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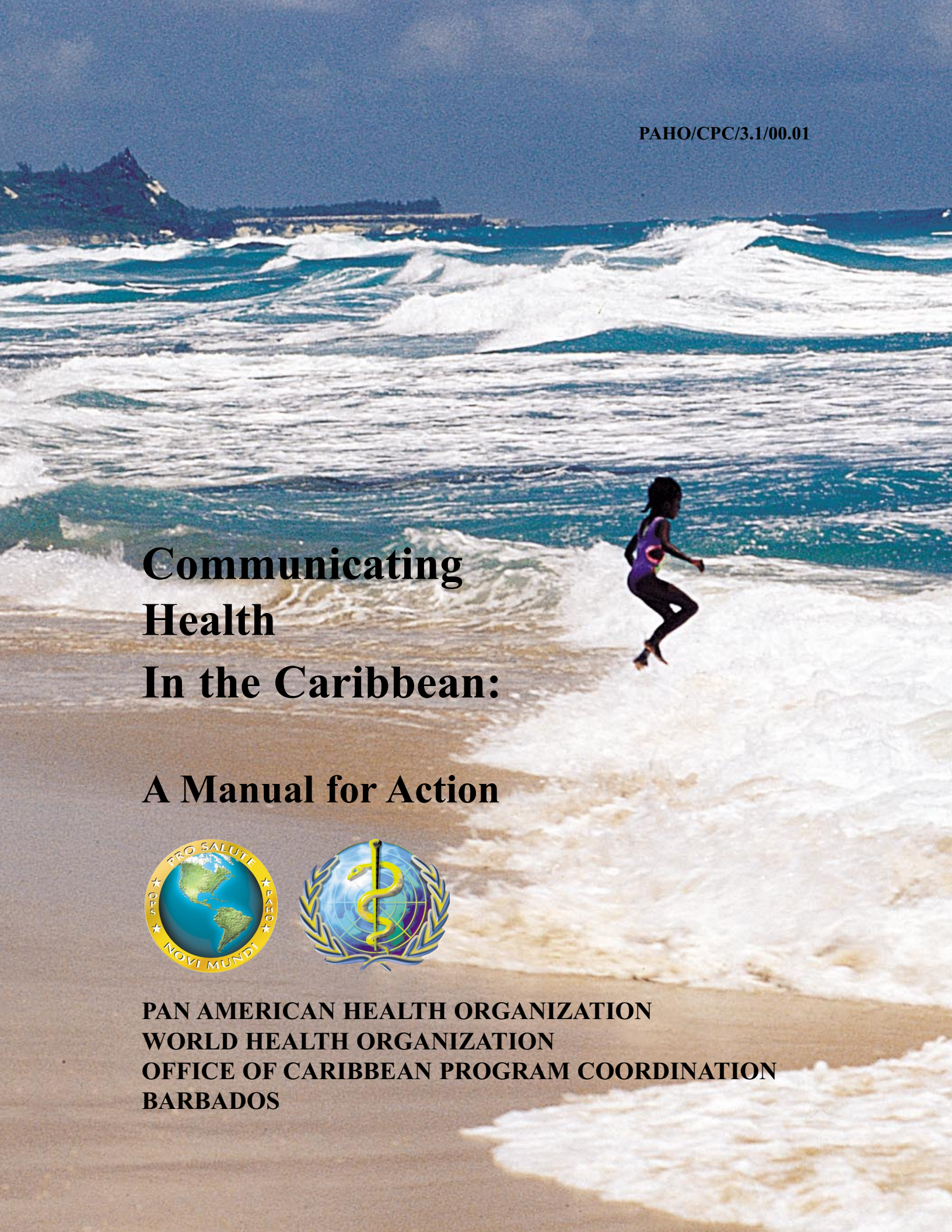

Communicating Health In the Caribbean:

A Manual for Action

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION
OFFICE OF CARIBBEAN PROGRAM COORDINATION
BARBADOS

Cover illustration:
Young girl playing in the surf
Photograph: Ronnie Carrington

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Communicating Health in the Caribbean: A Manual for Action

Pan American Health Organization
World Health Organization
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Contents

Preface

Health communicators and decision-makers in the English-speaking Caribbean have come to recognise the relationship between health behaviours, for example, balanced eating, physical activity, mild consumption of (or abstinence from) alcohol, access to clean air and the prevention and control of various disorders.

Health communication is integral to the prevention and control of the priority health issues facing Caribbean countries, including issues as diverse as non-communicable diseases, substance abuse, vector control and HIV/AIDS. The growing recognition by health personnel of the role of communication interventions in targeting relevant behaviours is a welcome development.

Health communication is defined as the crafting and delivery of messages and strategies based on target audience research to promote the health of individuals and communities. Methods draw on marketing and communication techniques used so successfully in commercial advertising of products, many of which are harmful to health, borrowing from these methods in an attempt to alter popular consumption patterns and promote healthy alternatives. The terms social marketing and social communication are labels for this process.

Traditionally, Caribbean health planners and decision-makers based their communication strategies on the dissemination of health messages mainly through mass media channels to heterogeneous audiences. The underlying assumption was that because our messages were inherently good, those whom we wished to target would be willing recipients once we succeeded in reaching them. Mass media channels were often the preferred routes of dissemination. For many years health communicators assessed the success of such strategies by the extent of their information coverage, or numbers of people reached, and the quality of the design of messages. The cuter and glitzier communicators perceived designs to be, the more favourably assessed were the strategies.

However, despite the design of several creative health communication initiatives for behaviour change in the Caribbean, the results are not impressive. Breastfeeding rates in most countries have not improved, the prevalence of smoking and other lifestyle-related chronic disease risk factors such as obesity, excessive alcohol consumption, and sedentary habits have not, in general, decreased, and women have failed to utilise Pap smears, iron supplementation tablets, and other health centre resources as they should. Health communicators began to re-assess their strategies.

Seeking answers, in 1993 in Port of Spain, Trinidad & Tobago, the PAHO/WHO Office of Caribbean Program Coordination (CPC) convened a meeting of a multidisciplinary team of health-related representatives from across the region. That meeting drafted a Caribbean Charter for Health Promotion that affirmed the importance of the reciprocal relationship between environmental supports and behaviours leading to wellness and preventing disease. The six-point charter accorded a central role to behaviour change theories to drive intervention strategies such as advocacy, social communication and social marketing that promote health to various sections of the population.

The development of this manual is another step in that process. It is designed to support those health promotion initiatives that address the behaviour change/environment matrix. The CPC recognises that a wealth of literature and other support materials on health communication exist. Specifically, communicators in the region have drawn on the guidelines provided in another Pan American Health Organization (PAHO) publication: *Making Health Communication Programmes Work in Latin America and the Caribbean: A Manual for Action*. None of the available publications, however, sufficiently addresses the behaviour/cultural context of the Caribbean sub-region. This publication attempts to fill that gap. The manual provides some basic guidelines for the planning, implementation and evaluation of health communication strategies. It is an important companion to two other CPC publications, the *Caribbean Charter for Health Promotion* and the *Caribbean Cooperation in Health II: A New Vision for Caribbean Health*. This trilogy of publications provides a solid foundation on which to develop theory-based information strategies for targeting behaviour and its environmental constructs. No serious team of health promotion stakeholders should be without copies.

Acknowledgements

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About this manual

This manual is designed to assist anyone who wants to influence health behaviour in Caribbean communities. Health providers, schools, media houses, advertising agencies, women's and community groups, national and regional governmental and non governmental organisations (NGOs) may all find this document useful in their health communication efforts. It is intended to support the Caribbean Charter for Health Promotion and the Caribbean Co-operation in Health Phase II with a simple format for designing effective health communication strategies. By its implementation and monitoring, PAHO hopes to document practical Caribbean experiences in health communication, especially in situations that endure severe resource limitations.

Examples from health communication efforts all over the region illustrate the manual. We celebrate their creativity and success and encourage planners of new initiatives to document the process.

2

Introduction

2.1 The Caribbean setting

The Caribbean Sea touches the shores of North, Central and South America. Its waters lap at islands inhabited by English, Spanish, French and Dutch-speaking people. Among our continental populations some pre-Colombian languages survive.

The English-speaking Caribbean has a history of co-operation for economic benefit through the Caribbean Community (CARICOM). Approximately 10 years ago these countries began to address health priorities through the Caribbean Cooperation in Health (CCH) and Phase II of the CCH was initiated in 1998.

Through CARICOM and PAHO several Caribbean institutions have been established to provide resources for health. These include the University of the West Indies (UWI), the Caribbean Food and Nutrition Institute (CFNI) and the Caribbean Epidemiology Centre (CAREC). Caribbean Ministries of Health and Education and other institutions, including Non-Governmental Organisations (NGOs), have long been involved in health education. However, there is recognition of the need to emphasise new approaches to deal effectively with health challenges that currently face the Caribbean sub-region. Health communication is one of these approaches.

Health communication is a relatively new concept and discipline. The decision to produce this manual, based on scientific principles, for the English-speaking sub-region is motivated by a need for Caribbean health communicators to address old and new community health problems more effectively. However, planned systematic communication campaigns are a well-established feature of health promotion.

Catching a Message

In 1987 the Caribbean Food & Nutrition Institute (CFNI) mounted a regional mass media campaign to reduce and prevent the incidence of food-borne illness. The campaign was directed to food handlers, school children, housewives and household helpers. Three television spots and fifteen radio spots were produced with the assistance of media specialists and nutrition-related personnel. A catchy jingle incorporated messages on the theme: “keep foods covered, clean, cold and safe”. All the countries provided television and airtime free of cost for over a year. Messages were pre-tested and radio and television spots monitored. A post-test evaluation of knowledge indicated that the messages were heard and recalled by the desired audiences. Though findings with regard to behaviour were inconclusive, the campaign represented a watershed in improved relationships between health and mass media practitioners.

A health communication programme is the planned change in a group's behaviour for better health
Photo: Ronnie Carrington

2.2 Post-colonial trends

An historical overview of the English-speaking Caribbean reveals a pattern of ideologies and practices that formed health conditions in the region and continue to influence the way contemporary health communication is being carried out.

Across the English-speaking sub-region religious and civic organisations pioneered health intervention strategies and complemented governmental public health programmes with ad hoc initiatives aimed at behaviour change. For example, Ministries of Health subsequently developed community programmes initiated by family planning associations.

In the 1960s the Save the Children Fund employed a unique combination of preventive and curative, educational and medical programmes in the Windward Islands, launching comprehensive programmes in child care and nutrition (see also page 26). Supplementary feeding, growth charts, immunisation, day care services, and public health education complemented improvements in hospital facilities, family planning technologies and day care training[1].

Since the 1980s macroeconomic policy has led some territories to reduce expenditure in sectors perceived as 'unproductive' by market-driven priorities. Where health and social welfare infrastructure was already unstable further deterioration has occurred[2].

A drug culture with its accompanying violence impacts on health status. Recently citizens have observed cash-strapped governments turning to churches, women's groups, youth organisations, professional associations, service clubs and business enterprises to disseminate the messages that will inspire people to adopt healthy lifestyles.

This trend is likely to continue. Its effects are heightening community ripeness for well-planned interventions.

2.3 Cultural factors in health communication

Caribbean audiences comprise a unique blend of race, class and gender relations packaged into a population of less than 10 million and spread across an archipelago joining North, Central, and South America. Harsh economic realities have resulted in patterns of migration over the years, a decline in agriculture and a growing reliance on tourism. These patterns, and more recently, a steady diet of North American media, are shaping people's self-perception and also our perception of families, leaders, heroes, communities, countries and health.

