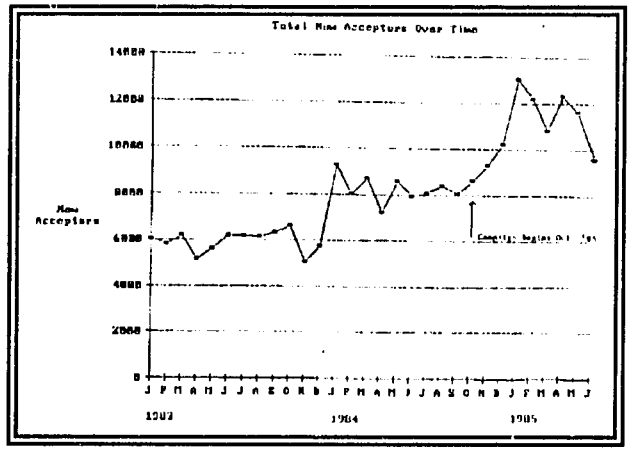
Instructions

Ask team members to read the example and study the figure in small groups.
One group should present how the example demonstrates a comparative evaluation.
The other group must give their conclusion without reading the one presented here.
Compare the two approaches.

Example 3. Time Series Applied

The Peruvian team wanted to measure the impact of their family planning intervention, specifically the objective of increasing the numbers of couples seeking information and accepting contraception at clinics. They had data on family-planning service use for several months before the intervention, so they decided to construct a time-series chart that would measure the primary evaluation objective, "Did the intervention produce an increase in the number of family planning visits to government clinics among individuals not previously using modern contraceptives?"

The MOH provided records for clinic attendance for 21 months before the intervention and nine months after. The chart recorded new acceptors (couples accepting modern contraceptives for the first time) and total clinic visits over this period. Almost all areas reported the new acceptors made up between zero and eight percent of their monthly visits over the 21 month period. These simple descriptive statistics do not show the team variation over time or in relation to the intervention. Charting the new acceptors showed a clear upward trend. If they compare the number of new acceptors in an average month before the campaign (6,937) and afterwards (10,866), the jump in acceptors is substantial. This simple comparison shows powerful effects for the intervention as the chart below demonstrates.



When the team studied the chart, they found two important problems with their conclusion. First, the upward trend existed before the start of the intervention. The pre-post differences may be merely two points on a long-term upward trend. Second, there are substantial month-to-month differences. Total clinic visits increased over time, so the percentage of acceptors remains approximately the same. The team wanted to see if there were other ways to account for the increase in acceptors other than the intervention. They looked at ways to predict what would have happened without the intervention. Their analysis showed that acceptors made up approximately two percent of clinic visits before the intervention. The team compared the number of acceptors that would have been expected without the intervention with the actual number recorded. What conclusions might they have drawn?

They concluded there was no apparent difference between predicted and post-intervention scores. The inference is that there was no intervention effect. This inference illustrates a major advantage of the time-series design. It permits you to distinguish results of your program from changes that would have occurred in the absence of the program.

Background Information

Carrying Out an Evaluation Plan

The following four steps will help you to determine an evaluation plan for your intervention.

Step 1. Establishing Evaluation Objectives and Indicators

It is first necessary to establish the objectives of your evaluation. They are not your communication strategy objectives, but they will be linked to those objectives. They are indicators of what you expect to see change as a result of your intervention in knowledge, practices, or health status. They are based on your evaluation objectives (see Question 6).

The following questions will help you develop a list of evaluation objectives:

- Why are we conducting this evaluation?
- What do we hope to measure or demonstrate?
- Who is our audience for the evaluation findings?
- Who will use the findings?
- For what decisions?

- Set the priorities
  Choose the most important and feasible objectives and the indicators that are most useful and practical to do. Of these objectives, which are most important and feasible? Setting priorities for your objectives helps you focus.

- Determine most useful/relevant objectives
  Of the objectives left on your priority list, which would be the most useful? How will the findings be used? A final examination of your list will help you eliminate any further evaluation objectives that are not necessary to explore. Even if you have the funds to evaluate all of your initial objectives, it is better to make your evaluation manageable and practical with results you can apply to future programs. Choose the most important and feasible objectives and the indicators that are most useful and practical to measure.

- Review funds
  Do you have the funds necessary to carry out your evaluation? Available funds will influence the size of your sample and the complexity of your research design. After examining your complete list of evaluation objectives, if you do not have the funds necessary to conduct research for every objective, simplify your design, cut down your sample size, and/or reduce your list of objectives and indicators by eliminating those that are less important.

Step 2. Determining a Research Design

The design to be chosen will respond to the evaluation objectives selected previously. The design will be descriptive, time series, or A/B comparative depending on the results needed and what they will be used for.

Step 3. Analyzing Evaluation Results

The analysis of evaluation results will be done using the key findings, communication objectives, feasible behaviors to be adopted, knowledge and attitudes to be changed, and the health status to be affected.

Step 4. Making Use of Your Evaluation Data

Program Planning. Evaluation results can be used to consider different strategies for the next phase of a communication-supported program.

Adapt Existing Program. Evaluation results can be applied to improve a program. These changes would be similar to those made or considered during early impact and follow-up monitoring.

Move on to New Programs. Evaluation can lead in many directions. For example, if your original objective was to teach mothers the dangers of dehydration and the uses of ORS, your evaluation will show you when this has been achieved by a critical mass of mothers and it is now time to make plans to sustain the practice and move on to something new.

For example: You may discover particular barriers to the use of ORS in a special group of mothers. Your new health communication program could be aimed at this segment

of the population. Or you might find that pharmacists are indeed teaching mothers about ORS and mothers are adopting it, so the treatment has gained visibility; however during the evaluation, physicians voice their doubts about ORS and so you might design a new health communication program to create materials to educate doctors.

Exercise 4. Establishing Evaluation Objectives

Materials

Copies of Example 4, Establishing Evaluation Objectives
Copies of the chart, Evaluation Objectives, Indicators, and Techniques

Instructions

Have team members read the example and use the principles to develop sample evaluation objectives that might be used for the Philippines evaluation.
They should choose an evaluation objective and two findings that would indicate that the objective has been reached (indicators), select the audience to be researched, and choose the technique to be used to measure each indicator.
Have them discuss their decisions and compare them with the choices made by the Philippines team as presented in the example and chart.
How were their choices similar? How were they different?

Example 4. Establishing Evaluation Objectives

The Philippines measles team hoped to determine whether their program had produced measurable levels of change in vaccination practices. To carry out an evaluation, they worked together to establish their actual evaluation objectives and indicators.

First they reviewed the communication strategy objectives that they had developed in their original plan. They had four communication objectives with a fifth objective that they later added as a result of monitoring (improve the interpersonal communication skills of immunization health workers at three clinics within one year). They developed a list of objectives and corresponding indicators for each communication objective. They developed the Evaluation Objectives, Indicators, and Techniques Chart, with indicators in priority order, to assess the components of one objective: Improve the interpersonal communication skills of immunization health workers. Which of the designs they chose is comparative? Why?

Evaluation Objectives, Indicators, and Techniques		
Evaluation Objectives and Indicators Determine to what extent:	**Audience**	**Technique**
Health workers are using new behaviors (which behaviors practiced)	Health workers after training	Observation
Performance was improved by training	Health workers before and after training	Observation of two groups
Mother understand health messages (knowledge)	Mothers	Exit interview
Information and practice has improved (knowledge and practice)	Mothers after seeing trained versus mothers seeing untrained health workers	Exit interview
Community perceives improvement in clinic services	Community members	Questionnaire, focus group

Exercise 5. Choosing An Evaluation Design

Materials

Copies of Example 5, Applying a Comparative Design; Appendix to Question 8, Section 1
Worksheet 25-1, Evaluation Design

Instructions

Ask your team to read the descriptions of the comparative evaluation designs and principles included in the Appendix to Question 8.
Have them choose an appropriate evaluation design for the Philippine case. Compare your team's choice with that described in the table below for the Philippine team.
Next have them work in teams to complete Worksheet 25-1 for an objective of their own intervention. The worksheet already includes one example of possible choices for the Philippine intervention.
Ask team members to include a rationale for selecting this method, audience, design, and technique. Ask them to discuss and compare their choices with each other and with the choices given in the chart.

Example 5. Applying a Comparative Design

The Philippines team wished to measure behavioral change, so they chose a comparative design. Since they thought about evaluation before doing their baseline research, they had gathered very specific, pre-program information. Therefore, they were able to use a pre/post group design to compare the knowledge, attitudes, and practices of their

health workers before the campaign when there was not an active communication component aimed at producing demand for vaccinations, and after the campaign to determine how effective the strategy had been.

Examining their evaluation objectives and the audiences for the intervention, they determined research techniques that would best gather this type of assessment information. The determination of design and method also enabled them to more specifically detail the audiences with whom they would conduct their evaluation. The following chart illustrates their selections.

INDICATOR	AUDIENCE	TECHNIQUE	REASON
Performance has improved by training (practice/behavior)	*Trained* health workers and *untrained* health workers (control)	Observation	Extent of behavior change. How change relates to intervention.
Understand health messages (knowledge)	Mothers at clinics *before* and mothers at clinics *after*	Exit interview	Extent of change in mothers understanding. How change relate to intervention.

Example of Analyzing Evaluation Results

Some of the key findings that the Philippines evaluation yielded follow.

Evaluation Findings

Health status/practice:

- Measles vaccinations increased significantly among the 12- to 23-month old children in Metro Manila, from 23 percent to 45 percent.
- Coverage for all other immunizations also increased significantly by at least 20 percent.
- The proportion of children who had not had any vaccinations decreased from 59.1 percent to 38.1 percent.
- The special vaccination day brought more mothers into the health centers than on other days.

Service:

- The extended hours did not result in a large number of mothers bringing their children into the health centers for measles vaccinations.

Media:

- Mothers cited TV advertisements as the most common source of information regarding the campaign: 97 percent cited TV; 37 percent, radio; 21 percent, poster at health center; and 9 percent, newspapers.

Analysis:

- Stimulating demand for vaccinations resulted in the increased timeliness of measles vaccinations, knowledge of the specific need for measles vaccination, and knowledge of where and when they could be obtained.
- During the campaign the rate of missed opportunities for giving vaccinations decreased; however, the rate was still too high. Work needs to be done to further reduce levels of missed opportunities.
- Some health workers still lack knowledge of MOH vaccination policy and appear to be reluctant to follow policy even though they know what it is. They appear to be unwilling to give vaccinations unless mothers have cards (research showed that mothers only bring their card if they are coming for vaccinations and not for sickness. And mothers and health workers appear reluctant to give several injections at the same time or to have children vaccinated if they are sick).