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[1] Peggy Antrobus, Macro-micro Linkages in Caribbean Community Development. Doctoral thesis 1998

[2] Bernadette Theodore-Gandi, Health of the Adult. In Health Conditions in the Caribbean, PAHO Scientific Publication No 561 1997 p236

Yet despite increasing global mass media penetration, the Caribbean personality maintains its cultural complexity and uniqueness of thought and behaviour. While we look more and more to mass media, especially television, for information, Caribbean audiences still value our informal system of social interaction. Word of mouth remains a potential instrument of credible communication, especially in rural communities.

Successful programmes pay attention to the unique communication relationships developed in a variety of settings. In rural Jamaica, for example, opinion leaders including lawyers, midwives, and public health nurses and inspectors, command much influence and authority. Inner-city communities have their political "dons" or self-appointed "protectors" or "enforcers", and in the wider community nurses, doctors, and talk show hosts mediate and shape the flow of information in their respective situations in much the same way that private health practitioners do for citizens who use those services.

In addition, different population segments within individual countries adhere to many myths, institutions, and practices with implications for health promotion. Some of these are:

- a woman's security in old age is guaranteed when she "has her lot", her "quiver full"; that is, gives birth to many children.
- family planning is an attempt to diminish the black population.
- to be obese is to be well fed, and is therefore a sign of good health.
- it is wise to overeat when possible: "feast today and famine tomorrow".
- "a woman's place is in the home".
- "spare the rod and spoil the child".

To gain the attention and respect of their audiences, health communicators must recognise these beliefs and perspectives and respect the people who hold them before seeking to influence their health-related behaviours. The challenge before the prospective communicator, therefore, is the study of how to deliver messages and initiate strategies in a culturally sensitive and appropriate manner.

2.4 Lifestyle Behaviour Concerns

In addressing the broad issue of disease prevention and control in the region, we have a more realistic chance of influencing some behaviour risk factors than others. The main risk factors are:

- Sedentary lifestyle
- Indiscriminate eating habits
- Smoking
- Excessive alcohol consumption
- Unsafe sexual practices

Sedentary Lifestyle

One consequence of inadequate urban planning is the proportionately few recreational facilities in most Caribbean communities. Recent studies of physical activity patterns conducted in Jamaica and Guyana suggest that urban populations tend to lead sedentary lifestyles. This problem may be worsened by the high proportion of leisure time spent consuming mass media products, especially television. Statistics demonstrate that Jamaicans spend at least 25 hours per week watching television, listening to radio and reading.

For more than a decade, however, a counter trend of public awareness of the value of physical exercise has been growing. Spacious, convenient, and relatively secure locales, such as the Savannah in Trinidad, the Mona Dam or Police Officers' Club in Jamaica, the Sea Wall and National Park in Guyana, the Garrison Savannah in Barbados, and Frigate Bay in St. Kitts, attract health-conscious citizens to their open spaces.

"Media-ted" Jamaicans

A 1998 study by CFNI showed that Jamaican audiences have similar tendencies to North Americans when it comes to media consumption. Respondents were asked if they had watched television during the previous week and to indicate how many hours were spent viewing television on each weekday, and on Saturdays and Sundays. Of all respondents, 88.5% (1838) reported that they had watched television the week before. Among the 239 respondents who said they did not watch television, 47% reported they had no television sets, 20% had no time, 15% had no interest, 6.3% did not respond, 6% had eye problems and 1% complained of too-high electricity bills.

Information from a 24-hour recall was also analysed. Results showed that 76% viewed television during the period under study, while 4.8% listened to radio. The results showed that a higher proportion of residents in Kingston, the capital, spent part of their day watching television compared with respondents of other towns and rural areas. Mean time spent was also highest for Kingston respondents, with less time in other towns and in rural areas. On the other hand, the lowest percentage of respondents from Kingston listened to radio with the highest among respondents of other towns and rural areas. However, mean time spent listening to radio was highest among Kingston residents and lowest among rural respondents. Overall mean time was 2.4 hours per day. There was no gender difference in the proportions of respondents viewing TV while a higher proportion of male respondents (5.9%) listened to their radios compared to females (4.0%). Women spent more time watching television (4.1 hours compared to 3.9 hours for men) while men spent more time (2.6 hours) than women (2.3 hours) listening to radio.

Data also showed that proportions viewing television and mean number of hours spent doing so both decreased with age. The reverse is true for radio listeners whose number increased with age. Hours spent listening to radio also increased with age.

Indiscriminate Eating

Food consumption studies indicate a tendency among Caribbean people to overeat and to overdo their intake of salt, sugar and fats. This problem is compounded by the absence of regulatory policies and support systems governing the marketing of foods. For example, labelling and laboratory testing facilities common among the more developed countries are not institutionalised in the region.

Mind the Meat

Dietary patterns in the Caribbean have been changing over the past 35 years. Most countries now have a total caloric intake 8 to 40% above the per capita population goal of 2,250 cal. per person per day. The increase in total calories has been mostly a result of an increase in animal food (meat, poultry, milk, and butter) with the regrettable exception of fish, which is less accessible. Thus the total fat available is in excess by 10% to 180%. Whole grain cereals are sufficiently available in most countries. On the other hand, none meets the requirements for fruits, vegetables, roots, tubers and legumes. In fact, 10 out of 12 countries do not meet more than 50% of their recommended population goals of fruits, vegetables, roots and tubers.

The prevailing dietary situation in the region is conducive to a high incidence of some chronic diseases. In fact, analyses of food availability data indicate that the countries that have higher per capita caloric availability also have significantly higher mortality due to diabetes. Countries that have higher total fat availability have a significantly higher death rate from coronary disease and cancers of prostate, breast, colon and rectum. At the same time, countries with a higher availability of fruits, vegetables, cereals and ground provisions have lower rates of coronary heart disease and colo-rectal cancer.
From CFNI: 1995

Smoking

Despite ad hoc anti-smoking initiatives, many Caribbean people smoke. Lack of meaningful regulation in mass media cigarette promotion, especially targeting youth and women, perpetuates the problem. There are few smoke-free environmental settings and even fewer promotion incentives for non-smokers. However, there is some effort in this regard, such as at the Grantley Adams Airport and the Chefette fast food chain in Barbados.

WHO's Smoking in Curaçao?

A WHO-sponsored self-administered questionnaire on smoking was distributed to all 245 physicians working on the island of Curaçao in1995. The survey achieved a response rate of 61% (without reminder letters). 33% of respondents were current smokers. The habit was more prevalent in males (68%), and the mean daily consumption was 11.8 cigarettes. Smoking prevalence and smoking behaviour amongst Curaçaoan physicians proved to be highly similar to the data revealed by Dutch studies, even though the smoking prevalence within the Curaçaoan population is lower than in the Netherlands. These findings may support the hypothesis of professional socialisation in medical school. Curaçaoan and Dutch physicians also express similar opinions on smoking. Doctors demonstrated insufficient knowledge of smoking cessation methods and the relationship between smoking and diseases; they also reported that they want more information about smoking cessation programmes.

Excessive Alcohol Consumption

With the notable exception of road safety through the promotion of sobriety ("If you drink – don't drive") there are few Caribbean programmes targeted at influencing behaviour regarding alcohol intake. By contrast, alcohol is heavily marketed by promotional strategies that include compelling product image-building strategies demonstrated by their lucrative sponsorship of sporting and other cultural events, especially for youth and students.

Unsafe Sexual Practices

A long held concern regarding unwanted and teenage pregnancy has assumed even greater importance with of the increasing prevalence of infection with the Human Immunodeficiency Virus (HIV) and resulting Acquired Immunodeficiency Syndrome (AIDS). The Caribbean is, alarmingly, the geographical area with the fastest-growing HIV/AIDS prevalence after Sub-Saharan Africa.

2.5 Disease Prevention and Control Mechanisms

Most countries in the Caribbean Community have a strong network of health centres to support chronic disease prevention and control and other wellness initiatives. Among other services, health centres promote the following:

- frequent Pap smears and mammograms
- exclusive breastfeeding practice
- nutrition assessment and counselling
- chronic disease monitoring and control

However, the reach of these health facilities in some countries is below desired levels, reducing their potential impact on the chronic diseases and other health concerns. In some instances facilities are not sufficiently accessible to health care users with regard to: location, comfort levels, and staff attitudes toward service in general. Communication initiatives must address these concerns if they are to be effective.

2.6 Media

The Caribbean has a strong oral tradition. Countries have an average 80% literacy rate and this, combined with modest economic means, accounts for radio being a popular and highly accessible medium. According to available data (Mock Yen et. al, 1995) there is an average of five radio sets to one television set in the Caribbean subregion.

Country	**Population (000s) 1997 +**	**Radio sets (000s)**	**Television sets (000s)**	**Ratio of Radio to Television sets**
Antigua & Barbuda	67	56	28	2:1
Aruba	71	12	6	2:1
Bahamas	288	120	40	3:1
Barbados	262	360	60	6:1
Belize	224	88	10	91
Cayman	33	20	*	*
Dominica	71	100	*	*
Grenada	93	200	*	*
Guyana	847	400	*	*
Jamaica	2,515	1,250	400	3:1
Montserrat	11	5	1.5	3:1
Trinidad & Tobago	1,307	700	350	2:1
St Kitts & Nevis	41	100	12	8:1
St Lucia	146	200	10	20:1
St Vincent & The Grenadines	114	200	70	3:1

* No figures available Sources: Sound Advice: Book Two: Radio Education Unit, University of the West Indies 1995 and Health Situation in the Americas: Basic Indicators 1997, PAHO.

In recent years, several larger countries have experienced an explosive growth in electronic media. Jamaica, with a population of 2.5 million and per capita GDP of $1,563, has seen the number of television stations grow from one to three in less than five years. There has also been a dramatic growth in the number of radio stations, from two to seven over a similar period. In addition there is a growing number of community stations in the island.

Trinidad & Tobago, with 1.2 million inhabitants and per capita GDP of $4,049, had a similar explosive growth of the electronic media with seven new radio stations and two new privately owned television stations within a five year period.

Barbados, with 260,000 people and the highest GDP ($5,562) after The Bahamas ($10,308) has long maintained two daily newspapers.

A generation ago there was typically a single national public service radio and television broadcaster. Following liberalisation throughout the region multiple media outlets emerged, including cable television and direct broadcast satellite services. These entities compete in relatively small markets. Additionally, other media-borne features of a liberalised economy clutter the environment with information making it increasingly difficult and expensive to reach target audiences with health messages that are designed to address Caribbean realities.

Despite this increase, television stations in the region today account for only two-thirds of all viewing, as exposure to cable channels and VCRs grows dramatically. Hence, stations must compete more aggressively for advertising revenue than in the past, a situation that threatens the independence of news and entertainment. The intense competition in media often leads editors, writers and producers to focus on the more sensational aspects of the news story in hand in an effort to beat the competition. In this scenario, health information is a regular casualty. Hence, stories about conflicts in the sector, manpower inadequacies, equipment and drug shortages, and incidence of diseases, dominate media time and space, while developmental stories, such as progress in health reforms, are downplayed or overlooked.

In such an environment, socially useful information is rarely translated into mainstream media products. If and when it is, unless the difficulty of securing sponsorship is overcome, the message is relegated to the least attractive time of day for viewers and listeners.

Most national governments own some major electronic mass media entity. Only recently have private sector interests developed a stronghold in this aspect of the media market. By contrast, print has always been an area of mainly private ownership. The larger countries have two or three daily newspapers while in smaller territories presses bring out two or three weeklies or biweeklies.

The size of populations coupled with internal and external pressures on an increasingly shrinking dollar have important implications for the financial base of mass media. Small media markets and the fragile state of the dollar leave them vulnerable, hence the policy implications for media content. The withdrawal of even one key advertiser can potentially endanger the sustainability of some media entities. In this climate imported canned television programmes flourish. Also, given the region's close proximity to the United States of America, there is easy access to satellite transmissions from that country.

Satellite dishes, VCRs and computers are breaking down traditional communication borders. In the Kingston metropolitan area of Jamaica, 28% of households have access to a dish and 21% to a computer (not counting satellite access at work sites). The picture is very different just 20 miles away in the adjacent rural parish of St. Thomas, where the figures are less than 1% and 2% respectively. New technologies accessible to the more affluent few are increasing the gap between the 'haves' and 'have-nots' of information.

Notwithstanding the reach of mass media in health promotion, "alternative" media play a useful role. While elsewhere the term connotes non-mainstream operations, in the Caribbean context it refers to alternative formats used in mainstream media. Popular theatre, dance, calypsos, reggae and other musical genres, riddles, oral history and story-telling are all attractive, alternative methodologies to which a growing spread of local community and self-help groups attach importance.

2.7 Advocacy

In social- marketing terms, advocacy is a promotional tool that utilises mass media and other strategic communication channels for targeting politicians, legislators and other decision-makers. Advocacy in this sense associates popular personalities with the championing of health causes. As reported in other parts of the world, many successful initiatives that address some of the concerns described above have 'factored in' advocacy as a key component.

In the past decade citizens' groups and non-governmental organisations have been applying communication methodologies to be heard at policy level and to raise public awareness. In an information age, advocacy – that is, seeking public support for a particular cause – is essential to survival. What was once considered 'specialist knowledge' is now everybody's business.

In such a world a Windward Islands banana farmer understands trade regulations and 'the global financial architecture' so as to advocate for decisions impacting on his or her family's livelihood. Caribbean grassroots groups advocate for 'health content' across a spectrum of governmental and international protocols using a human rights framework of sexual and reproductive rights. In this scenario women's non-governmental organisations, for example, have been instrumental in theorising the inter-relations of health, women's empowerment, human rights, and government accountability[3].

Political, economic and environmental conditions are interwoven into the complex causes of ill health, well beyond the influence of communication efforts *per se.* An effective health communications programme must often address a spectrum of audiences to have an impact on the primary audience being addressed. Today, governmental policy

[3] The International Conference on Population and Development (see Glossary ICPD)

decisions to develop tourism as an economic mainstay are commonplace. HIV/AIDS demands that health implications for citizens in the 'informal economy' of prostitution and 'romance tourism' and indeed the population as a whole be built into economic planning. Policymakers understandably unwilling to enter the hotel rooms of the nation may well be a target audience of a health communication strategy whose goal is to promote condom use among commercial sex workers, male and female.

It is crucial that decision-makers understand health as a developmental value and in most situations it is necessary to build advocacy into health communication. Social marketing techniques can be used to impress upon policy- makers the need to allocate resources for health communication. One-on-one methods are also highly effective depending on the circumstances, agencies and individuals involved.

Currently there are concerted attempts at health reforms in CARICOM. Deregulation of services, privatisation and 'self-care' are features of this trend away from the public health model. In this setting, health advocates will have to be very creative, seeking receptive settings where they may, and wherever possible, urging for legislation and regulatory practices that have a beneficial impact on people's health choices.

Potential advocacy issues include:

- Legislation governing control of cigarette and alcohol marketing practices e.g. media advertisements.
- Policy on the provision of community recreational and other leisure time facilities in town and community planning.
- Food labelling.
- Provision of food control mechanisms, e.g. laboratory testing personnel and procedures.
- Policy adherence to international baby-friendly initiatives in support of breastfeeding.
- Food safety legislation and other policy commitments.

Low-budget Communication Strategies

Whether a promotional strategy employs advocacy, social marketing, development communication, health education or social communication, it is aimed at promoting health and wellness by encouraging people and communities to change specific attitudes and behaviours.

While social marketing has much to recommend it, the marketing of social products, based on commercial principles, requires a heavy investment of time, money and human resources that most public agencies in the Caribbean cannot afford. Political and other key decision-makers are unlikely to entertain these costs when allocating scarce resources. Even so, this does not negate the importance of proper or appropriate financing of promotional incentives. However well designed a project may be, without appropriate financing and staff, its chances of success are minimal.

Many Caribbean countries are adept at mounting special events to generate support for programmes. These too require start-up resources and careful preparation and implementation

Walking is an enjoyable and inexpensive way to exercise
Photo: Ronnie Carrington

2.8 Changing health behaviour

Anyone who has tried to set up a health promotion programme directed at behaviour change, or even tackled the difficulty of changing his or her own habits to complement a more healthy lifestyle, knows that it's not easy. In the first place we need more than information. A 1996 PAHO study of media audiences[4] showed that Caribbean people are more health-conscious today than we were ten years ago, as this study in Jamaica shows.

Health Media Scores High With Well Informed Jamaicans

A PAHO study of media audiences in Jamaica showed mass media to be an important source of heath information with 80% of interviewees responding that they consult the media for this purpose. Television was cited as the principal medium for information on health and was selected by 80% of the audience while 63% generally obtained information through radio and 59% through newspapers. Other health topics of interest were:

• Nutrition, diet and exercise	34%
• Hygiene	17%
• HIV/AIDS	16%
• Sexually transmitted diseases (STD) prevention	11%
• Blood-related issues	10%
• Diabetes	9%

The public has more information, but are our actions informed? Health service workers *know* that screening for cervical cancer is related to decreased mortality from the disease, yet in most English-speaking Caribbean countries less than 20% of women at risk go for regular screening[5]. It is common knowledge that prostate cancer is the leading cause of cancer deaths in men in the Caribbean and a greater awareness of the disease could prompt men to undergo periodic assessments as necessary. Yet the number of those screened for both diseases is less than optimal.

[4] Report on a Survey to Evaluate the Coverage of health Information in the Media. Market Research Services Ltd. April 1996

[5] PAHO CPC Cervical Cancer Control: Project Report on the Meeting of the Steering Committee October 1993

Callers in the over-forty age group bombard radio doctors. Youth spend millions on the consumption of sports gear advertised through the manipulation of 'health fashion' images[6]. Still, our eating habits, lack of exercise and poor attention to emotional well-being is responsible for much ill-health and disability in the population[7].

Many chronic non-communicable diseases, including coronary heart disease, hypertension, some cancers and diabetes could be prevented or minimised through behaviour change. Yet there appears to be a dearth of legislation and political will to enable a range of positive factors from non-smoking in public areas to greater Caribbean food security[8].

Studies recommend that programmes focussing on self-esteem and interpersonal skills, resolving conflict and coping with stressful situations should be integral components of primary health care and the education system. It is critical to include adequate counselling and support services in communities for promotion of mental well-being through social networks and support. This requires greater collaboration between state and non-governmental sectors[9] and would be enhanced by well-planned health communication.

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[6] Consumption patterns for Latin America and the Caribbean reveal the following: a regional average of 1 television set for every 5 persons; the highest availability of telephones at 86 lines per 1,000 people - in Barbados there is a telephone for every 3 people; The Bahamas has the highest energy use (6,864 kg per capita compared with Grenada's 293 kg and St Vincent &The Grenadines less than 200 kg); The region drives 6% of the world's automobiles; Trinidad & Tobago has the highest CO_2 emissions in the region at 13.3 metric tons per capita; In the early 1990s there were 200 MacDonald's fast food sites in LA and the C'bn; by 1996 the figure reached 837 - the largest number in the developing world (Source: UNDP Human Development Report 1998)

[7] Bernadette Theodore-Gandi, Health of the Adult in Health Conditions in the Caribbean, PAHO Scientific Publication No 561 1997 p 245

[8] In 1983 Caribbean governments agreed on a regional food production plan. It is still to be implemented (Source: Caribbean Opinion Vol 1 No 4 May 1991

[9] Bernadette Theodore-Gandi, Health of the Adult in Health Conditions in the Caribbean, PAHO Scientific Publication No 561 1997 p 247

3

General principles of health communication

Successful health communication interventions,
especially those aimed at influencing behaviour,
work best when our strategies stress
mutuality and shared perception.
This contrasts with the ‘hypodermic needle’ approach
which assumes that information sent to the target audience
will achieve magical results.
As we shall see, a successful outcome depends on
which of these approaches planners adopt when designing messages.
The health promotion planner often shapes a strategy
by choosing among options that represent one or the other approach.
For some purposes transmission types of solutions are preferable;,
for others mutual solutions are more appropriate.
To further facilitate the planning process, review the following
guidelines before preparing messages and strategies.

3.1 Establish whether the problem is a communication one

The first decision is to determine whether the problem is amenable to solution through communication[10]. This question goes to the fundamentals of any proposal and sets the stage for the standards of experience and analysis that stakeholders will require for the long haul. If stakeholders answer 'yes' to this question the team is ready to move to the second level of preparation outlined in General Principles of Health Communication. For example: the aim of a HCP is to promote increased consumption of vegetables in a community, but the poor state of the roads prevents supplies from being trucked there. In such a situation the problem must be addressed at the policy-making level.

As the planning process continues into the programme development and implementation stages, the quality of the questions brought to each step will have direct bearing on decision-making (which is in essence our team's responses to those questions). Flawed decision making at any point can lead to the development of a programme that is 'off the mark'[11].

3.2 Develop good planning tools and practices

Begin by defining the health problem that the health communications programme is intended to address. Go beyond a narrow description of 'the problem' to include its social setting, that is, the economic and political dimensions of the health issue. Drawing on the knowledge of stakeholders and research available from as many sources as possible, describe the situation at local, national and regional levels. Seek out useful sources of health-related information such as the Ministry of Health, PAHO, University of the West Indies, University of Guyana, UNICEF, CAREC, and CFNI. In addition media houses sometimes have libraries or documentation centres with files on health.

Be sure to record and to engage each stakeholder's analysis and major cultural issues in the situation (for example, the issue of Kweyol nation language in public education in St Lucia and Dominica). A wide definition of the health problem will clarify the rationale for the participation of stakeholders and from it the team can sketch an outline of available and potential resources.

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[10] "Making Health Communication ProgrammeProgrammess work in Latin America and the Caribbean: A Manual for Action" Health Promotion ProgramProgramme, PAHO, Washington, D.C. 1991 p 14.

[11] Ibid p 14

3.3 Know your audience

However modest or grand the financing of a programme, success depends on the delivery of the health message to an audience. If an audience rejects the message, there may be a number of explanations. For example, the message may have been too complicated and therefore misinterpreted. It may not have been received. It may conflict with the target audience's beliefs or values. A message may be excellent in content but if the audience does not 'tune in' to the channel of communication (the messenger) used to deliver it the communication strategy was not effective. This is why audience research is as important as all other phases of research to be managed for health communication.

3.4 Go to your audience

People will not go out of their way to find the team's message. Therefore, we must place the message where the audience will encounter it. When doing audience research, ask people where they get their news and where they go in their free time. If the team learns, for example, that the target audience listens to the radio, place the ads there and work with radio talk show producers, hosts, disk jockeys and journalists to get coverage of your issue. If the people in your audience do the shopping for their household, work with local supermarkets to put the message in their stores. If those you are targeting like dance hall or liming or blocko, design your material for that environment and distribute it where they gather. Persuade the programme sponsor to stand the cost of a demonstration of the product or behaviour change concept you are promoting. Data on audience research conducted in your country or area may be available from recognised advertising agencies, the media houses themselves, or from CFNI, PAHO and UNESCO.

3.5 Talk to those you are trying to reach

The key to communication is talking with and *listening to* people. The wants and needs of the target audience are the focus of all aspects of any programme. When it comes to learning what our customers want a little ingenuity goes a long way. Ask them! Sit in the reception areas of health centres and hospitals. Go to where the people you are trying to reach go (the dry cleaners, the mechanic, the clinic) and talk to people as they wait. Ask them if they know of your organisation and what you offer. How do they talk about their experiences with the health issue your team is addressing? What do they need to help them use your services or adopt the behaviour you are promoting? The team may be surprised at what it learns and at how willing people are to talk about themselves. Some useful information is available in a report published in Cajanus, Vol 33 No. 1: "Studying Food Consumption Patterns in Dominica: Lessons Learnt".