Making Use of Your Evaluation Data

Evaluation results can be used to consider different strategies for a communication supported program. In the case of the measles example above, results suggested the following specific actions:

- Health center staff knowledge is a problem. Additional training or refresher training could provide necessary information.

- Staff attitudes are a problem. Encourage changes in attitude through intensive workshops on interpersonal communication.

- Lack of vaccination cards is a problem. Prepare mass media messages encouraging mothers to always take their cards to centers, regardless of the reason they are going.

- Mothers' reluctance is a problem. Help them understand the importance of vaccinating sick children or the acceptability of multiple vaccinations.

Synthesis

Reasons to evaluate are (1) the need to know what and how the intervention happened and (2) lessons learned and benefits received. Types of evaluation are (1) process, which describes program efficiency and the process of implementation, and (2) impact and outcome, which demonstrate changes and causality. Evaluation research designs for process evaluation include descriptive designs using observation, case studies, interviews, and records. For impact and outcome evaluation, they include comparative designs using times-series and A/B designs.

The four principle steps to conducting a simple evaluation are as follows.

Step 1: Establish priority, useful evaluation objectives and indicators.

Step 2: Determine the appropriate research design, including type, methods, and audiences.

Step 3: Analyze evaluation results with a view to adapting existing programs or moving on to new programs.

Step 4: Make use of the evaluation data.

Application

1. Ask your team to fill in Worksheet 25-2, Evaluation Analysis, for two evaluation objectives for their planned intervention. If they do not yet have evaluation findings, they will need to fill in the worksheet with examples of anticipated outcomes of their intervention. The worksheet includes an example from a diarrheal program.
2. Discuss the teams' choices and the value of the information they will generate for the program.

Worksheet 25-1

Evaluation Design

Program:

Date:

SELECTED METHOD (Comparative)	AUDIENCE (Mothers with children under age two)	INDICATOR (Mothers are more satisfied after encounters with trained health workers than with untrained)	DESIGN (Time Series)	TECHNIQUES (Observation)	REASON FOR SELECTION (Measures changes in mothers' satisfaction over time which indicates their future intent to use service).

Worksheet 25-2

Evaluation Analysis

Program:

Date:

AREAS/BEHAVIORS (OBJECTIVES) EVALUATED	KEY FINDINGS	APPLICATION
(Mothers mixing ORS packet)	(- Standard liter not used - Did not use whole packet)	(- Identify a common available standard liter - Promote using one packet to one liter)

SECTION III

ADDITIONAL TOOLS

NOTE TO READERS: This Policy and Procedures Manual was originally developed by HEALTHCOM Resident Advisor Jose Ignacio Mata in collaboration with the Health Education Division of the Ministry of Health of Honduras. This translation of the original Spanish version is presented here as an example that readers may choose to follow in creating a similar manual for their own health communication unit. Your unit may be much smaller or larger than the one that is described here; therefore, your own manual may be much simpler or much more extensive than this example. We recommend, however, that you try to cover all of the topics listed in this manual regardless of how much or how little detail you include.

POLICY AND PROCEDURES MANUAL FOR A HEALTH EDUCATION UNIT

I. Defining Health Education and Communication

The World Health Organization defines health education as "that part of health care that deals with promoting healthy behaviors." This promotion of healthy behavior should not be a one-way affair; it should be based on a knowledge and clear understanding of the current behavior of the general public so that it can, in turn, assist the public in understanding the ways that this current behavior affects individual health.

The promotion of healthy behavior should not be a vertical process instituted between the organization and the general public but rather a two-way process of communication based on continuous consultation with the public to guide decision-making throughout that process.

Health communication can be defined as the process of understanding and responding to the needs for information and motivation felt by a specific audience in order to support the adoption and correct application of behaviors benefiting the health of the individual and/or his or her community.

The health communication approach is based on the following premises:

- Understanding and responding to the needs for information and motivation felt by an audience involves consulting that audience in order to identify, in collaboration with its members, any health problems and the behaviors that cause them.
- Supporting the adoption and correct application of behaviors beneficial to health involves consulting both the audience and health organizations in order to define those behaviors and support the conditions favoring their proper application. In this regard, solutions should reflect the local context, satisfy local needs, and be applicable using local resources.
- Knowing whether solutions promoted have benefited the health of the individual or the community involves consulting the audience in order to evaluate the usefulness of those solutions.

Individuals and communities are responsible for their own health, provided that they have available the resources for developing healthy behaviors. It serves no purpose, for example, for a person to know everything there is to know about nutrition if he or she does not have available the means to feed himself. For this reason, health education should promote behaviors that are adapted to the ability of their users to adopt them and put them correctly into practice.

II. Objectives of Health Education

The objectives of health education cannot be different from the objectives and goals of national health policy, inasmuch as education will be an instrument for effectively achieving them. The role and objectives of health education are framed within the strategy of such a national health policy.

The general objectives of health education can be defined as follows:

1. Delivering to the greatest possible number of members of the priority population group information on behaviors that will be of benefit to their health and to the health of their community, on the availability of health services, and on the way such services can be used.
2. Motivating the greatest possible number of members of the target population to adopt the health behaviors being promoted and make use of available health services.
3. Training the members of the population group to correctly apply such health behaviors, thereby obtaining the expected benefits.

The above-listed objectives indicate that the function of health education is not limited to providing information on healthy behavior. Nor can it remain at that level, since if the public has a knowledge of a particular behavior but fails to adopt it, the effort will have been in vain.

Likewise, health education does not consist merely of actions designed to encourage the public to adopt a particular set of behaviors, since if such behaviors are not learned correctly, they may even be counterproductive. Or, if they cannot be applied due to a lack of resources, a sense of frustration and future distrust might be created among the members of the target audience.

Health education should transfer health behaviors, adapted to the ability of the audience to adopt them, to priority segments of the population and train the members of those population groups in their correct application.

III. Health Education Methodology

The health education methodology involves the following steps:

1. Identification and prioritization of the health problems to be addressed and, based on those problems, determining the particular segment of the affected population group to which the actions and messages will be directed.
2. Conducting research on the knowledge, opinions, attitudes and practices of the population with regard to the priority problems identified.
3. Systematic planning of health education and communication actions.
4. Development of high-quality educational materials. In order to ensure their effectiveness and appropriateness, these materials should be pretested with the target group prior to final production and distribution.
5. Implementation of the communication plan by integrating the various elements of that plan with the active participation of the community and in coordination with any other organizations involved (providers of inputs, universities, grassroots organizations, etc.).
6. Follow-up and monitoring of the implementation of the plan and evaluation of the impact of the activities and of the effectiveness of the various elements of the plan.

STEP 1. Identification and prioritization of the health problems to be addressed and, based on those problems, determining the particular segment of the affected population group to which the actions and messages will be directed.

A first step in the health education methodology involves setting priorities, in collaboration with Ministry authorities and in accordance with national health policy, those health problems on which educational actions are to be focused.

Definition of the health problems leads to the identification of the population group involved in the manifestation of, or solution to, those problems. Identification of the population group makes it possible to direct research and communication activities toward this particular audience.

STEP 2. Conducting research on the knowledge, opinions, attitudes and practices of the population with regard to the priority problems identified.

It is not possible to plan or implement effective health education activities in the absence of a thorough knowledge of the views of the target population with regard to the various priority health problems identified. A knowledge of those views will make it possible to design strategies that are truly focused on the root of those problems.

Research conducted on the various segments of the population group involved in the health problem makes it possible to decide:

a. Which current behaviors involving the health problem will need to be modified or eliminated and which new behaviors will need to be introduced.
b. What the target population will need to know about the new behaviors in order to be motivated to adopt them and put them correctly into practice.
c. Which communication media will be most appropriate for delivering the new knowledge and health behaviors to the various population segments.

There are a number of different techniques that can be used to conduct research on the general public. The most useful of these, based on their ability to generate an appreciable volume of information with relative ease, includes observation, surveys, open-ended interviews and focus groups. Participatory research methods can also be used in this step, though it will be necessary to bear in mind that such methods should refer specifically to the particular health problem being studied.

STEP 3. Systematic planning of health education and communication actions.

Health education and communication actions should be framed within a systematic plan in which the following are clearly defined:

a. behavior to be promoted,
b. objectives to be attained through promotion,
c. particular segment of the general population to which promotional activities will be directed,
d. messages by means of which the behavior will be promoted,
e. media that will be used in the promotional activities and the way in which such media will be integrated into a coherent strategy,
f. materials that will serve as a vehicle for the messages to be conveyed in each of the individual media,
g. schedule to be followed in the promotional activities,
h. coordinating mechanisms for implementing the plan,
i. mechanisms for monitoring and evaluating the various stages of the plan, and
j. resources to be used in implementing the plan.

STEP 4. Development of high-quality educational materials. In order to ensure their effectiveness and appropriateness, these materials should be pretested with the target group prior to final production and distribution.

Both the messages and the communication materials to be used should be tested and pretested with a sample taken from the population group to which they are to be directed.

Materials testing will seek to evaluate the ability of the materials to attract the target population, to convey the message in such a way that is comprehensible to that particular population to make the group feel involved with the message and to accept it, and to induce the members of the group to adopt a particular behavior or action.

STEP 5. Implementation of the communication plan by integrating the various elements of that plan with the active participation of the community and in coordination with any other organizations involved (providers of inputs, universities, grassroots organizations, etc.).

In implementing the communication plan, primary importance should be assigned to ensuring community participation, through the use of volunteer health workers. Implementation of the plan will seek to achieve the highest possible rates of coverage and impact.

Coverage depends to a large extent on the selection of appropriate media and on the timeliness of message dissemination, that is, the messages should be disseminated at those times during which the target population is exposed to a particular communication medium, and the target population should receive them precisely when the advice to be transmitted is required. Impact depends primarily on the appropriate selection of the behaviors to be promoted, as well as on their ease or difficulty of application.

In order to promote community participation of the community in identifying solutions to its own health problems, community-level health volunteers, who are properly trained for the task and equipped with the appropriate communication materials to reinforce their efforts, should be used.

STEP 6. Follow-up and monitoring of the implementation of the plan and evaluation of the impact of the activities and of the effectiveness of the various elements of the plan.

The health education and communication plan should establish the appropriate time and methods for conducting the continuous monitoring of the operation of the various elements of the plan as well as the periodic evaluation of the impact being achieved in terms of changes in the knowledge, attitudes and behaviors of the target population with regard to the health problem being addressed.

The evaluation should lead to the reorganization or follow-up of the communication activities being conducted so that the previously defined objects and goals can be achieved.

For conducting the evaluation, it will be necessary to use research techniques such as surveys and interviews, depending on the population segment.

IV. Areas of Activity of the Health Education Division

There are basically two areas of activity in which the Health Education Division is involved:

1. The design, implementation and evaluation of educational communication strategies through the integrated use of a number of different mass and interpersonal communication media, following the previously described methodological steps.

2. Promotion of community participation with a view toward making communication more a part of the community by training community volunteer health workers and providing them with educational materials to support their activities.

These two general areas of activity should complement each other in the development of a strategy. The action of mass media in the dissemination of health messages is strengthened and is more easily sustained through the efforts of volunteer community health workers.

The work of the Health Education Division is based on the premise that community participation is an efficient methodological instrument for achieving the health objectives of the general public.

The purpose of community participation in the analysis of health problems is to ensure that the community understands that:

- The health of the community depends on the responsibility of each of its members for his or her own health.
- There are diseases, such as cholera, polio, measles, TB, AIDS, etc., in which the failure of a single individual to take the necessary preventive measures may affect the rest of the community, with deadly results.
- The health of one community is contingent on the responsibility exhibited by other communities in the area and the region.

A community that neglects its health can transmit diseases to other communities as a result of the mobility of its inhabitants. A community that pollutes water sources with human waste affects all of the other communities that depend on those sources of water.

- Individual health depends on the conditions prevailing in the environment in which the individual moves.

A community that does not have available minimal infrastructure for environmental health, such as that required for the proper disposal of human and solid waste, exposes its inhabitants to infectious and vector-borne diseases.

From the above, it can be concluded that health maintenance is a social responsibility both of the individual vis-à-vis his neighbors as well as of the community vis-à-vis its inhabitants and neighboring communities, and not merely an aspiration to which the community itself is free to assign a priority as it sees fit.

The role played by community participation in solving health problems involves enabling the community to:

- provide support to its members in their efforts to adopt and maintain appropriate health behaviors.
- maintain environmental conditions that favor health and prevent the dissemination of any potential disease.

The prime movers for promoting community awareness with respect to both individual and social responsibilities with regard to health, as well as the implementation of activities favoring health, are the volunteer health workers. Volunteer health workers represent those members of the community who are conscious of these objectives and willing to voluntarily provide their support in transferring them to their community.

In order for volunteer health workers to be able to promote good health in their communities, they should receive continuous basic and refresher training as well as be provided with the inputs and educational materials that will enable them to efficiently discharge their responsibilities.

V. Mission and Functions of a Health Education Division

Mission Statement:

Contribute to the reduction of the mortality and morbidity rates for those diseases identified by the Ministry of Health as being the primary causes of death in the country through the promotion of knowledge, attitudes and behaviors favoring the health of the general public.

Functions:

1. Formulate, review and continuously readjust its organization to better ensure the achievement of its objectives and compliance with its functions.
2. Establish health education and educational communication activities toward that end at the various levels of the Ministry of Health.
3. Formulate, implement and analyze research efforts with respect to the knowledge, attitudes and behaviors of the general public as regards health problems.
4. Formulate educational communication plans and strategies with respect to health issues in accordance with the priorities and objectives set by the Ministry of Health.
5. Produce the necessary educational communication materials necessary for implementing the educational and communication strategies.
6. As part of the communication strategies, implement and evaluate training activities directed toward the community and the volunteer health workers.
7. Promote, through the use of volunteer health workers, the participation of the community in the analysis and solution of its own particular health problems. Produce educational materials to support the actions of the volunteer health workers.
8. Evaluate the educational communication strategies and plans being developed.
9. Formulate, implement and evaluate continuous training plans for its staff on the various methodological and technical aspects of communication and health education.
10. Formulate an annual work plan in accordance with the policies and priorities established by the Ministry of Health.

FUNCTION 1. Formulate, review and continuously readjust its organization to better ensure the achievement of its objectives and compliance with its functions.

The organization of the Health Education Division, or HED, should be adapted so as to facilitate the implementation of the areas of activity deriving from the methodology of educational communication and social marketing. This organization should also be flexible in order to make it possible to respond to the evolution of that methodology.

The organization of the Health Education Division is focused on the implementation of the principal areas involved in the methodology:

a. Research, which includes all those actions involving consultation with the general public, such as:

- the initial research effort conducted with a view toward formulating communication strategies
- impact evaluations (both formative and final) and the continuous monitoring of the communication activities deriving from each strategy
- pretesting of the communication materials prior to their final production

b. The planning and implementation of communication actions

Such planning includes all actions related to:

- the design of communication strategies based on the results of the research efforts
- the design and production of communication materials
- the establishment of radio broadcast schedules and mechanisms for distributing graphic materials
- the management and supervision of the process of implementing the communication plans and the continuous monitoring of the functioning of the various elements of those plans

c. The training of personnel at the various health levels

This activity includes:

- the training of health personnel in health education techniques and methods
- the training of community health volunteers in health and educational communication issues
- the design and production of the educational materials necessary for reinforcing these training activities

This structure should also take into account two levels of operation: the central level and the regional level, with their clearly defined, respective responsibilities and spheres of activity.

The Health Education Division at the central level will be responsible for:

- Establishing health education at the national level.
- Training and advising regional health education offices in the application of the steps involved in the social marketing and educational communication methodology.
- Planning, implementing and evaluating communication strategies for priority national health programs.
- Supporting, to the extent of its capabilities and material and human infrastructure, the health education activities planned by the various regions, in accordance with their particular needs.

The Regional Health Education Offices will be responsible for:

- Contributing to research efforts designed to study the knowledge, attitudes and practices of the population groups in their regions, in order to incorporate the results obtained into the general research activities being conducted on national priority issues.
- Working with community personnel (guardians of health, health auxiliaries, midwives, teachers, etc.) by advising them of methods to promote community participation and supporting their continuous training in health and communication issues.
- Providing support for the distribution of educational materials in their areas of influence and radio messages to be broadcast by local radio stations.
- Planning, implementing and evaluating communication strategies for priority programs in their areas of influence.
- Requesting from the central level the support necessary for producing their educational communication materials.

FUNCTION 2. Establish health education and educational communication activities at the various levels of the Ministry of Health.

Establishing for health education includes:

a. Establishing a methodological procedure to follow in health communication and education efforts.

This methodological procedure assumes the following premises:

- Any health communication activity originating in the Ministry should be part of a systematic plan and form a part of a carefully formulated strategy, and should in no case constitute an isolated activity.

- Messages and media should be selected following consultation with the target audience of the health program being addressed.
- Communication materials should meet quality standards that will ensure their effectiveness.
- As part of such quality standards, communication materials should be pretested prior to their final production.
- Communication plans should include provisions for training the health personnel involved in the program addressed by the plan, not only in the technical norms of that plan but also the educational and communication issues. In this way, health personnel will become efficient facilitators of the actions called for in the communication plan.
- Health communication plans should be continuously monitored through the use of systematic monitoring mechanisms. In addition, they should be evaluated periodically in order to analyze their effectiveness and make any adjustments necessary to ensure proper functioning. They should also be evaluated at the conclusion of the implementation process in order to analyze their impact on the target population.

b. Establishing the responsibilities and leadership of the Health Education Offices in work related to this activity.

This leadership will involve:

- Establishing, in coordination with the authorities of the Ministry of Health at the central and regional levels, priorities for health education.
- Participating in the development of the annual plans for the various programs, in order to formulate, in collaboration with the appropriate individuals, the education and communication components for those programs in accordance with established norms.

c. Establishing, in collaboration with the highest management levels of the Ministry, the mechanisms for financing health communication and education activities.

Such financing will be based on:

- Funds budgeted by the Health Education Division to cover staff payments, nonpersonal services, procurement and maintenance of equipment and commodities, and payment of per diem and training costs, as well as the design, implementation and evaluation of at least two annual communication interventions with areas of continuing priority interest at the national level. These funds will be requested in the annual work plan prepared by the Division and will be incorporated into the general operating budget of the Ministry.

- Funds allocated for health communication and education within the plans of the various programs, prepared with the active participation of the staff of the Health Education Division.
- External technical assistance funds made available under special projects.
- Funds generated by the sale of services through its various production units to other government entities or NGOs involved in health education. Such activities may include sales of communication materials (flip charts, educational videos, etc.) or the preparation, using its own equipment, of graphic productions for government agencies or organizations that currently contract such services to outside entities.
- Funds or materials donated by public or private enterprises in support of particular health-related activities or the production of specific communication materials for specific health topics.

Note to Readers: In the original version of this document, 28 pages were devoted to an explanation of Functions 3-9. Because this material is already covered in Questions 1 through 12 in Section II, Methodological Tools, of the Tool Box, we have deleted these 28 pages from this copy of the manual.

FUNCTION 10. Formulate an annual work plan in accordance with the policies and priorities established by the Ministry of Health.

The annual work plan for the Health Education Division will consolidate the activities involved in the application of the communication methodology to the various priority health programs.