3.6 Identify audience segments

Segmentation is a market research practice that involves identifying and researching subgroups of the larger population. Good marketers know that it is not possible to sell to the general public. 'One size does not fit all'. Segmentation provides the best opportunity for reaching the right audiences with the right message. Social marketing campaigns often fail when the right audiences are not addressed. The profile of a female worker in garment manufacturing differs from a female life insurance agent. Rather than focussing on "teenagers in general" the wise team may focus on say, either urban or rural schoolchildren. Before launching a campaign, orient key people to the goals of the campaign and enlist their support. Identifying the audiences to target can greatly facilitate communication efforts.

The concept of segmentation is based on a view of differentiated audiences with their sub-audiences. An audience consists of sub-groupings that are internally homogeneous but differ from each other. The team will need to select sub-groups that are alike with respect to one or more characteristics of the target audience. Sub-groups receive different messages and/or are reached through different channels. Almost any personal characteristic may be used for segmenting a market. While theoretically, the possibilities are many, resources will likely be a limiting factor. Selection of segmentation factors follows a contingency principle – every type of case tends to have its own preferred segmentation. The following examples are provided as a guide:

By Belief

People perceive the world differently. Depending on experiences and environmental influences, the same phenomenon may mean different things to different individuals and groups. A programme aimed at getting people to improve their eating habits would address the importance of planning and preparing meals in certain ways. First we would need to find out what people mean by "meal" – for some it's a way to stay alive, for some a social event, and for others a means of good health. Communication efforts will benefit from these distinctions.

By Attitude

It is generally accepted that communication directed at audience segments that already agree with a viewpoint and those who do not are different (Lumsdaine and Janis 1953). For the former, 'how to' information (Rogers 1983) in the form of one-sided argumentation is most suitable. The latter sub-group requires 'what and why' information in a form that discusses counter arguments. Segments with attitudes that differ greatly have to be treated with careful insight since messages may result in boomerang effects, such as have been noted in anti-racist campaigns (Cooper and Jahoda 1947; Vidmar and Rokeach 1974).

By Behaviour

The difficulty in describing certain social groupings and intended publics by the application of simple demographic classifications leads social market researchers and marketers to look for other descriptions. Some work with lifestyle characteristics. A good example comes from anti-drug and anti-smoking campaigns among young people. Those who smoke or use illegal drugs require different approaches than those who do not. In health education an important behavioural segment is the high-risk group that can be identified through screening projects.

Good social marketers will recognize the importance of targetting children, who often develop consumption habits in childhood that will persist in adulthood
Photo: Ronnie Carrington

3.7 Know that your health message competes with others

In our commodity-oriented world, one approach is to "sell" the consumer on health like any product. But because behaviours and attitudes require long-term commitment (ie they have a "high price") this is harder to do than selling than a bar of soap, or even a car. Behaviour change communication is a process of understanding people's situations and influences. Product positioning determines how the target audience thinks about your product as compared with "the competition".

A brand of cigarettes may be promoted as the freshest, the classiest, the most feminine, the most masculine, and the most fun. So too a "health product" needs to be

[12] Definition by Rockefeller Foundation, Communication and Social Change Network.

positioned in relation to the alternatives. Campaigns develop messages that respond to concerns, use communication to persuade people to increase their knowledge of situations and to change behaviours and practices that place them at risk[12].

For example, a 'Buy Local' campaign requires a thorough knowledge of the benefits of local foods in order to position the campaign effectively with regard to the competition – foreign foods. Product positioning is a comparative relation based on benefits of the product (What will it do for me?) or upon removal of barriers (How difficult is it for me to do?) By talking about the health product with the audience, the team learns the benefits people value most and the barriers they foresee.

3.8 Use theory

Health communication is enhanced by the use of theory, that is: an informed perception of reality that describes, explains and predicts why people behave the way they do. (See Appendix B) The theories suggest a range of techniques and approaches that support behaviour change strategies.

While there are no magic bullet solutions to behaviour problems, the most effective communication intervention strategies find the right media and content, directed at the right audience in the right place. The key here is to use the relevant elements of various approaches, such as social marketing, development communication, and community mobilisation.

3.9 Use incentives

Amidst the world's media publicity explosion the competition for attention encourages the use of incentives. People are more likely to practice behaviour for which they expect to be rewarded. A woman may elect to practice weight management by eating and exercising right if she is confident that she will look more attractive and generally feel better about herself.

Contests and other gimmicks use rewards to gain the attention of an audience in much the same way as they are used to draw clients to the marketplace. In recent years CFNI has been using a quiz competition to promote nutrition among secondary school children. This contest is proving an excellent incentive for enticing children into the nutrition information marketplace.

3.10 Lobby the political will

Some health communication programmes require policy change. A health communication strategy may target policy makers as an initial or concurrent step. Stakeholders with access to decision-makers provide a vital link between the team and policy levels. In any event policy makers are a strategic segment audience in nationally aimed programmes and their understanding of health issues must be gained.

3.11 Mobilise resources

PAHO has demonstrated that health promotion is effective when programmes assist individuals and communities to take decisions to protect their health. Programmes should also seek to encourage and assist the relevant institutions to provide services and technologies required for resolving problems[13]. A team that takes the time to engage in a thorough situational analysis often finds the community being targeted is rich in resources that can be used to improve the chances of success of the health communications programme. A clear definition of goal, purpose, output and activities, with a budget, will also enhance efforts to mobilise resources from external donors. CAREC successfully utilised the services of artists and local media houses in mounting a national/regional campaign called “Make Measles History” with astonishingly good results.

3.12 Research and plan

The methodology requires the health communication team to research all phases of the process. Include a plan for monitoring and evaluation *in the planning stage*. A programme planning tool[14] can be useful in facilitating this process. This is an instrument for clarifying the goal of the programme (what needs to be done), its purpose (the particular change strategy to be used), its output (what the project will deliver) and its activities (what will actually be done). The team will find this instrument useful in formulating a budget, another essential tool for any communication programme.

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[13] Making Health Communication Programmes work in Latin America and the Caribbean: A Manual for Action”, Health Promotion Programmes, PAHO, Washington, D.C.1991 p1

[14] For example, the Logical Framework Approach to Project Design (see Bibliography)

3.13 Make your programme better

The cornerstone of effective communication planning is evaluation. That is why this manual has built in a mechanism that will help the team determine what you have accomplished at every stage. Use this information to improve your programme. The team will need to test and refine messages or products with members of the target audience. When a programme is implemented, the team will need to monitor activities to assess whether they are occurring as planned. How many "media hits" (mentions of the programme) did the team achieve? Are the people in the target audience the ones who are using the programme? The answers to such questions will let you know whether the team needs to make adjustments while you still have the opportunity to do so.

Developing Targeted Messages

A 1999 study in Jamaica showed that in general women had strong concerns about body size. While most women indicated a desire to lose weight and or to maintain a body size consistent with good health, many, based on past experience, were unconvinced that traditional methods of diet and exercise could to solve their problem.

Life Underwriter: "If I go on a diet, I'll lose the weight, but it comes right back…so I don't bother with the dieting anymore…"

Ministry worker: "…It (diet and exercise) don't work all the time."

Garment worker: "Me nuh eat fi all two days…mi nuh know wey else fi do...me (exercise) machine no help at all."

Factory worker: "Some people born fi fat."

While these and other comments reflected a great deal of frustration arising from past failed attempts, women generally acknowledged the benefits in maintaining a healthy body size and might be willing to consider recommended weight control activities. Based on this conclusion the communicator could draw on appropriate theories that use motivational messages.

4

Creating Teamwork in Communication

Whenever people work together for change,
even with the best of intentions, problems may arise.
It is advisable to anticipate this possibility and to lay the foundation
for dialogue before the detailed project work begins.
While health communication as a concept and discipline is relatively new,
planned, systematic communication between health workers
and the communities they serve is long established.
The work of public health inspectors, nurses,
and physicians is based in health communication.
These health care professionals may also work as
teams to strengthen the delivery of their messages.

Small Team – Big Results

St Vincent and the Grenadines' first paediatric specialist[15] illustrated the effectiveness of teamwork in the early 1960s with a strategy for reversing one of the highest incidences of infant mortality in the region. In dealing with a health problem caused by what he dubbed vividly 'the twin killers' of malnutrition and gastro-enteritis, he worked with a core team comprising a public health inspector, public health nurse, home economics teacher, and social worker.

Together they conducted a series of public education programmes in schools throughout the island. Travelling from one school to the next, the team changed according to locality drawing on local teachers, agricultural extension officers and non-governmental organisations as appropriate. Collectively they delivered a whole greater than the sum of its parts.

A message that countered a false belief about feeding infants, for example, was believable coming from a nurse respected in the community. The word of an agricultural extension officer about what nutritious foods could be grown for the family's use in small backyard gardens was more likely to be acted upon than the same message delivered by the physician. Meanwhile, the doctor was the team member best qualified to diagnose disease and whose authority was most effective in altering hospital administration policy.

This team successfully communicated culturally recognisable messages promoting available, affordable, and easily prepared foods, reversing the prevalence of diarrhoea and malnutrition.

At home their audiences adopted simple alternative practices. At the hospital new institutional arrangements were put in place. One result of their health communication programme was a change in the way health workers in that territory related to peers in other specialist areas and to key sectors of public service. Another was empowered communities whose conscious actions affirmed their children's entitlement to health.

[15] Dr Kenneth Antrobus, former Maternal and Child Health (MCH) Advisor to PAHO. Dr Antrobus devised this strategy in St. Vincent in the 1960s when he worked as paediatrician with the Commonwealth Save The Children Fund.

4.1 The team

The people who come together to develop the communication activity, whether in the Ministry of Health, an NGO or a school, must develop a working relationship. It is essential that the team develop a dynamic mix of stakeholders[16] and that a standard of dialogue allowing for innovative ideas and problem solving be maintained. A well-motivated team may be small or large and must include individual members with experience in the crafting and delivery of health messages, such as a health educator, media practitioner, sociologist, policy-maker, planner or popular theatre expert. "How to" and "who will" strategies for an equitable and productive division of labour, including the mobilisation of human and financial resources, are a must.

4.2 Point of view

The very first communication happens between the members of the team. At the outset individuals involved need to say, "where I/my agency/my department/my organisation/ is coming from". The clearer the statement of parties' motivation, the better the understanding of what interests and resources each party brings to an effort. The more precise the definition of roles and responsibilities taken by that party, the better the quality of the end product.

Teamwork requires clarity. The interests of different parties may conflict. In an extreme case, for example, a minister of religion's moral obligation to uphold a particular interpretation of scriptures and a medical practitioner's ethical obligation to confidentiality may collide. Happily, team relations do not often encounter difficulties of this magnitude. Suffice it to say the management of those relations takes a common approach to build a culture of respect among all involved, recognising the strengths that each team member brings to the effort.

4.3 Complexity of issues

Much health communication work in Caribbean countries is done through the commitment of health educators, dieticians, agricultural officers, writers, theatre groups, community based organisations and others without a background in behaviour or

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[16] Stakeholders are representatives of interest groups and institutions who bring cultural, professional and technical knowledge and financial support to health communication activities, and who have a stake in the outcome of the programme.

communications theory. With the growing likelihood of a team deciding on mass communication interventions, audience research will help ascertain what people will respond to. A media manager's involvement insures effective use of channels. These professionals specialise in the timing and spacing of programmes to avoid saturation. Their greater knowledge of diversity and structure prevents rejection by an electronically targeted audience. On the other hand, health communication is not dissemination of knowledge only and the best design insights may be offered by members of the target group, themselves stakeholders in the interventions "aimed at them". The compilers of this Caribbean-specific manual take the view that communication efforts towards behaviour change must be multifaceted and theory-driven, addressing many cultures and attitudes related to health.