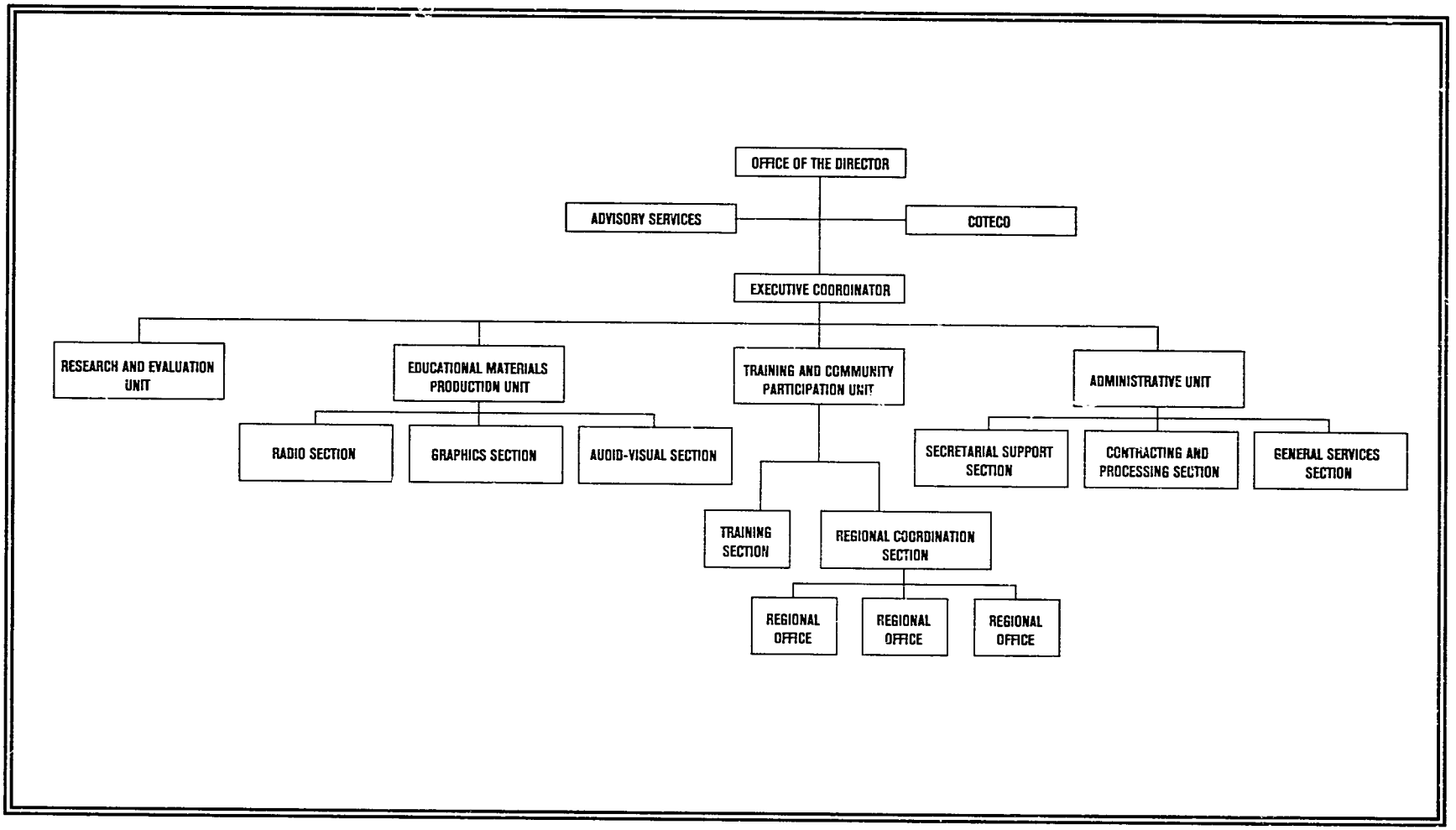
In preparing the annual work plan for the Division, the individuals in charge will examine the activities from the communication plans for each priority program, and those having the same implementation period will be consolidated.

For any other communication activities that may be required by the programs or divisions of the Ministry, the Health Education Division will implement the following activities:

- Advise on planning for communication activities.
- Advise on selecting a private entity for producing the materials necessary for implementing the plan.
- Support, to the extent possible, the production of communication materials.
- Train the staff of the health program in the implementation of the various activities involved in the educational communication methodology.

Organization	**Methodology**	**Media**
Research and Evaluation Unit	KAP Survey of the Population	Mass Media Communication Campaigns
	Impact/Outcome Evaluation	
Educational Materials Production Unit	Design of a Strategy and Communication Planning	Mass Media Materials
TCC	Design and Pretesting of Materials	Training Materials
Training and Community Participation Unit	Production of Educational Materials	Training and Community Participation Promotion
	Long Distance Training • Guides • Programs	
	Regional Educators	
	Volunteer Health Workers	
Administrative Unit		

Organizational Model of the Health Education Division



VI. Components of the Health Education Division

The Health Education Division of the Ministry of Health is composed of four different components:

- Decision-making and management
- Planning and coordinating
- Implementation
- Support

In addition to the above, which constitute the essence of its organizational structure, the Health Education Division has access to advisory services provided by national and international organizations for managing specific projects or activities.

A. Decision Making and Management Components

The decision-making and management components of the HED are as follows:

1. **Office of the Director of the Division**
   This office is responsible for the management and administration of all activities related to the Health Education Division, in accordance with its functions. It is responsible for securing approval plans and budgets by forwarding them to the appropriate higher level offices. In addition, it is responsible for coordinating the activities of the Division with those of all of the others divisions and programs of the Ministry, as well as for maintaining exclusive and direct contact with the Directorate General of Health, to which it reports.

2. **The Office of the Executive Coordinator**
   This office is responsible for coordinating the functioning of the various units of the HED as regards the implementation of activities resulting from compliance with the functions assigned to the Division. The Office of the Executive Coordination reports directly to the Office of the Director, to which it is attached and which it represents and replaces in the event of the absence of the Director.

B. Planning and Coordinating Components

The discharge of certain of the functions of the Health Education Division involves the coordinated participation of its various units. Accordingly, there are many activities for which planning should be developed jointly. The Technical Coordinating Council (TCC) exists for that purpose.

TCC is a strictly technical entity created for planning activities and making the necessary technical decisions to ensure the efficient implementation of the various functions of the Division. It is chaired by the Office of the Director of the Division or by the Office of the General Coordinator in representation of the Director, and is made up of the heads of the Units of Research and Evaluation, Training and Community Participation, and Educational Materials Production. To assist it in its decision-making functions, TCC may request the attendance at its meetings of any of the technicians from the various units.

TCC will use a team-work method in discharging in the following functions:

1. **Analyzing health education priorities and programming the necessary activities to address those priorities.**
   In carrying out this function, TCC will meet with the appropriate individuals from the various Ministry health programs to identify the educational needs of those programs. The establishment of such needs will lead to selecting priorities and the development of communication plans for each program.

2. **Analyzing and approving plans for activities involving research, materials pretesting and evaluation.**
   In carrying out this function, the Research and Evaluation Unit of the Health Education Division will submit to TCC its plans for implementing these activities for the various health programs.

3. **Formulating communication strategies and plans, in a joint and coordinated manner, with all of the units of the HED.**
   Communication strategies and plans will be formulated by TCC based on the results of the research on the current knowledge, attitudes and practices of the target population with regard to the health topic being addressed. Accordingly, TCC will draw up the various elements of the communication plan.

4. **Analyzing training plans.**
   The Training and Community Participation Unit will submit its training plan to TCC for analysis.

5. **Analyzing the budgets of the various activities deriving from the communication plans.**
   The Administrative Unit will submit to TCC for analysis the consolidated budget containing the individual budgets of the various activities.

6. **Formulating the annual work plan for the Health Education Division.**
   TCC will consolidate the plans of the various units of the HED and formulate, in consultation with those units, an annual plan that will integrate in a coordinated fashion all of the various activities involved.

7. **Analyzing and approving communication materials prior to final production.**
The Educational Materials Production Unit will submit to TCC ideas and formats for the materials to be used with the various communication media chosen for use in a particular strategy. From these, TCC will select those which are most appropriate to the objectives of the strategy, so that the necessary sketches can be prepared for pretesting. Once this task has been completed and the changes resulting from it have been made, the Educational Materials Production Unit will submit to TCC its final sketches for approval prior to final production.

8. **Redesigning communication strategies in accordance with the results obtained from monitoring and evaluation activities.**
TCC is responsible for reformulating strategies by incorporating the changes suggested by the results of the various evaluation activities.

In the process of applying the communication methodology, TCC will establish dates on which it will meet in order to carry out the activities deriving from its functions.

C. Implementation Components

The Implementation Components of the Health Education Division are as follows:

- Research and Evaluation Unit
- Training Unit
- Educational Materials Production Unit

1. Research and Evaluation Unit

This unit is responsible for carrying out the following functions:

- Formulating plans for research on the knowledge, attitudes and behaviors of the population with regard to health problems, as well as population preference in communication media.
- Formulating plans for monitoring and evaluating health communication strategies and plans.
- Directing and supervising activities involving research, materials pretesting, monitoring and evaluation.
- Training personnel that participate in gathering information for the various research, materials pretesting, monitoring and evaluation activities as well as for the evaluations of the communication strategies and plans.
- Consolidating and analyzing the results of research, materials pretesting, monitoring and evaluation activities.
- Preparing reports on research, monitoring and evaluation activities and submitting them to TCC for analysis as well as to the Office of the Director of the HED for approval and distribution.

- Formulating any relevant recommendations to enable TCC to develop communication strategies and plans and periodically adjust such strategies and plans in accordance with the findings of monitoring and evaluation activities.
- Designing and testing research instruments for collecting information from the general public through research, materials pretesting, monitoring and evaluation activities.
- Preparing methodological documents in the area of its specialty in order to provide support for the continuous training of the staff of the HED as well as of the Ministry in general.

2. Training and Community Participation Unit

This unit will have two sections, the Training Section and the Regional Coordination Section, and will be responsible for discharging the following functions:

- Designing, implementing and evaluating a strategy to ensure the continuous training of volunteer health workers using mass media (both radio and graphic) in combination with the production capabilities of the Health Education Division.
- Formulating the training component for the communication plans of the HED. This component will be integrated with the communication strategy in order to deliver new knowledge and health behaviors to the volunteer health personnel as well as to the target population.
- Preparing the content and format for training materials aimed at volunteer community health personnel.
- Formulating, implementing and evaluating a plan for the continuous training of the staff of the Health Education Division at the regional and central levels in areas related to their work.
- Preparing instructions explaining the use of communication and interpersonal training materials such as flip charts, etc.
- Coordinating, in collaboration with regional health educators, activities designed to provide support and supervision to the volunteer health workers and ensure the participation of that personnel in the process of collecting information in the field for research, materials pretesting, monitoring and evaluation activities.
- Establishing, at the level of the various health regions, the necessary mechanisms and network for distributing the communication materials.

3. Educational Materials Production Unit

This unit will have three sections, the Radio Section, the Graphics Section and the Audio-Visual Section, and will be responsible for carrying out the following functions:

- Preparing sketches of the formats for the communication materials to be used in the various communication media in accordance with the strategies formulated by the Technical Coordinating Council and submitting them to the latter for analysis and approval.
- Preparing scripts and story boards for audio-visual materials.
- Preparing at least two preliminary versions of each radio and graphic material for pretesting.
- Submitting to TCC and the representatives of the health programs material designs for technical pretesting.
- Participating in the pretesting of materials with the target population.
- Modifying preliminary designs by incorporating the results of the pretesting.
- Producing the final version of each material.
- Establishing the technical specifications for the requests for quotations for printing graphic materials.
- Supervising the printing of graphic materials in order to ensure their quality.
- Establishing radio broadcast schedules in accordance with the preference and exposure of the population to the various radio stations.

D. Support Components

1. Administrative Unit

The support component of the Health Education Division will be the Administrative Unit, which will be divided into three sections: the Contracting and Processing Section, the Secretarial Support Section and the General Services Section.

The Administrative Unit will have the following functions:

- Consolidating, in collaboration with the heads of the various units, the budget for the Division and administering the implementation of that budget.
- Requesting the disbursement of funds allocated to the Division from the appropriate offices of the Ministry as well as from funding agencies.
- Developing the specifications and terms of reference for the bids involving the procurement of goods and services and submitting them to the appropriate office of the Ministry of Health.
- Drafting and processing contracts, purchase orders, payment orders, per diems and other actions related to the implementation of the Division budget.
- Establishing a reasonable period of time for completion of its activities and providing the necessary follow-up to those activities.
- Exercising appropriate control over staff attendance and completing the necessary paper work to process vacation leave, sickness leave, etc.

- Providing the necessary secretarial support to the various units of the Division.
- Assuming responsibility for the cleaning and maintenance of the offices and equipment of the various units of the Division.

VII. Minimum Personnel Requirements

UNIT	TYPE OF PERSONNEL	NUMBER
Research and Evaluation Unit	Unit Head	
	Primary Researcher	1
	Researchers/Evaluators	1
Educational Materials Production Unit	Unit Head	
	Communicator Specializing in Educational Materials Production	1
• Radio Section	Equipment Operator	1
	Producers/Script writer	1
• Graphics Section	Principal Designer/Draftsman	1
• Audio-Visual Section (if video equipment is in place)	Video Editor	1
Training and Community Participation Unit	Unit Head	1
	Principal Trainer	
• Training Section	Trainers	1-5
• Regional Coordination Section	Regional Coordinators	1
	Regional Trainers	1
Administrative Unit	Administrator	1
• Secretarial Support Section	Secretaries	2
• General Services Section	Messenger	1
	Janitor	1

VIII. Staff Functions of Each Unit or Section

A. Research and Evaluation Unit

Researcher/Evaluator

1. Participate in training events involving health-related subjects offered to the staff of the HED by the various health programs.
2. Participate in the formulation of the objectives as well as in the development of plans for research, pretesting and evaluation activities and submitting them to the Technical Coordinating Council.
3. Participate in the formulation of research hypotheses.
4. Design the forms (surveys, interviews, etc.) and guidelines for the various quantitative or qualitative research techniques to be used in the research, pretesting and evaluation activities.
5. Participate in the training of the personnel selected to gather information in the field.
6. Participate in the pretesting of the forms and guidelines for the research, pretesting and evaluation activities and prepare the final designs for these materials in accordance with the results of those activities.
7. Participate in the process of gathering information in the field and act as supervisor of this activity as required.
8. Participate in the consolidation of the data generated in the research, pretesting and evaluation activities.
9. Participate in the analysis of the results of the research, pretesting and evaluation activities and submit the corresponding recommendations to TCC with regard to the formulation or modification of communication plans and to the Educational Materials Production Unit with regard to any changes resulting from the pretesting activities.
10. Participate in the preparation of reports on the research, pretesting and evaluation activities and in their submission to the various ministry health programs.
11. Participate, in its area of expertise, in the training events organized by the Training and Community Participation Unit and write articles on those areas for the training publications produced by this unit.

B. Educational Materials Production Unit: Radio Section

Equipment Operator

1. Operate the recording and reproduction equipment of the Radio Section.
2. Make copies of radio productions in the amounts and form required for pretesting in the field.
3. Make copies of radio materials in the amounts required for dissemination and deliver them to the Contracting and Processing Section for distribution to radio stations.

4. Participate in the pretesting of radio production materials after receiving training in this activity.
5. Keep an inventory and up-to-date control over the equipment belonging to the Radio Section.
6. Provide the necessary maintenance to the equipment belonging to the Radio Section in accordance with the appropriate service manuals.
7. Advise the head of the Educational Materials Production Unit with regard to any damage to or malfunctioning of the equipment under his or her responsibility.
8. Keep an inventory of radio supplies (cassettes, tapes, disks, etc.), as well as a register for controlling their appropriate use, and request restocking of inventories on a timely basis.
9. Participate in the health-related training events offered to the staff of the HED by the various health programs.
10. Participate, in the area of his or her expertise, in the continuous training activities provided for the staff by the Training and Community Participation Unit.

Radio Producer

1. Write copy for radio spots and programs in accordance with the messages identified in the communication plans.
2. Prepare at least two different radio spot formats for each message.
3. Submit the formats for the consideration of the health program for purposes of technical review and make any changes deemed necessary.
4. Submit the formats to TCC for its review and approval.
5. Submit the formats to the Research and Evaluation Unit and participate in the preparation of the instruments for pretesting those formats.
6. Produce recordings of the formats for their pretesting, using the resources available to the HED.
7. Participate in the pretesting of the formats with the target population, under the supervision of the staff of the Research and Evaluation Unit.
8. Participate in the consolidation and analysis of the results of the pretesting activities.
9. Make the necessary modifications to the formats in accordance with the results of the pretesting exercises.
10. Contact the radio announcers that are to participate in the final recording of the radio spots and negotiate terms of payment and the conditions of their contracts.
11. Produce the final versions of the radio spots by directing the dramatization of the radio spots and programs and participate actively in such activities if required.
12. Participate in training events in health-related subjects provided to the staff of the HED by the various health programs.

13. Keep an up-to-date file containing copies of all implemented radio productions.
14. Produce the audio portions of audio-visual materials.
15. Participate, in the area of his or her expertise, in the training events organized by the Training and Community Participation Unit and write articles on subjects related to his or her area of expertise for the training publications produced for this purpose.

C. Education Materials Production Unit: Graphics Section

Principal Designer/Artist

1. Prepare graphic designs for printed materials by producing sketches of the illustrations for those materials.
2. Prepare at least two versions of posters for both technical review and pretesting with the target population.
3. Submit the illustration to the health program for technical review and make any changes necessary as dictated by the results generated from the technical review.
4. Submit the graphic formats to the Research and Evaluation Unit so that the latter can prepare the appropriate pretesting forms.
5. Prepare a sufficient number of copies of the graphic formats for their pretesting.
6. Participate with the Research and Education Unit in designing the instruments for pretesting materials and in the implementation of the pretesting in the field.
7. Incorporate into the graphic designs any changes deemed necessary in accordance with the results obtained from the pretesting exercise.
8. Prepare the final art work for the graphic materials as well as the technical specifications required to obtain price quotations for printing services.
9. Supervise the process of printing the materials.
10. Supervise and coordinate the work of the artists/illustrators to ensure the timely production of art work.
11. Keep an up-to-date file of both the initial and final versions of art work for all jobs performed by the unit, together with several examples of printed materials.
12. Participate, in the area of his or her expertise, in training events organized by the Training and Community Participation Unit and write articles on subjects in his or her area of expertise for the training publications produced by that unit.
13. Participate in the training events in health-related subjects provided to the staff of the HED by the various health programs.

D. Education Materials Production Unit: Audio-Visual Section

Television Editor

1. Participate in the preparation of story boards for audio-visual and television spots and programs.
2. Edit television productions (spots and programs) and incorporate audio materials into such productions.
3. Collaborate in the filming and production of audio-visual materials.
4. Make the necessary copies of television materials.
5. Keep an up-to-date inventory of the editing equipment under his or her responsibility and provide such equipment with appropriate maintenance in accordance with the specifications contained in the corresponding users manuals.
6. Advise the head of the Educational Materials Production Unit of any damage to or malfunctioning of the editing equipment under his or her responsibility.
7. Keep an up-to-date inventory of the resources and supplies required to discharge his or her responsibilities as well as of their authorized use, and request the restocking of such supplies on a timely basis.
8. Participate in the training events on health-related subjects provided to the staff of the HED by the various health programs.
9. Participate, in the area of his or expertise, in the training events organized by the Training and Community Participation Unit and write articles on subjects in his or her area of expertise for the continuous training publications produced by that unit.

E. Training and Community Participation Unit: Training Section

Trainer

1. Identify and analyze the expectations of HED staff with respect to the areas in which they require training.
2. Prepare plans for the training components of the educational communication strategies formulated by TCC.
3. Design, implement and evaluate a system providing for the continuous training of community volunteer health workers by integrating the capabilities and resources of the HED.
4. Design, implement and evaluate a system providing for the continuous training of the HED employees.
5. Propose the training materials necessary for providing training to the target population and health personnel.
6. Prepare the content for the educational materials required for implementing the training activities.
7. Pretest the technical aspects of training materials in collaboration with the staff of the relevant health program.

8. Prepare the instructions for the proper handling of communication and training materials.
9. Participate in the organization of the training events described in the annual work plan of the HED.
10. Participate directly in the training of volunteer health personnel in the norms of the various programs and in the methods and techniques of educational communication and the promotion of community participation.
11. Design and implement plans for evaluating the impact of training activities on the knowledge, skills, and performance of the participants in such activities.
12. Contribute to the establishment and maintenance of a documentation center containing educational, training and reference materials, as well as a copy of all technical documents and reports produced by the HED in its many activities.

E. Training and Community Participation Section: Regional Coordination Section

Regional Trainer

The regional educators report to the Regional Coordination Section and are stationed in the various health regions of the country.

1. Collaborate in the process of gathering information in the field for the research, materials pretesting and evaluation activities carried out by the Research and Evaluation Unit of the HED, toward which end they will receive appropriate training.
2. In those regions where no central level personnel are available to coordinate field work for research, pretesting or evaluation activities, the regional educators will be responsible for organizing the process of gathering information in their regions through the application of the use of appropriate instruments and for returning the completed instruments to the central level.
3. Keep an up-to-date record of volunteer health workers and attend their scheduled meetings.
4. Take advantage of the meetings with volunteer health workers to:

    - Distribute educational materials to volunteer health workers who will in turn distribute them to their communities.
    - Obtain from volunteer health workers information regarding their needs and expectations in the area of training and pass that information back to the Training Section.
    - Obtain comments from the volunteer health workers with regard to the long-distance training system and transmit this information in the form of feedback to the Training Section.
    - Contribute to the training of the volunteer health workers to ensure their efficient participation in health education activities, by providing them with talks on or specific practice in subjects such as the following:

- How to conduct a focus group for analyzing a particular subject with the community
- How to administer a survey
- How to use a flip chart for community training
- How to prepare educational support materials with locally available resources
- How to evaluate changes in your community
- How to promote community participation
- The most common concerns of the general public with regard to the various health subjects and ways to respond to those concerns

- Participate in the supervision of volunteer health workers in the community.
- Answer any concern or questions that the volunteer health workers may have.
- Collect information, cases and anecdotes that can be channeled to the HED in the form of feedback and be used by the latter in its educational materials.
- Develop plans for promoting community participation through the volunteer health workers for the various health-related subjects.

IX. Quality Control Standards for Production of Communication Materials

Note to Readers: To save space, we have deleted this section as its contents are covered in Section II, Questions 16-21, of the Tool Box.

GUIDELINES FOR FORMULATING NATIONAL POLICY FOR HEALTH COMMUNICATION AND EDUCATION

Seminar Guide

Original Text: José Ignacio Mata
Additional Input: Reynaldo Pareja

Introduction for Seminar Facilitators

The seminar within the HEALTHCOM strategy

In addition to responding to an actual need of many countries to organize their health communication activities, this seminar constitutes the basis for introducing the series of training action workshops on the HEALTHCOM methodology. It forms a part of the proposal made up by those training events as the first event in the series. One of the conclusions of the seminar is the training of those members of the health staff of the Ministry of Health (MOH) as well as of the various public and private organizations involved in health education and communication in an effective methodology that can be adopted as a single, standardized methodology for all concerned. The seminar will no doubt become one of the guidelines for developing the national health communication policy.