4.4 Sustaining Success

While we can note several countrywide interventions over the last decade, it is difficult to determine which intervention in a particular case had the desired effect. The measure of success is sustainability of the desired behaviour change. Too few health communication programmes developed and implemented in the Caribbean measure changes in their target group's behaviour. This manual demonstrates methods of monitoring and evaluating a health communication intervention throughout its life span and urges you to apply them to your programme.

A good team will ensure that the message is well placed
Photo: Trevor Peacocke

5

Steps in health communication programme (HCP) development

This HCP manual lays out **18 steps** for
the planning, implementation and evaluation of your programme.
HCP worksheets at the back of the manual
are a handy format for organising teamwork at every step.
Terms are defined in the **glossary**, and **appendices** provide further detail.

Section 5 outlines the step-by-step methodology activated by
a health communication (HCP) team in the development of the programme.
First, become familiar with the **HCP co-ordinator's guide** on page 37.
This is a tool for documenting the team's decisions. Good documentation of good decisions is essential to good programming.
The person responsible for documentation (the HCP co-ordinator)
should monitor each step using the guide.
Before beginning the planning process the team should preview
ten steps (1 – 10) in **planning and strategy** starting on page 30.
A review of sections 3 and 4 may help stimulate your ideas.
Steps 11 – 14 will assist the team in the **selection of communication channels and selection and development of materials**.
Step 11 (*re* channels) and 12,13,14 (*re* materials) are interdependent and are designed to fit the communication strategy statement drafted at step 9.
Each step is accompanied by **questions for** the task at hand.
The quality of the team's answers to these will inform the quality of decisions and the foundation of the plan. Questions are generic and the team may wish to fashion them specifically to the context and setting
in which the health communication is being developed.

5.1 The HCP Co-ordinator's role

Every team needs both a project co-ordinator and a chairperson working together with the team. If the chairperson is like the captain, the HCP co-ordinator is like the navigator. He/she must be equipped with skills and materials for recording research findings, decisions, implementation and evaluation activities. The co-ordinator prepares a simple summary of each step in time for subsequent meetings. From this record anyone assigned the task can shape the notes into any particular instrument required by the health communications team. A good co-ordinator has the bird's eye view of the methodology and by 'forward-and-backward-looking' he or she anticipates the plan's unfolding and the team's direction.

The HCP co-ordinator records the communication process from beginning to end. The starting point for planning is the team's review of the 18 methodological steps for carrying out a successful health communication programme. The co-ordinator lists these steps and, as the plan unfolds, maintains a precise record of the team's decisions, mapping the overall direction and the fine detail of the health communication in terms of that methodology. The co-ordinator offers a draft report for review at the conclusion of each step, and makes the revisions indicated by the team. This process helps to clarify all aspects of planning including the team's internal structure and lines of accountability that are the basis of monitoring and evaluation.

To focus team discussion and to make recording less difficult the manual is designed with **questions** and an **HCP worksheet** for each step. However, given the dynamic nature of dialogue, speakers will invariably take off on tangents, reverse upon themselves, be longwinded or anecdotal.

When well managed by the chairperson (the one in the 'driver's seat' of the HCP process and who *must be* a different person from the HCP co-ordinator) these diversions are beneficial to good planning. They create spaces to debate key issues of concern, illustrate scenarios, demonstrate methodologies, raise important new questions, and generally enrich the team's understanding of the complexity of the work at hand. The co-ordinator selects key elements from this information for the documentation of ideas.

From time to time during every team discussion the co-ordinator should review the **co-ordinator's guide**, a list of quick indicators appropriate to each step, to ensure that he/she (and therefore the team) is 'on the right road' for each step and in readiness for the next.

Be consistent in ensuring that the person responsible for any particular task is tagged and that the substance and timing for required follow-up be noted. This will make ongoing monitoring easier.

Various instruments (graphs, matrixes, spreadsheets) for recording may enhance the material, particularly where technical systems are employed, but the secret to good report writing, like any form of communication is 'keep it simple'.

5.2 Ten steps to planning and strategy selection.

Corresponding worksheets (1 – 10-C) at the back of this manual will help you organise your plan.

Before beginning the planning process, the health communication team should preview these steps bearing in mind three guiding principles to effective planning: ***research, assess and select****.*

5.2 Ten Steps to Planning and Strategy Selection for an HCP

WITH HCP WORKSHEETS 1 to 10-C

Aim:

Know your team, the audience and its environment. Plan your health communication strategy and record it as a programme plan and timetable.

Method:

Research, assess, select, and record your plan.

Tools:

HCP WORKSHEETS 1 – 10c, co-ordinator's guide, resource directories.

HCP steps 1-10:

The planning stage should incorporate the following elements:

1. **A health communications team that has reviewed the process for planning a health communication programme and identified elements of the health problem.**

2. **A definition of the health problem and a decision on what aspect of the problem is amenable to solution through communication.**

3. **A stakeholder analysis.**

4. **A situational analysis.**

5. **Objectives of the HCP - goal, purpose, and outputs (or expected results).**

6. **A description of the target audience.**

7. **Anticipation of programme evaluation options.**

8. **A realistic determination of resources.**

9. **A communication strategy statement.**

10. **A written programme plan and timetable.**

To achieve step 1: a health communication team that has reviewed the process for planning a health communication intervention and identified elements of the health problem

The health communication team comes together to review the steps required in planning a health communication programme, to list the methodology for carrying out the intervention and to set up a system for recording the process[1].

Key concept = plan.

The **health communication team** is the vehicle that must carry the process from beginning to end. It must be strong and well cared for. It must be in good working order and supplied with enough fuel to make the journey.

The person or agency initiating the communication will contact prospective members of the team asking them to come together for the first meeting.

A letter of invitation makes a general statement about the health problem and the communications programme envisioned. It should also explain the purpose of the initial meeting to:

a) form the health communication team
b) review the process for planning the health communication intervention
c) list the major methodological steps for carrying out the intervention and put them in sequence

The letter should also identify the resources and/or area of knowledge the person invited is being asked to represent on the team. He/she must be prepared to assist in the research process for data and funding and other inputs needed for planning, programme development, implementation, evaluation and reporting. This establishes at the outset the general areas of accountability required of individual team members.

The first activity of the team is to **review appropriate sections of this manual**, designed to guide the process. Step by step the team should 'write over' the manual according to the needs of a particular health communication plan.

Ensure this and each subsequent meeting has a capable **co-ordinator** appointed beforehand. The co-ordinator may or may not change with each meeting, but ought not to be the chairperson or facilitator.

Co-ordinator's guide - step 1

- Note features of the health problem under discussion.
- Major methodological steps for carrying out information gathering activities.
- References for a resource directory (eg Ministry of Health directives in the health area, studies) and for a directory of possible financial sources.
- Other documentation on file includes letter of invitation, names of team members.

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[1] A Toolbox for Building Health Communication Capacity 1995 USAID, HealthCom, Academy for Educational Development Q1-1

Example of a HCP letter of invitation

Ministry of Health, National Heroes Square, Somewhere in The Caribbean

January 04, 2001

Earnest N. Enthusiastic
Co-ordinator
Wetland Wanderers Association
10 Hummingbird Rd
Carib City

Dear Mr Enthusiastic,

The Ministry of Health notes the steadily increasing number of cases of dengue being reported by clinic and hospital personnel, and by doctors in private practice. Our Public Health Inspectors report continuing high levels of household and container indices of the *Aedes aegypti* mosquito.

It is our intention to plan and implement a health communication programme targeting householders, aimed at reducing the numbers of breeding sites for the mosquito.

You, or a representative of your agency, are invited to participate in a meeting to initiate planning of the communication programme. We recognise your agency's valuable contributions to environmental and health issues, and hope you will join us at Meeting Room 2, Pelican Building, Ring Road, Carib City on March 07, 2001 at 9.00a.m.

Sincerely,

_____
Worthy Bond
Chief Medical Officer

To achieve step 2: a definition of the health problem and a decision on what aspect of the problem is amenable to solution through communication

This task engages the team in formative research (see Glossary, APPENDIX E-1 to E-3) on the health problem as experienced by those affected. The team becomes familiar with complexities of the problem, decides what aspect of the problem is amenable to solution through communication, and determines priorities for action[2]

Key concept = assess

The more experienced the members of the HCP team, and the more reliable their data, the better the definition of the health problem. Quantitative research and the qualitative dimensions of the health problem experienced by individuals and communities are needed. For example, a communication programme addressing drug addiction needs demographics, social indicators, and input from people who are familiar with substance abuse cultures. They should be represented on the team.

A **resource directory** (APPENDIX A) is a tool of reference materials for your HCP. A comprehensive directory aids a sound definition of the problem. Good research results yield the audience's beliefs and current behaviours regarding the health problem. These in turn define feasible behaviours that the intervention will ask the target audience to perform[3].

Questions for defining the health problem:

1. **What is the health problem to be addressed?**
2. **Who is affected by the problem and how?**
3. **Are people affected by the problem represented on this communications team?**
4. **Are people aware that the problem could affect them?**
5. **What circumstances (economic conditions, race, class and gender relations, religious convictions) shape the problem in its social context?**
6. **Who will the proposed programme affect, positively or negatively?**
7. **How are they likely to react using their interests and political leverage?**
8. **Are people who have done health communication activities before on this team?**
9. **What activities (past and ongoing) are addressing the health problem?**
10. **What are media or other organisations doing?**
11. **What can this team say and do to help alleviate the health problem in some way?**
12. **What resources are available?**
13. **What part of the health problem will the team address with this programme?**

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[2] Making Health Communication Programmes Work in Latin America and the Caribbean: A Manual for Action 1991 HPP, PAHO Washington DC p 14

[3] "Those behaviours are turned into specific communication messages with specific objectives". A toolbox for building Health Communication Capacity 1995 USAID, HealthCom, Academy for Educational Development Q1-1

Through a process of research, assessment and selection, the health communication team generates information in the forms needed for developing health communication. The HCP co-ordinator organises the research material into **a written definition of the health problem** in the context of the evolving research methodology by following the guide:

Co-ordinator's guide - step 2 (see health problem definition e.g. on page 38)

Elements of the health problem definition

- Describe the health problem (what is happening to whom, where, when, why), its incidence and magnitude, its effects on individuals and communities, its causes, preventative measures, and its solutions and treatments.
- Describe characteristics of the high risk groups, their age, sex, ethnicity, places of work and residence.
- Note any health service/supply problems compounding the issue.
- Note information about culture, economic obstacles, perceived benefits, causative and preventative behaviours and related knowledge and beliefs; and attitudes of the target audience or those influential in the life circumstances of the target audience.
- Note any gap in any information that may need research.

Characteristics of communication channels

- Information about patterns and use of health related services, media preferences and habits, and information sources that are considered credible by the target audience.
- Strengths and weaknesses of possible formal and informal communications channels.
- Information about national, regional and local media, both formal and informal and channels.

Documentation of information and research sources

- Compile a reference list of related government departments, agencies, research reports (Ministries of Health, university studies, media surveys, grassroots initiatives, etc.) noting methods, approaches, protocols, and audiences.

Outline of possible audiences

- Note both the ultimate beneficiaries of the communication materials (audience) and other groups who are involved in the issue. The team planning an intervention on HIV/AIDS for example and developing messages for prostitutes may need to work with (and therefore develop communication materials for) health service providers such as doctors, nurses and pharmacists.

Other possible sources of problem statement information

- Ensure the team has discussed all areas and noted who is accountable for what input.

Defining the heath problem

Anaemia in antenatal women in Jamaica:

In Jamaica there are reports of a problem of anaemia, especially among pregnant women. Despite receiving medical advice and instructions to take iron supplements, the level of compliance remains low. The following are some of the responses given to the question: "What do you understand are the reasons for taking extra iron during pregnancy?"