How to Use this Guide

To date, this seminar has been held only in Perú. Accordingly, it is the Peruvian experience that has served as the basis for preparing this guide. Both the structure of the seminar as well as its content should be enhanced as it is held in new sites. In addition, this guide has been designed merely to guide facilitators on one possible way in which the seminar can be managed. It is left to the best judgement of the facilitators as to whether to modify the content of the subject matter or to illustrate the subject matter with examples drawn from their own experiences.

Given the expected level of the participants and the fact that the idea behind the seminar is to formulate a policy for a specific context that is known better to the partici-

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pants than to the facilitators, the latter should at no time assume a "teaching-learning" attitude. Rather seminar content will consist of mutual analysis and search for conclusions. From this perspective, the role of the facilitators is to conduct such an analysis from within the basic guidelines for developing a policy. This involves defining the objectives of the policy; determining a method to govern implementation of the actions deriving from the policy; and identifying coordination mechanisms that will render viable the participation of the organizations involved in such actions as well as the rational, shared use of resources.

To aid in conducting such an analysis, this guide contains a number of points that might be enhanced by the experience of or particular method used by the facilitators. Given the level of the participants, group work will be proposed not so much as a participative or democratizing way in which to manage the seminar, but rather as a means to conduct more extensive work on each of the subjects covered. Each group will be able to devote all available time to a single topic. The layout of the classroom and the tone for the entire meeting should be more reflective of a meeting of a board of directors to analyze a particular topic than of a group of participants present at a series of presentations or talks on such a topic.

General Objective

To initiate a process of developing and adopting of a national health communication policy

Specific Objectives

- To be able to identify the overall components involved in a national health communication policy
- To define, in coordination with high-ranking officers of the Ministry of Health and representatives of its primary support organizations (WHO, PAHO, UNICEF, USAID and others), the basic guidelines for developing a national health communication policy
- To review national and international experience in the use of health communication as a basis for developing a national policy
- To define mechanisms for the future definitive formulation and consolidation of a national health communication policy

Coordination

The office charged with organizing and coordinating the seminar should be the Directorate of Health Education or an equivalent entity.

Participants

- The Minister of Health or a representative that can ensure that the latter will receive clear information on the issues analyzed and conclusions reached in the seminar
- Directors General or heads of the various health programs of the Ministry
- Representatives of international organizations involved in health education (the World Health Organization (WHO), the Pan-American Health Organization (PAHO), the United States Agency for International Development (US/AID), UNICEF and other projects containing health education components), as well as non-government organizations (NGOs) involved in this field. Decision of who should participate will depend upon the specific country situation.
- Representatives of Social Security institutions and of the Ministry of Education
- Representatives of the Medical Association

Duration

One full day

Methodology

The seminar constitutes the first step in a process for developing the national health communication policy. In this sense, it represents an attempt to define, at the highest possible level, common criteria that will make it possible to establish an agreement with respect to the importance of educational communication in achieving the health objectives of the country.

In a subsequent step, an inter-institutional technical commission will be appointed to prepare a first draft of the National Health Communication Policy based on the conclusions drawn during the seminar.

This draft will be sent to all of the individuals participating in the seminar for their analysis and comments, after which the definitive document will be drawn up.

The seminar will be a combination of presentations of experiences that will be illustrative of the functions, areas of action, limitations of health communication, and joint work efforts by the participants leading to an analysis of and reflection on the issues generated by the guidelines for developing a communication policy.

Given the level of the participants, emphasis should be placed on ensuring that the

policy guidelines will be the result of the active participation of all those present. In this regard, the sessions will be open in nature. Even though there will be speakers who will present particular subjects, those present at the seminar will be free to participate and provide their opinions by asking for the floor whenever they consider it appropriate.

In order to encourage such participation, steps should be taken to avoid seating those present as if they were about to listen to a talk to be given to them. Rather, it is desirable to have available tables at which the participants can be seated in such a way that they will be able to see each other. The Minister of Health should be seated at the head of the seating arrangement, together with the moderator or person in charge of coordinating the seminar. It will be the latter who will introduce the speakers and moderate the interventions by following the previously established agenda. The speakers may be distributed among the participants and make their presentations from their seats or by proceeding to the head of the room to make their presentation and then returning to their seats. This will depend on local custom and protocol.

I. Conducting the Seminar

Morning:

Presentation of a number of successful experiences in which the communication strategy has been the decisive factor in determining the success of the health program.

Through group exercises and question guide, the participants will develop the content for:

- Objectives, a function and organization of health communication
- Elements of a methodological process for health communication
- Coordination and resources for health communication

Afternoon:

The afternoon will include presentation of group findings and a guided discussion on "Why a National HEALTHCOM Policy?"

A committee will be named (volunteer/votes) to draw up of a policy and a work schedule will be defined for it.

Suggested Agenda for the Seminar

8:00 - 9:00 a.m.	Opening ceremony and introduction to the seminar
9:00 - 10:30 a.m.	Presentation of three successful experiences in using communication to achieve the objectives of a health program
10:30 - 10:45 a.m.	Coffee Break
10:45 - 12:30 p.m.	Group work on the following topics: • Objectives, Function and Organization of Health Communication • Elements of a Methodological Process for Health Communication • Coordination and Resources for Health Communication
12:30 - 2:00 p.m.	Lunch
2:00 - 3:30 p.m.	Presentations and review of conclusions
3:30 - 4:45 p.m.	Presentation of video and open discussion: "Why a National Health Communication Policy?" (Moderator makes theoretical resumé)
4:45 - 5:00 p.m.	Coffee Break
5:00 - 5:30 p.m.	Definition of Committee: by vote/volunteer basis Definition of work agenda: · first draft · approval process · difussion of policy · decision
5:30	Closing ceremony

II. Inauguration of the Seminar and Introduction of Participants

The seminar will be inaugurated in accordance with the custom and protocol determined by the Ministry of Health as being appropriate for such events. Following the inauguration, the Ministry representative charged with coordinating the event (preferably the director of the office in charge of communication for health education) will proceed to introduce the activity.

He or she will explain the objectives of the seminar and the methodology to be used, provide the schedule and agenda, and then ask the participants to introduce themselves by stating their organization and the duties they perform.

The facilitators of the event will do likewise when it is their turn to introduce themselves.

The Ministry representative will emphasize the importance of the active participation of those present by asking questions or expressing opinions whenever they deem appropriate. He or she will stress the nature of the event as a sort of working session rather than attendance at a series of lectures.

III. Presentation of Three Successful Experiences in the Systematic Use of Communication to Achieve the Objectives of a Health Program

Note: Either two or three may be used, as determined by the facilitators. It has been shown that these examples are highly explanatory and motivating.

Time: From 9:00 a.m. to 10:30 a.m.

Duration: One and one-half hours (30 minutes for each presentation)

Materials: Those available to illustrate the presentations. For some, statistical tables are available in reports on file at AED which may be copied onto overhead slides. For others, as with the case involving the experience in the Dominican Republic, audio-visual materials are available.

Procedure: In presentations given in seminars conducted in Latin America, I suggest that any of the following experiences, which are amply documented by AED, be used:

- Strategy for promoting the use of condoms in the Dominican Republic. AED has available audio-visual material to illustrate this experience. (Advisor: Dr. Reynaldo Pareja)
- Strategy for the Tuberculosis Control Campaign in Honduras. (Advisor: Mr. José Ignacio Mata)
- Strategy for promoting the use of oral rehydration salts in Guatemala. (Advisor: Mr. José Romero)
- Strategy for the Acute Respiratory Infection Campaign in Honduras. (Advisor: Dr. Patricio Barriga)

The facilitators coordinating the seminar may use any of their own experiences. The only condition is that such experiences reflect the formulation of a communication strategy based on the results of formative research and contain the various elements proposed by the AED methodology.

A summary of the presentations will be found in Appendix 1. Copies should be made for the groups to consult while working.

IV. Reflection Exercise of the Experiences Presented

Time: 10:45 a.m. - 12:30 p.m.

Materials: markers, flipchart paper

Objective: To reflect in a group session on the elements involved in developing a successful health communication intervention

Procedure: Divide participants into small working groups. Instruct them to reflect upon the experiences presented. Give each group the Question Guide for this section (Appendix 4) to come up with their conclusions. These will be reported to the general group in an assembly session. GIve each group flipchart paper and two markers.

The facilitator must read aloud the instructions in the guide to make sure that participants understand the exercise should be done with only one of the experiences presented. Each group selects the experience with which they want to work.

The facilitator should go from group to group to aid the discussion process and see that group members do not stay long in any one section of the Question Guide.

He or she also must make sure each group has nominated a narrator for the answers for the General Assembly.

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V. Presentation and Review of Group Conclusions

Time: 2:00 p.m. - 3:30 p.m.

Objective: To give participants the chance to confront in an assembly the various group analysis and answers to the Question Guide.
Give participants a feel for the seriousness and technical level all the elements involved in a health communication strategy

Procedure: Ask a member of one of the groups to read out the conclusion to the section "Objectives, Function and Organization of Health Communication." Summarize findings on a flipchart. Ask if any of the other groups have something new to add. Complete the list.

Do the same thing with the next group and list the "Elements of a Methodological Process for Health Communication." With a third group obtain their ideas on "Coordination of Resources for Health Communication."

If any main ideas are missing from the conclusions, fill them in. Give a brief explanation of the ideas. You will find a detail description of all these ideas in Appendix 3. Make sure these points are covered:

(1) Objectives of health communication dialogue between general public and health organization

- Assessment of target audiences' knowledge, attitudes and practices
- Organization of health communication relation between central level and realities of population in areas of influence

(2) Elements of Methodological Process

- Systematic strategy framed within a process
- Technical criteria for choosing media channels not personal preferences
- Evaluation criteria defined beforehand and included in process
- Prioritization of health problems
- Research findings orient content definition
- Clear definition of behaviors to be achieved as related to research findings
- Coordination of implementation plan
- Follow up, monitoring and evaluation

(3) Coordination and resources for Health Communication

- Incorporation of the institutions involved
- Create an Implementation Plan
- Include the private sector (pharmacies, association of advertisers, etc.) and grassroots organizations, midwives, and other NGO's
- Training of health personnel and other related persons

VI. Theoretical Exercise

Open Discussion
"Why a National Health Communication Policy?"

This exercise allows the participants to express their opinions and provide comments with regard to the initial presentation and group exercise.