- To make the baby strong/healthy.
- To keep the mother's body healthy .
- To strengthen blood/increase haemoglobin (Hb) level.
- To increase appetite.
- To help during delivery.
- Don't know.

Reasons for non-compliance given by women who had been instructed to take supplements but were not doing so:
Received none at the clinic/received no prescription
Experienced side effects
Eating iron rich foods/not important or necessary/Hb is normal
Don't like taking pills/afraid to take/tastes bad
Other reasons
Financial difficulty/not covered by insurance
Not sure/can't recall/no reason
No response

Persistent widespread anaemia in Guyana:

Arising out of the widespread problem of anaemia detected in a 1996-97 study in Guyana, was an evaluation of the reasons for the persistence of the problem in the country. The assessment involved a series of interviews and discussions with informants from government, private sector, non-governmental organisations and the public. Samples from the local flourmill were collected for analysis of iron content. The assessment targeted the capital Georgetown and five other regions. Findings were that flour produced by the local mill NAMILCO and consumed regularly by almost all the population was fortified with iron and available in the school-feeding programme. A wide range of iron fortified products were also available. Other findings suggested that the supplementation programme needed expanding. Poor dietary practices, including infant feeding, were deemed to be a possible contributory factor. Parasitic infections appeared to be a major problem in the country. Based on these findings it was recommended that a multisectoral anaemia control programme involving components of supplementation, fortification, and public health measures should be undertaken and supported by a nutrition education communication programme.

Source: CFNI

To achieve step 3: a stakeholder analysis

The team embarks on a stakeholder analysis of those people, institutions and social groups who will benefit from, may have an interest in, or may present obstacles to, the health communication programme. Through this research process the team shares and builds knowledge of the complexity of factors, forces and mechanisms involved. Representation on the communications team may not be possible in all cases, but networking and cordial relations with all sectors must be maintained.

Key concept = assess

Some stakeholders are represented on the team but all groups and individuals with a stake in the programme must be considered in planning. The interests and objectives of decision-makers, the sponsoring or executing institutions, should be taken into account. The participation of beneficiaries, or target population, in programme design and implementation places their needs and the circumstances that govern their present existence into the formulation of priorities and indicators for evaluation.

Refer to the resource directory for sources of available data regarding key players in the issue at hand. For example, Ministry of Health directives or dialogue with people carrying the institutional memory of non-governmental organisations working on social issues will help determine stakeholders' priorities for the health communications programme. The following four questions and the team's response will evoke the information required for a thorough stakeholder analysis.

Questions for assessing stakeholders:

1. **How does each member of the team assess his/her organisation/interest in relation to the:**
   - **environment in which he/she lives and works?**
   - **experience, knowledge and skill he/she brings to/represents on the team?**
   - **funding sources, institutional and technical resources, political access?**
   - **research sources (documented and/or community-based)?**

2. **What other organisations/individuals are currently involved in similar health areas?**
   - **Assess the local/national/regional/international location, area of concentration, activities and target audience of their work**
   - **Would sharing information, materials, staff or funds with any other groups enhance the impact of this team's work?**

3. **Can this team's relationship with other individuals/agencies be strengthened to increase political, financial, media, and community support for the intended health communication?**

4. **Describe possible communication channels (local, national and regional; community-based and electronic). What are their characteristics, strengths and weaknesses?**

Again, the team's assessment and selection of information contained in the answers to these questions should facilitate further planning and ultimately programme design. These guidelines will assist the co-ordinator to organise the research material into a **stakeholder analysis** in the context of the evolving methodology.

Co-ordinator's guide – step 3

- Record input from each member of the team re: skills, resources (financial and knowledge), political access (community, governmental).
- Take note of each team member's analysis and recommendations re individuals and agencies that will benefit from, or present obstacles to the programme.
- Name member(s) responsible for inviting other stakeholders to join the team.
- Note those stakeholders who for practical reasons will remain outside the team.

To achieve step 4: a situational analysis

A health communication intervention is not merely a group decision to produce and disseminate information about a health problem. Behaviour change usually takes a long time. A methodical, theory-based plan, relevant to people's situations and the production of sensitively placed messages with specific objectives has the best chance of success. The team determines its priorities based on many components. Data gathered from the previous steps (health problem statement, stakeholder analysis, and available communication channels) contribute to this analysis. The identification of gaps furthers the team's knowledge of the health problem, the audience and environment. This research process is called a situational analysis.

Key concept = assess

The following questions are a method of critically treating the data already gathered. The answers will assist the team in placing the health problem being addressed in a theoretical context. In preparing for these discussions, the team should review theories of communication for behaviour change (see APPENDIX B), particularly Social Learning Theory (Bandura). Also refer to the team's existing tools: the **resource directory**, the **stakeholder analysis** and the **description of available communication channels**.

Questions for a situational analysis (determining priorities)

1. **What does the team know?**
2. **What does the team need to know?**
3. **What further audience research is needed (e.g. demographics, education level, media preferences)?**
4. **Will the team need to conduct KABP (see Glossary) studies (e.g. through self-administered questionnaires, focus group interviews)?**
5. **What benefits and barriers to communication and behaviour change exist?**
6. **What need for special approaches (e.g. use of play in targeting children)?**

Based on the discussion of these questions the co-ordinator maps out the situational analysis as follows:

Co-ordinator's guide - step 4

- Team's assessment of all players in the external and internal environment (revised stakeholder analysis).
- Political, social and cultural influences at work.
- Financial and institutional resources required including available communication channels.
- Determine quantitative and/or qualitative surveys to be done and arrangements for these including a note on members accountable.
- An updated definition of the health problem.
- Identify other activities that may impact on the plan.

To achieve step 5: objectives of the health communication programme: goal, purpose and output

Programme objectives establish what the intervention is designed to accomplish and indicate how its effects will be measured. The programme goal points to the *reason for* the overall change and describes a specific improvement sought in one aspect of the health of a certain population (e.g. change in health status). The purpose responds to the question *in what way* and describes a change in the way people or institutions do things that will affect or impact on the goal. Output or expected results state the specific results you desire to achieve the purpose.

Key concept = plan

Goal, purpose and output are the foundation of programme development and evaluation. Communication outputs must be clear and 'actionable'. The team must separate cause from effect, use simple, concise statements, and use strong action verbs in phrasing strong objectives which serve as a kind of programme contract. In step 9 the team will write a communication strategy statement drawing on planning done in this step. The co-ordinator would do well to ensure now that the team knows the frame for a good strategy statement and keeps it in view, as this will simplify the final drafting later on.

Components of a strategy statement are sequentially: programme objective; primary and secondary audiences; specific target information to be communicated; and benefit to be communicated. Indicators anticipate activities to be planned to assess these objectives after they have been implemented. Also, a foundation for a work plan and timetable to be drafted in step 10 is laid here.

Questions for defining goal, purpose and output:

1. **Having reviewed the situational analysis what, if any, ongoing activities by other agents bear a relationship to this team's programme plans?**
2. **What are the stated goal and purpose of such existing programmes?**
3. **Consider the example on the following page. Can a relationship between this and ongoing health programmes be established in terms of goal and purpose?**
4. **Define in simple, concise statements:**
   the overall reason for the programme (goal)
   the way it is being done (purpose)
   what is to be done (outputs)
   how it will be done (activities)
   for whom (target audience and secondary audiences)
   the cost of the programme (budget and other resources)
5. **What indicators of achievement for the goal, purpose, and output, can the team think of?**

Co-ordinator's guide –step 5

- State realistic goal and purpose. Determine whether the team needs expert help (e.g. from a statistician, psychologist, epidemiologist) to set realisable rates of change.
- State outputs in terms that are: specific; attainable; prioritised to direct the allocation of resources; measurable to assess progress toward the goal and purpose; and time specific.
- Record the team's brainstorming on indicators of achievement in relation to outputs, purpose and goal.
- Layout a work plan listing the activities and resources (including money) needed to achieve the outputs and implement the communication strategy. Include a cost-effectiveness assessment per individual items listed. Include timelines in the work plan.
- Note in what way country information storage and retrieval systems (available or being developed in Caribbean countries) may be useful.

Goal, purpose and output of HCP Development

The **goal** of the team's health communication programme may be the **purpose** of a national programme relating to a particular issue. At the same time the **purpose** of the team's HCP may be the **goal** of efforts localised to a health centre in a particular community. These concepts are graphically illustrated with a Logical Framework Approach Matrix. Point of view determines purpose: national, HCP, or health centre.

	National	Health Communication Programme Team	Health Centre
Goal	Decrease Mortality from Cerv. cancer		
Purpose	Increase # women by Pap sm. Screening	Goal → Incr. # women screening by Pap smear	
Output		Purpose → Develop strats: Paps for > 35s every 3 yrs	Goal → Develop strats: Paps for >35 every 3 yrs
Activity		Output	Purpose Increase # community campaigns
		Activity	Output
			Activity

Goal, purpose and output of HCP Development

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Look at the left bloc of the matrix headed **National**. Suppose the existing goal of a national health communication programme (decided by the Ministry of Health) is:
Goal (National) = to decrease mortality from cervical cancer.

And suppose the purpose at national level is:
Purpose (National) = to increase the number of women screened by Pap smear.

Now suppose your team has researched, assessed, selected steps 1 to 4 of this manual and is ready to make a decision about the team's HCP goal. The team could elect to state the programme goal in the terms in which the purpose of the national programme is stated. Note the middle bloc of the diagram headed **Health Communication Programme Team**.
Goal (HCP) = to increase the number of women screening by Pap smear.

The team could define the purpose of your HCP as:
Purpose (HCP) = to develop strategies to encourage women over 35 to go for Pap smears every three years. (This could accord with the viewpoint of the Health Education Unit in a Ministry of Health)

Meanwhile, a community health centre is organising its own health communication programme. Having done their research, etc, they decide that the appropriate goal for their programme is your team's HCP purpose. Look at the bloc on the right side of the diagram:
Goal (Health Centre) = to develop strategies to encourage women over 35 to go for Pap smears every three years.

The health centre purpose could be:
Purpose (health centre) = to increase the number of community level campaigns by primary health care nurses (or the number of community health aides employed) to promote regular smears among women over 35.

To achieve step 6: describe target audience

Effective health communication interventions reach audiences who respond to a message. Formative research enables the team to develop specific audiences (people who you want to reach and influence with your messages). A diversity of interests, needs, concerns and priorities abound in different segments of the public and it is unwise to target unspecified audiences. This research step will assist the team in developing profiles of audiences and their environments. The team can obtain further KAPB data by talking to people in different settings (bars, schools, buses, etc), through focus groups, and with qualitative and quantitative surveys.

Key concept = select

Even with a well-stated health problem and clear objectives, information about the people affected by the health problem may be undocumented or outdated. The team already has some information about the target audience and may have considered the need for further audience research (step 4). If so, this is the time to do it. This may involve **quantitative** or **qualitative** research (see Glossary) or may use a combination of methods.

By detailing precisely who your target is, the team can separate the segment or **segments of the audience** (see Introduction 3.6) from the rest of the public and from one another. The team may find that it wants to reach several distinct population groups in one communication programme. Deciding who will not be a target audience for the health communication is a valuable, resource-saving exercise.

If the team is designing a communication programme that will be implemented over a long period, build **audience tracking** into your programme plans. This will help you find out what your target audience knows, thinks and does before you begin activities. Periodic surveys assess progress and the need for modification of new activities. Audience tracking measures the behaviour change among the target audience when the programme is completed. A common problem with audience surveys is bad timing. A tracking exercise conducted well into the programme or after the activity is a waste of resources. Sporadic or incompatible results cannot be compared.

Questions for determining the target audience:

1. **What are the physical characteristics of each audience segment (sex, age, type and degree of exposure to health risks, medical condition, disorders and illnesses, health history of family)?**

2. **What are their behavioural features (lifestyle characteristics, group memberships, media preferences, and health-related activities)?**

3. **What demographics pertain (occupation, income, formal education, family situation, places of residence and work, cultural characteristics)?**

4. **What are audiences' psychographic characteristics (attitudes, opinions, beliefs, values, self-appraisal and other personality traits)?**

Co-ordinator's guide – step 6

Identify and segment audiences

- Note team members' discussion for or against audience segmenting. Limited resources are the obvious argument for not segmenting an audience. It is always less expensive to present a programme to one large audience than to several smaller and homogeneous audiences. However, in most cases the latter strategy will be more effective. On the other hand, not all situations benefit from increased group homogeneity. The team must use its discretion regarding the appropriateness of segmentation to the situation at hand. Avoid dogmatism.
- Distinguish the characteristics of the different audiences you want to affect.
- Select one audience segment as the most important.
- Decide which audiences are less critical (because of their health risk status, their influence on or link to the primary target audience), or because of the constraints of programme resources.

Establish Audience Tracking Systems

- Decide whether audience tracking is appropriate at an early planning stage.
- Note the team's proposals for a particular research methodology (or combination of methods).
- Note the time frame and contact people responsible for audience research, including media houses.

Information on consumer behaviour patterns is crucial to organizations that target children and adolescents with social products
Photo: Ronnie Carrington

Audience segmentation

Commercial marketers rely heavily on segmentation research and describing the market in terms of its segments. This is appropriate in health communication as well. Identification of relevant segments has been crucial to the success of many health campaigns based on the social marketing model. Manoff (1985) lists eight audience groups and their roles in describing a breastfeeding promotion programme in Brazil.

1. The doctor, who would be instrumental in persuading mothers to breastfeed.
2. The health services, to which mothers would turn for advice.
3. The hospitals, which introduce new practices and revise old ones.
4. The infant food industry, which would insure that breast milk substitutes were marketed.
5. Industry in general, which has to comply with existing laws affecting breast-feeding mothers.
6. The community, which would offer psychological support and facilities for breastfeeding.
7. Government officials, who would initiate new policies.
8. The mothers, who would be encouraged to breastfeed longer.

To achieve step 7: anticipation of programme evaluation options

Look ahead to Section 10. Note the distinction between formative and summative evaluations explained in step 17. Having defined indicators of achievement (for outputs, purpose, and goal) at step 5, the team is ready to develop a strategy on *how* these indicators will be measured after implementation. Elements of an Evaluation Design (APPENDIX E-2) describe the basics of a formative evaluation on the outcome of communication objectives. A decision about the kind of programme evaluation strategy possible will depend on the nature of the intervention and the channels under consideration. The programme will benefit in the long run if the link between audience research that reveals the features of a health problem in a segment or target audience and components of a final programme evaluation method are clear to the health communication team.

Key concept = assess

This is a good time for the team to anticipate its evaluation plans. Pre-testing will be required at step 13. Down the road at steps 17 – 18 you will be evaluating the programme. Formative evaluation planning relates to communication outputs. A good grasp of evaluation will come in handy at step 10 when the team draws the programme plan and timetable.

Questions about what kind of programme evaluation is best for this intervention:

1. **Has the team reviewed monitoring and evaluation possibilities in step 17?**
2. **How long will the programme run? Will the implementation phase be long enough to permit measurement of significant effects and periodic adjustment?**
3. **Does this team want to repeat or continue the programme?**
4. **Are the objectives measurable in the foreseeable future?**
5. **Which programme components are most important to the team?**
6. **Is there management support for public demand for programme accountability**
7. **What aspects of the programme best fit the team's priorities?**
8. **Will an evaluation report help future funding?**
9. **What evaluation methodology is best suited to this programme?**

Co-ordinators guide – step 7

- Determine what sources (personnel and information) the team needs to choose and plan your evaluation strategy, building these into the programme whenever possible.
- Ensure that everyone on the team understands the evaluation concepts explained in step 17 and the quantitative and qualitative research concepts explained in the Glossary.
- Make notes on the comparative advantage of a particular design or combination.

To achieve step 8: a realistic determination of resources

Having developed a more precise description of the audience segments the health communications team reviews and updates resources available for the programme.

Key concept = assess

By now the health communication team has a clear picture of the objectives and indicators already identified and wants to plan its activities and budget around these. The team must have a handle on its resources in order to be realistic about what can be accomplished. The team is already familiar (step 2) with resources available for the programme. Setting realistic expectations will lead to a well-designed communications strategy (step 9) and avoid frustration.

Questions for reassessing resources:

1. **Is a productive programme along the intended lines possible?**
2. **Are sufficient resources available to proceed?**
3. **What are the greatest areas of need?**
4. **What programme activities will contribute to answering these needs?**
5. **What resources are available re: staff (committee members, associates from other programmes, volunteers); re budgets (media services, etc); re information (about the issue, the target audience, the community, the media structure, educational materials); re time (weeks, months, years planned to complete the communication programme); re programme evaluation?**
6. **What community activities and other factors that may contribute to the programme exist?**
7. **What barriers to the programme exist?**
8. **What resources has the team identified that can best be used to implement activities?**

Co-ordinator's guide – step 8

- Describe the activities that will contribute most to answering those programme needs the team has identified.
- Itemise resources available for the communication programme re: staff, budgets, information, time.
- List existing community activities and other factors that may contribute to the programme.
- List barriers to the programme.
- List the resources that best fit the constraints of your situation.

To achieve step 9: a communication strategy statement

A communication strategy statement describes in terms of activities and tasks how the outputs will be achieved. It is a test of whether the team has enough information to begin developing its messages. Seeking organisation and community approval of the strategy at this early stage can lay the basis for co-operation in the coming implementation stage.
Key concept = plan

The team must be satisfied that its preparations are complete. Namely: it has clearly articulated what needs to be done (has stated its objectives –goal, purpose and output); it is familiar with and knowledgeable about the audience with whom the team wants to engage (has researched segment audiences); it knows the greatest areas of need and the resource constraints (has realistically determined its resources); it has identified activities based on indicators (has the basis on which to detail activities and tasks). Now it is ready to design the communication strategies most likely to have meaning to the audience.

The health communication strategy statement requires imagination. In drafting it, the wise team is guided by research already gathered about what the audience perceives as important or valuable. Remember, *in terms of communication* this is different from the team's raison d'être (the team's perception of the benefit of improved health). For example, a health communication programme strategy to encourage safe driving among adolescent drivers, recognised that safety and accident prevention were not perceived by teens to be compelling benefits. Rather, the loss of independence and peer approval that would result from losing a driver's license were motives to drive safely[4].

A good strategy statement forms a foundation and boundaries for creative development. It provides all programme staff with a common direction for developing all messages and materials. It contains the tactics that will be used to reach audiences with appropriate messages and it describes audience benefits, ie what the audience will gain that they perceive as valuable. Audience benefit is important to the creative development of messages.

Questions for drafting a communication strategy statement:

1. **What are the programme objectives?**
2. **Who are the primary and secondary audiences?**
3. **What specific target information is to be communicated?**
4. **What benefit, as perceived by the audience is being communicated?**
5. **What activities did the team identify as practical, given accessible resources?**

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[4] Making Communication Programmes Work in Latin America and the Caribbean: A Manual for Action 1991 HPP PAHO p25

Co-ordinator's guide – step 9

At step 5, the team planned what needs to be done (defined goal, purpose, and output). Now the team is going to design the strategies to get there. Basically, the communication strategy statement fine-tunes the objectives from step 5.

- Record the team's responses to the above questions and get the team to restate its responses to each *as tasks* in the communications strategy. Each programme task must contribute to the established objectives. Each must be targeted to the identified audiences. Messages and materials must incorporate the benefits and other information in the strategy statement. Review with the team what was learned about audiences and their perceptions (that had been researched through the focus groups and other means at step 6).
- Review with the team the list of communication channels bearing the audience in mind.
- Review with the team the resources available for the programme***.**
- Draft the communication strategy statement ensuring that all programme elements are compatible with the strategy.

*** Once the communication strategy is written, the well-prepared team will consult its resource list. Stakeholders and communication specialists are sources of information about existing materials, information you will need in Section 8.2. Make use of these contacts in researching and soliciting materials from the agencies that produced them. The team will assess (step 11) whether they are suitable for your HCP. Remember that materials must be consistent with the strategy statement.**

The HCP co-ordinator should ensure that the appropriate letters are drafted to secure these samples.

To achieve step 10: a written programme plan and timetable

This step represents fine detailing of activities. All elements of HCP planning are recorded in a programme plan. The team organises the programme tasks and their rationale and evaluation according to this blueprint. A time schedule for programme development and implementation is the final planning step.
Key concept = plan

Drawing on components of the HCP design developed in the preceding steps, the team pulls together a list of programme tasks and provides an explanation (ie description of needs and strategies) of the plans for the benefit of the organisations to which members are accountable. Note the programme plan builds-in the team's programme evaluation plans. As the work proceeds the team will continue to evaluate its strategies.

A final planning step is a time schedule for programme development and implementation. The team brainstorms on every conceivable task from the time of writing the plan to the intended date of completion. The more thorough and detailed the tasks you build into the timetable, the better your plan with regard to workload, costs and evaluation. The more realistic the timetable the more likely to keep to schedule.

Because the best-laid plans of mice and men can go awry, the timetable must be treated as a flexible management tool. The co-ordinator will want the team to update it regularly, perhaps monthly, to track progress and record changes in costs and timing.

Questions for constructing the programme plan and timetable

1. **What are the planning tasks for each HCP objective?**
2. **What are the related implementation tasks for each HCP objective?**
3. **What are the evaluation tasks on each objective?**
4. **Who is responsible for each task? By what date? What resources are required?**
5. **What types of evaluation (formative, summative) will we use in step 17?**

Co-ordinator's guide – step 10

- The co-ordinator may use the mapping tool (**HCP WORKSHEETS 10A and 10B**) to organise the team's input on the above questions. The result will be the team's first programme product, the HCP Plan and Timetable. See also Elements of Evaluation Design for evaluation options.
- Ensure that arrangements are being made for the dissemination of materials coming in the implementation stage (step 15). It is vital that the team builds good interpersonal relations with dependable and expert contacts. Programme plans and timetables can be designed with back-ups and fail-safes to mitigate boo-boos. Picture it: a flat tire on the community vehicle scheduled to meet participants at the airport (someone can ensure beforehand that there's a spare tire or taxi fare in the kitty) or the radio link-up technician gets sick on the day of your show (a second will have been put on stand-by and can be quickly available).

5.3 Four steps to selection of communication channels and the selection and development of materials.

Corresponding worksheets (11 – 14) at the back of this manual will help you organise your selection.

Steps 11 (re channels) and 12,13,14 (re materials) are interdependent.
Each must suit the other and each must fit the communications strategy statement drafted in step 9.

5.3 Four steps for Channel and Material Selection and Development

WITH HCP WORKSHEETS 11 to 14

Aim:

To choose effective channels, to produce messages based on theory-informed experience, and to pre-test and refine materials for dissemination.

Method:

Select, pre-test, revise, select.

Tools:

HCP WORKSHEETS 11 – 14, communication strategy, budget, programme timetable.

HCP steps 11-14:

11. **Affordable, accessible and credible channels consistent with the communication strategy statement.**
12. **Well-designed, believable materials consistent with the communication strategy statement and ready for pre-testing.**
13. **Pre-tested materials.**
14. **Final package of materials consistent with the programme plan and ready for dissemination.**

Radio for Health

The Diabetes Association of Jamaica (DAJ) has been using radio in its public education programmes since 1970. In 1987 the Association analysed the series and found that it showed certain shortcomings, frequently attributed to mass media efforts in the health field, namely that many attempts at health promotion are often boring, avuncular and largely misdirected when compared to the promotional efforts from the commercial world.