Duration: One hour and fifteen minutes

Time: 3:30 p.m. to 4:45 p.m.

Procedure: Present first video "Health Communication: Partnership for Survival" which comes with this package. If you do not have a VCR, go directly to the discussion using the Question Guide. Hand out the Question Guide to each participant. (Appendix 4.) One of the seminar facilitators will moderate the session. Another will summarize the interventions in succinct phrases that he or she will write on flipchart pages, which will subsequently be fastened to the walls of the room so that they will be visible and available during future analytical exercises.

Experience has shown that most interventions will deal with one or more of three broad areas: (a) the objectives, functions and organization of health communication; (b) methodological aspects; and (c) aspects involving coordination and the rational use of resources. The facilitator in charge of writing down the main ideas expressed by the participants should group these ideas together in accordance with these three broad classifications.

Members of the secretarial pool providing support to the seminar will type up the results of the interventions and subsequently distribute them to the participants, specifically those selected as committee members to draw up the MOH's Health Communication policy.

Materials: Flipchart and sheets
Markers

VII. Review of Conclusions

If possible during the break, an effort should be made to have the secretarial support staff prepare clean drafts of the conclusions reached by the groups and reproduce a sufficient number of copies so that they will be ready for use in the plenary session.

One of the facilitators will moderate the plenary session and once the conclusions of the three groups have been presented will invite those present to participate in a discussion and provide their opinions with respect to such conclusions.

Once the time allotted for this activity has expired, the facilitator will briefly summarize the conclusions regarding each of the subjects addressed and explain that the next step consists of forming an inter-institutional commission to prepare an initial draft of a national health communication policy. This draft will be sent to the participants with the request that within a predetermined period of time they forward their corrections and comments to the chairman of the commission so that a final draft of the document can be prepared and submitted to the Ministry of Health for approval, dissemination and appropriate decision-making, as required.

The Committee will have to follow the work agenda defined by all the participants. This should contain: date of first draft, approval process, and diffusion of policy definition.

VII. Closing Ceremony

The closing ceremony will take place under the direction of the Minister of Health or his or her representative, following the institutional protocol applicable in such areas.

Appendix I

Presentations

Communication Strategy for the Tuberculosis Problem in Honduras

Problem

In 1991, tuberculosis-caused morbidity was increasing at an alarming rate in Honduras. As a rule, when patients finally sought attention at hospitals and health centers, they would generally be in advanced stages of the disease. No one would seek attention at tuberculosis detection clinics on his or her own initiative. Patients at health centers would take flight at the mere suggestion that they submit to tuberculosis testing.

When health center nurses detected a patient with symptoms of respiratory disease and requested that the patient return to the laboratory with a sputum sample, in approximately 75 percent of the cases the individual would fail to return. Of the remaining 25 per cent, half would return with poorly taken samples. In these instances where it was actually possible to analyze the samples, when a positive case was detected it was difficult to locate the individual concerned because most of the time he or she would give a false address.

Dropout rates for patients receiving treatment exceeded 70 percent as of the fourth month and continued to grow in subsequent months.

Health Objectives

The National Tuberculosis Program established as its goal the detection of a specific number of symptomatic individuals per month and the analysis of a particular number of samples per month in the laboratory.

Health centers providing treatment to tuberculosis patients proposed to reduce to less than 20 percent the dropout rate for patients undergoing treatment with the hope of reaching the goal of 80 percent of all patients completing treatment and being cured.

Results of the Formative Research

With regard to the general population:

The research conducted on a sample of the population in various regions of the country revealed a considerable lack of knowledge with regard to the nature of the disease, the means by which it is transmitted, and the life expectancy of tuberculosis patients. Among other things, the research conducted on the general public revealed a widespread belief:

- That this disease is incurable and deadly. The life expectancy of someone infected with the disease is minimal.
- That the disease is extremely contagious, even as a result of casual contact with someone infected.
- That tuberculosis is a shameful disease because of the ease with which it is transmitted.
- That based on the above, the rejection and fear of tuberculosis patients was absolute in virtually all of the surveys conducted. The residents of some communities forced those discovered to have tuberculosis to move out of the neighborhood.
- That this disease was known as "tisis" when the patient had reached the acute stage.
- That this disease can be contracted not only by means of contact of any type with someone having the disease, but also by "serenarse" (coming into contact with the night dew) as well as by a number of different types of behavior involving exposure to abrupt changes in temperature.

Research conducted among patients revealed the following:

- When patients were advised that they had this disease, virtually all of them thought that there was no cure and that they would die despite the administration of medication.
- Fear of death was accepted with a sense of resignation, but fear of social and family rejection led those infected to cover up their sickness at any cost.
- At the time they were detected as being infected, all patients thought that the disease was transmitted by simple casual contact with someone having the disease.
- At the time they were detected as being infected, all were ignorant of preventive measures as well as of the appropriate measures for caring for someone infected with TB.
- Belief that the disease is incurable caused infected individuals to lose all interest in following any sort of treatment as they felt it would be a waste of time.
- Those who were just beginning to receive treatment experienced very bothersome side effects. Following an analysis of the causes, it was discovered that tuberculosis patients would go to health centers to receive their med-

ication while fasting out of the belief that medications are more effective when taken this way.
- None of those interviewed were aware at the beginning of treatment how long the treatment wold last.
- Shortly after beginning treatment, the symptoms of the disease would disappear. Upon feeling strong and healthy once again, many patients, would consider themselves cured and discontinue the treatment.

Research conducted among health workers revealed the following:

- Many of the tuberculosis program health workers displayed an attitude of fear and rejection of tuberculosis patients, which made it apparent that they were unaware of many of the realities of the disease and that they both shared and reinforced the myths prevalent among the general population.
- Health worker training had been discontinued. In many cases, when training did exist, it was not in accordance with the latest discoveries regarding treatment of the disease.
- Compliance with the norms issued by central program management was extremely low in the various regions.
- Health workers performed almost no educational activities directed toward tuberculosis patients. They limited their activities to clarifying certain doubts that the patients might have, based on their own perspective or their own level of knowledge.

Research conducted among members of the families of tuberculosis patients revealed that:

- The degree of knowledge of the disease and the fear of being infected was quite similar to that detected among the general public.
- Family members were unaware of the steps to be followed with tuberculosis patients and of the ways in which to assist in his or her recovery and eventual reintegration into family and social life.
- Family members were aware that they themselves were rejected by the general public out of fear that they too might be infected.

Audiences

- General population
- Patients
- Health personnel
- Members of patients' families

Messages and Channels Used in the Strategy

For the general population:

The objective of the initial stage was to present the disease as being curable and eliminate the rejection of tuberculosis patients by demythifying the communicability of the disease in patients already receiving treatment. In this way, it was hoped that the general public (neighbors, family members and friends), rather than rejecting the tuberculosis patient out of fear of infection, would pressure him or her to go to the health center and follow the recommended treatment as the only way to eliminate his or her ability to transmit the disease. Once the myth of the incurability of the disease had been eliminated and following the demythification of the patient's ability to transmit the disease, the program proceeded to promote the need for those showing any of the signs of tuberculosis to submit to testing. The messages transmitted in this stage were as follows:

- Tuberculosis is a curable disease if treatment is initiated in time.
- A tuberculosis patient that follows the prescribed treatment will no longer be able to infect others.
- If you have a dry and persistent cough for more than two weeks, go to the health center and ask them to conduct a sputum analysis.

The channels used for reaching the general public consisted of radio spots and three posters, each containing one of the messages.

For those for whom sputum analysis was recommended, leakproof glasses with a sealed lid were prepared. The outside of the glasses contained graphic explanations of the steps to be taken to ensure a good sputum sample.

For patients:

- Treatment must be completed; otherwise the bacillus will grow stronger and it will then be more difficult to get rid of it.
- Shortly after initiating treatment, the symptoms will disappear but the disease will not be cured until you have finished the treatment.
- In order to know whether you are cured, you should go for retesting when the health center tells you to do so.
- The treatment medication should be taken after meals, in order to reduce bothersome side effects.
- Steps to be taken in your daily life to facilitate recovery.

Information for patients was distributed by means of pamphlets given to them in health centers. In addition, health personnel were instructed to take advantage of those days on which tuberculosis patients arrived at the health center to receive their treatment to talk to them about the disease and about the steps that they should take

to speed their recovery. Health personnel were instructed to facilitate follow-up treatment to the greatest extent possible and to be flexible in specific cases.

Program staff encouraged the formation of groups of both patients and patient family members of patients to provide each other with mutual support with regard to the continuation of treatment and to provide support to new patients, based on their experience of having been beset by exactly the same problems and having found the way to overcome them.

For health personnel:
In addition to the above-listed messages, health personnel received up-to-date training in managing both tuberculosis patients and the disease itself. Health workers requesting transfers to other programs were listened to and their requests were granted

For members of the families of patients:
In addition to receiving the above messages, health personnel were instructed to include family members in the talks given to patients. The pamphlet prepared for patients contained many messages directed indirectly to family members.

Results

The evaluation revealed high levels of knowledge and acceptance by the general public of the fact that tuberculosis is curable and that the patient that is undergoing treatment can no longer infect others. Approximately 80 percent of those interviewed were able to list the steps to be taken if they experience a dry, persistent cough for more than two weeks.

Attitudes toward tuberculosis patients reflected some improvement during the campaign, shifting from rejection to compassion and a willingness to help and provide advice.

Work conducted during the campaign with regard to laboratory sputum analysis exceeded operating capacity, thus creating problems with excessive delays in the delivery of results.

Dropouts from the treatment program decreased by 50 percent.

An increase in voluntary requests received from health personnel to work in the tuberculosis program was observed.

Appendix 2

Questionnaire for the Reflection Exercise

Questionnaire for Group Reflection on the Experiences Presented

I. Objectives

Instruction: choose in the group the experience presented that best impressed the majority of group members and ask these questions.

1. What were the one, two or three most clear and distinct specific objectives defined by the Communication Strategy of the example presented?
2. How are these objectives related to specific behaviors, specific knowledge and specific attitudes?

II. Organization

3. How do you assume the MOH was organized intra-institutionally in order to be able to implement the health communication strategy and be successful (or not) in its goal achievement? (Be very specific in how the different departments within the MOH were organized and how they had to work together to make it happen. Who took what decisions, when and of what nature?)

III. Functions

4. What are the specific functions assumed by the implementors of the Communication Strategy? What did they do that was very specific to the achievement of the health communication goals that did not pertain to other technical areas?
5. What kind of decision making process did these implementors have to assume to be able to perform their assigned functions?
6. How did these functions affect the overall dynamics of the other MOH ongoing programs? Which functions created the most waves and resistance? How was resistance overcome?

IV. Methodological Elements

7. What communication activities carried out in the example were chosen?
8. What had to be in place, obtained or procured to be able to carry out those communication activities?
9. What services had to be contracted out in order to obtain the communication products?
10. How was the content of the communication strategy defined?
11. What type of research was necessary to define the content?
12. Who do you suppose carried out that research? Who finally took those results and how did they decide what was most important and least important?
13. How do you suppose the impact or success of the intervention was measured? What evaluation variables were used to carry out the impact assessment?
14. In your country's cost standards, how much do you think the intervention cost in general? What do you estimate was the cost pro-rated per number of persons reached?

V. Coordination and Resources

15. What were the MOH areas, departments or divisions involved in carrying out the communication strategy of your example?
16. How many people from the MOH do you think were involved in implementing the intervention?
17. What departments or programs of the MOH (or other sources) do you think contributed financially to make it happen? Human resources? Equipment? Other resources?
18. In the example analyzed, who do you think took the lead in the coordination of the various activities involved in carrying out the Communication Strategy? Who do you think should have taken the initiative?

Appendix 3

Guide of the Ideas To Be Obtained From Presentations

Ideas for Guiding the Reflection of the Presentations

Topic I. Objectives, Functions and Organization of Health Communication

Defining the Objectives of Health Communication

The general objective of health communication may be defined as establishing a dialogue between the general public and health organizations by means of which:

- health organizations are able to determine the perceived health needs of the population as well the knowledge, opinions, attitudes and practices of the latter as related to those needs and to the priority health areas defined by the health organizations, and
- the general public receives the information, motivation, and training necessary to improve its health situation through the adoption of behaviors that will prevent disease and aid in people's recovery.

Functions of Health Communication

This objective clearly defines its functions:

- Investigating, in collaboration with the general public, the health problems and needs of the latter by means of an assessment of their current knowledge, opinions, attitudes and practices; and
- Designing, implementing, and evaluating educational communication actions in a number of different media.

If it is true that health is "the responsibility of everyone" both (the general public as well as the various institutions involved), communication must be the most appropriate instrument for enabling the public and the organizations to reach an agreement with regard to a definition of priority health problems and how they can be overcome. There are those who argue that the problems must be prioritized by the population itself, as the latter will be unlikely to pay any heed to recommendations involving a

health problem that it does not consider to be a priority concern. This presents a problem in the case of preventable diseases. The general public considers a health problem to be a priority when it suffers the consequences of that problem, but does not consider issues related to the prevention of that problem to be of priority importance. For example, it is not possible to wait until the occurrence of an epidemic for the general public to decide whether to consider measles or polio as priority problems, even more important then safe water or the lack of food for their children, these later tend to be the most commonly mentioned priorities.
The determination of health priorities should strike a balance between what the population and health organizations identify as needs and problems.

The Organization of Health Communication

To efficiently carry out its functions, health communication requires an appropriate organizational structure. In addition, the personnel charged with carrying out those functions must have specialized education and should receive continuous refresher training.

On the basis of a unique methodological approach, the health communication organization must take into consideration, the decentralization of the planning and implementation of communication actions. Although the central level establishes parameters and methodological guidelines, it is at the level of the units into which the country's health system is subdivided (health regions, departments, and areas) that priorities should be established and specific plans developed. Such plans should take into account the particular characteristics, realities, and culture of the population groups located within their areas of influence.

Topic 2. Elements of a Methodological Process for Health Communication

Sometimes communication activities are the result of the particular decisions and personal preferences of the individuals in charge of a given program rather than a systematic strategy framed within a specific methodological process.

All too frequently health messages are shielded behind the easy solution of slogans generally lacking in significance for a population in need of concrete, practical and feasible advice. Certain communication media and channels are occasionally selected in accordance with the personal criteria and preference of program officials rather than as a result of a knowledge of the exposure and preferences of the population segments to which the messages are addressed.

Evaluation continues to be the most forgotten element in communication plans. For this reason, it is sometimes difficult to determine to what extent the stated objectives

in terms of behavior, changes are being achieved and which of the various elements of the communication strategy have been most effective in this effort.

A health communication policy should provide for the need to adopt a methodology for systematizing actions in this field. Such a methodology should include the following:

- The determination and prioritization of the health problems to be addressed based on objective data and on this basis, a decision as to which affected population group should be selected as the target of the actions and messages to be transmitted.
- Research into the knowledge, opinions, attitudes and practices of the target population with regard to the priority problems thus identified.
- The systematic planning of the communication actions. Such plans should include:

  - a clear definition of the behaviors to be modified by, or introduced to, the target population and the development and testing of practical, clear, and feasible messages in this regard, and
  - the decision as to which communication media and channels are to be used, based on the exposure and preferences of the target population and the nature of the messages.

- The development of high-quality educational materials. To ensure their efficiency and appropriateness, such materials should be pretested on the target population prior to their definitive production and distribution.
- The implementation of the communication plan by integrating its various elements and in coordination with all of the other organizations involved (providers of inputs, universities, or grassroots organizations).
- Follow-up and monitoring of the implementation of the plan and evaluation of the impact of the activities and effectiveness of the various components of the plan. The evaluation should lead to the readjustment and follow-up of communication activities until the established objectives and goals have been achieved.

Topic 3. Coordination and Resources for Health Communication

Another key element of a national health communication policy involves both coordination and the mechanisms for incorporating around a single plan and within the framework of a common methodology all of the various institutions involved, together with their resources.

Based on a common plan and a common methodology and under the coordination and leadership of the Ministry of Health, a number of different national and international

organizations can contribute to the implementation of any of the various elements of that plan or to the financing of the communication materials required for its implementation. Thus, for example, universities at both the central and regional levels can provide support in the implementation of assessments and evaluations in the form of practice work for social sciences students. Such students can also be of considerable assistance in the areas of production and testing of communication materials through schools of journalism, graphic or plastic arts.

A health communication policy should establish mechanisms for involving the Ministry of Education in the achievement of health objectives. Formal education programs should include priority health topics, so that the education of children and young people will ensure their future as adults who practice healthy behaviors. Students are also a valuable and inexpensive vehicle for transmitting health messages to other members of the family. It is the responsibility of the Ministry of Health to formulate the content of the health messages and provide appropriate training to teaching personnel.

Coordination mechanisms should also involve the private health sector.

- Pharmacies, for example, are in many cases the only source of information for entire sectors of the population that have no access to health professionals and depend on pharmacies to obtain relief for their ailments.
- Midwives, traditional healers, and other representatives of the traditional medicine sector, duly trained, can be very effective vehicles for promoting improved health behaviors.
- Professional health organizations, to whose members it is possible to deliver the messages to be promoted together with continuously updated information on the objectives and norms of the various health programs for managing the problems under their responsibility.
- Grassroots organizations through which it is possible to establish a dialogue with the prioritized population segments of the population and coordinate, in collaboration with the community, mechanisms for implementing the plans.
- Associations of advertisers and advertising agencies with a view toward incorporating health messages into the promotion of products related to health behaviors and regulating those which run contrary to appropriate health behaviors (alcohol, tobacco). An initial step in the implementation of a policy in this regard involves the development of an assessment that will make it possible to learn of the available public and private institutional resources (personnel, infrastructure, materials) for health communication and the search for mechanisms that will foster improved joint utilization of such resources.

A decisive element in the implementation of a health communication plan is the evaluation of the resources, both human and material, that are available to contribute to

achieving the stated objectives. In this regard, the training of health personnel is a critical element in the success of any strategy. Such training should have as its objective the delivery of a homogeneous message to the target population. It will be of no use, for example, to persuade mothers to vaccinate their children if the attitude of the personnel with whom they must deal in the clinic drives them away forever. Likewise, it will be of little use to promote breastfeeding if during the first consultation following childbirth the physician or pediatrician suggests that the mother use artificial milk as a supplement.

Within existing resources, it will be necessary to consider and evaluate the educational opportunities represented by out-patient consultations in health centers and all contact by the target population with the health services.

Appendix 4

Question Guide for the Open Discussion

1. Is it necessary for an MOH to define a health communication policy?

2. If the country already has a health communication policy, is it sufficient or does it need revision in light of the exercise done? If so, what needs to be changed?

3. What should be the objectives of the health communication policy?

4. What should be the functions of all those participating? If there is already a policy, are the functions well defined? Is there much overlap in them, creating a conflict of activities?

5. Are there any coordinating activities with other departments within the MOH or with other institutions that would need to be involved in the implementation of a communication strategy?

6. What methodological steps are essential to include in a health communication policy to ensure the allocation of resources and to save the methodological process?

7. How will the allocation of resources (human, financial and in equipment) be reflected in the policy definition?

8. Who should be in charge of the technical aspects of communication to ensure quality production and correct use of the country's media infrastructure?

9. Who should be the leader or the one responsible for the implementation of the health communication policy?

10. How will the policy reflect the priority health areas of the country?

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HEALTHCOM RESOURCES

To obtain specific publications or videos listed below, please write BASICS, 1600 Wilson Boulevard, Suite 300, Arlington, VA 22209, USA. The fax number is 703/312-6900.

Communication for Health and Behavior Change: A Developing Country Perspective, Judith A. Graeff, John P. Elder, and Elizabeth Mills Booth, 1993. (Available in the US only from bookstores or the publisher: Jossey-Bass Publishers, San Francisco, CA.)

Notes from the Field in Communication for Child Survival, Renata Seidel (editor), 1993.

Communication for Child Survival, Mark R. Rasmuson, Renata E. Seidel, William A. Smith and Elizabeth Mils Booth, 1988. (Available in French, Spanish, and English.)

Getting It In Focus: A Learner's Kit for Focus Group Research, Academy for Educational Development, April 1995. (Components include Video, Skill-Building Guide, and Handbook for Excellence in Focus Group Research; available in French, Spanish, and English; NTSC, PAL, and SEACAM.)

Results and Realities: A Decade of Experience for Child Survival, Renata Seidel, 1992.

Unlocking Health Worker Potential: Some Creative Strategies From the Field, Barbara L. Boyd and Willard D. Shaw, 1995.

The Value of Focus-Group Research in Targeting Communication Strategies: An Immunization Case Study, Lonna Shafritz and Anne H. Roberts, 1994.

Managing a Communication Program on Immunization: A Decision-Making Guide, Cecilia Cabañero-Verzosa, Marietta G. Bernaje, Eleanora M. De Guzmen, José Rafael S. Hermandez, Carmencita N. Reodica and Mario M. Taguiwalo, 1989.

Things Have Changed, (a video on behavior change), Lynda Bardfield Van Over, with *User's Guide Working for Behavior Change,* Reynaldo Pareja, 1995. (Available in French, English, and Spanish; NTSC, PAL, and SEACAM.)