The series was revised and re-christened "On the Alert". The word "alert" emphasised the need for vigilance by diabetics in managing their ailment. Staying alert has been and remains a consistent element of the DAJ's outreach message. The programme was broadcast January 1990 to December 1998 on alternate Sundays only at 2:15 p.m.

The objectives of the new series were to help the public, especially diabetics to:

- Identify the difference between Type one (1) and Type two (2) diabetes and to recognise early symptoms;
- Apply modern self-monitoring strategies for controlling diabetes;
- Share openly in public dialogue about diabetes as part of the process of adult learning on a national scale.

The high-point of the series was its theme song. Set to music and recorded by one of the country's leading popular bands (some of whose members were blind and possibly diabetic), the song spelt out the word D-I-A-B-E-T-E-S, thus:

D	**-**	**Drop the sugar!**
IA	**-**	**I Absolutely will now**
B	**-**	**Better off for knowing that**
E	**-**	**Every day I'm healthy still**
T	**-**	**Testing every week (if necessary every day)**
E	**-**	**Ever checking what I eat; exercising & staying away from starch and sugar**
S	**-**	**Sugar! And also all sweets, Oh yes! That's the key for me!**

An independent all media survey showed that 120,000 persons listened to the programme from start to finish. This represented a 13 percent share when compared with radio's most popular programmes. 'On the Alert' had the highest ranking of programmes broadcast on Sundays in spite of its irregular transmission schedule.

In addition, DAJ's membership showed 150 percent increase for the 1988-1990 period. None of the increases since the DAJ began its work had ever exceeded 100%. It seemed reasonable to conclude that the series was the intervening variable heightening motivation among diabetics to learn more and to become better organised in their treatment regimens. 'On the Alert' seemed to have been effective.

5.3 Selection of Channels and Selection & Development of Materials

To achieve step 11: select appropriate channels

With ten steps for health communication planning and strategy selection complete and the written plan in hand, the health communications team is ready to develop its communication tools. Decisions about channels are interdependent with decisions about the format of materials. A choice of channels for your messages is based on the previous assessment of possible communication channels (steps 2 and 4) and must be consistent with the strategy statement (step 9). The well-prepared team will have anticipated the need to assess existing materials (step 12) from the agencies that produced them and to have samples of such materials made available.

Key concept = select

Message delivery channels take many forms and each offers different benefits. **Face to face** communication among say, health workers, peers, family members, and community and religious leaders also happens during one-on-one exchanges between individuals from these constituencies when they interact. **Group delivery** is a term used to describe scenarios such as the work place or classroom. **Electronic mass media** can transmit news quickly to a broad audience and may be effective when appropriate and theory-driven. **Community media** such as mobile loudspeakers, cassette forums, radio and interactive popular and street theatre can be very effective. **Community and religious organisations, women's groups and other non-governmental organisations** often run programmes interacting with audiences selected by the communication team. Review the statement **Different Channels, Different Benefits** (**APPENDIX C**) before making decisions based on the following questions:

Questions for selecting appropriate communications channels:

1. **What channels are most appropriate to the health problem?**
2. **To what extent are they accessible and credible to the audiences concerned?**
3. **Which channels fit the programme purpose (defined in step 5)?**
4. **Are the channels being considered affordable to the programme?**
5. **Which and how many channels are feasible and affordable considering the time schedule and budget?**

Co-ordinator's guide – step 11

- Nationally, regionally and internationally recognised 'days', 'weeks', and 'years' (eg a launch on World Health Day) may be incorporated into the programme.
- Identify appropriate events, integrating them into the programme time frame (eg national festivals and village fairs).
- Record the channel selections the team has made and why.

Channels: strengths and weaknesses

Strengths	Weaknesses
TELEVISION High impact Audience selectivity Schedule as determined by HCP Fast awareness Sponsorship availability Merchandising possibility	High production costs Uneven delivery to market Up-front sponsorship commitments required
RADIO Low cost per contact Audience selectivity Growing nos. of community radio channels Schedule as determined by HCP Length can vary Facilitates use of personalities to help product identification	Non-intrusive medium Small audience per spot No visual impact High total cost for good reach Strong competition from other messages
MAGAZINES Audience selectivity Editorial association Long life Large audience per insert Excellent colour Minimal waste Merchandising possibility	Long time needed for measurable impact Readership accumulates slowly Uneven delivery to market Cost premiums for regional or demographic editions
NEWSPAPERS Large audience Immediate reach Short lead time Market flexibility	Difficult to target narrowly Highest waste High cost for national use Minimum positioning control Strong competition from other messages
POSTERS, BILLBOARDS High reach High frequency of exposure Minimal waste Can localise Immediate registration Flexible scheduling	No depth of message High cost for national use Best positions already taken No audience selectivity Restricted coverage Minimum time usually available

Source: A Programme Managers' Guide to Media Planning (Washington DC: SOMAKCK, The futures Group, no date) Reproduced with permission.

To achieve step 12: select materials

It is vital to have the right tools for the job, which means making decisions about what materials fit your budget and your audience. Different message designs must be developed to suit the channels selected. As noted in step 10, the processes for choosing messages, formats and channels are interdependent. Each step must suit the other and each must fit the communications strategy statement (step 8).

Key concept = select

Material production can be a time-consuming and costly process. Though it is often seen as the creative and tangible product of a health communication strategy, the team should consider whether creating new materials is necessary. There may be existing health communication materials (booklets, leaflets, posters, and videotapes) that can be used in your programme. Much excellent development communication material is produced by grassroots organisations lacking the resources to fund its wider application. It may take some time to acquire materials identified from the exercise below. A well-organised team will have reviewed the methodology for material selection well before and have the materials at hand when it is time to make these decisions. Refer to the communication strategy when considering the following:

Questions for identifying existing relevant materials:

1. **What agencies listed in the resource directory are possible sources for materials that have already been developed?**
2. **Do they offer accurate and complete messages?**
3. **Consider their: sources, format, adaptability, literacy level, relevance, suitability**
4. **Is it possible to discuss with the author of the material being considered their experiences in the field and whether any testing was done on the effectiveness of the message?**
5. **Should materials be modified to make them culturally appropriate?**
6. **Does the team need to pre-test the existing materials?**

With suitable materials for the programme in hand, the team can move directly to pre-testing. However, if the team is unsure about the appropriateness of materials, or if materials need alterations more than one pre-testing stage is recommended.

Co-ordinator's guide – step 12

- Ensure the materials and format suits the complexity, sensitivity, style and purpose of the message.
- Ensure that materials and format are compatible with the interests, media preferences, education, level of skill of the audience.
- In selecting a format, make sure the team calculates expenditure for distribution, promotion and process evaluation as well as production.

To achieve step 13: pre-testing materials

This step draws on technical expertise in the health communication team. In the Caribbean many resources exist for obtaining professional assistance. Pre-testing is a kind of formative evaluation to ensure that communication materials are appropriate for their audiences. Most pre-testing is qualitative research, involving a few people chosen as representative of the intended target audiences and not a statistically valid sample. Research provides the team with clues for revision based on audience response and gives direction regarding materials production and use. At this phase of programme development the team must ensure that arrangements initiated at step 10 are in place for the delivery of the materials to channels of communication.

Key concept = select

A variety of procedures may be used to test messages. The best methods for a particular programme depend on the nature of the materials, the target audience and the time and resources available for **pre-testing**. There is no formula for selecting a pre-test methodology, which must be tailor-made to pre-testing requirements. Sometimes using several methods in combination will help overcome the limitations of individual procedures.

For example, **focus group interviews** may be used to identify issues and concerns relative to a particular audience, followed by **individual interviews** to discuss identified concerns in greater depth. **Readability testing** should be used first in pre-testing draft manuscripts followed by individual questionnaires or interviews for materials with target audience respondents. **Central location interviews** regarding messages for television or radio permit contact with larger numbers of respondents, which is especially useful prior to final production of materials.

Qualitative research conducted in the early stages of programme development before full expenditure on materials provides the opportunity to correct flaws in methodology. Trained interviewers should be used whenever possible. In the case of focus groups and in depth interviews, this is essential.

Those team members responsible for promotion and dissemination have been following the programme plan and timetable drawn up by the team in step 10. Now they will want to finalise detailed arrangements with individuals and institutions concerning channels for dissemination. Interpersonal communication and follow up are essential to a dependable schedule.

Questions for deciding whether and how much to pre-test:

1. **How much do you know about the target audience?**
2. **How much do you know about them in relation to the health issue?**
3. **How new, controversial, sensitive or complex is the health issue?**
4. **What related research can be applied to the topic?**

Questions about planning and implementing a pre-test:

1. **What is the team's research objective?**
2. **What individuals and groups does the team wants to participate in the pre-test (members of religious organisations, schoolchildren, 'boys-on-the-block', etc.)**
3. **Is an incentive needed to encourage participation?**
4. **What safe, convenient, quiet and comfortable site is available and who will make the arrangements?**
5. **Where does the team have contacts for potential interviewers? (university faculties, teaching colleges, schools of continuing studies, advertising agencies may be of assistance)**
6. **What arrangements must be put in place to ensure feedback on pre-testing is provided to participants in the HCP to date, including pre-test audiences and stakeholders?**

Co-ordinator's guide – step 13

- Define the pre-testing requirements considering the objectives and resources available for the programme.
- Reach a team decision as to whether the professional judgement on the health team (health and communications specialists) is sufficient with regard to improving messages and materials, or if more expertise is needed.
- Write down the team's formulation of the research objectives. Ensure the team has stated them specifically to provide a clear understanding of what you want to learn. Measures of attention, comprehension, believability and personal relevance are key.
- Ensure the team formulates other specific questions that identify strengths, weaknesses based on pre-test objectives.
- The team should recruit more pre-test participants than are necessary to ensure there is a sufficient number of respondents.
- The team member responsible for these arrangements must be sure to thank respondents and indeed all participants who show up, and offer them the incentive advertised, even if their assistance is not required.
- If the team, or anyone on the team is offering reasons to avoid pre-testing, remind the team that the success of the health communication programme depends on a carefully planned pre-test.
- Record details for feedback of pre-test data to pre-test participants and stakeholders.
- Check whether any existing research exists.
- Determine research activity (e.g. focus groups, questionnaires, and interviews).

Pre-testing

Even if your presentation seems perfectly suited to the message and the audience the health communication team should pre-test.

Even a small pre-test is valuable to health communication planning because pre-testing alternative message concepts on an audience may help identify:

Messages with the strongest appeal

New message concepts

Confusing terms

Language used by target audience

Weaker concepts to be scrapped thereby saving production costs

In the Caribbean audience testing for health messages is insufficient.
Resources for the kind of audience research done by giant business corporations is beyond our reach.
Given these facts, is important for health communication teams to make a commitment to begin accumulating information on what types of content and appeals are successful with different groups.
(Rural communities are particularly neglected)
A centralised clearing-house on audience data and successful health communication content has been proposed[1]

[1] Making Health Communication Programmes Work in Latin America and the Caribbean: A Manual for Action 1991HPP, PAHO Washington DC p 45

To achieve step 14: produce materials

Based on findings from pre-testing message concepts, the team will want to refine the most promising approach and produce the materials. Both the channel and the purpose of communicating health information influence messages. Information may be designed to contain new facts, to alter attitudes, change behaviour or encourage participation in decision-making, or messages may be designed to advocate new policy approaches to health issues. Regardless of their purpose, messages must be assessed for a desired outcome and must reinforce the communication strategy. Therefore however creative or compelling a message, if it does not fit the objectives and identified audience, throw it out. (**APPENDIX D-1, D-2, D-3**)

Key concept = assess

Several factors help determine public acceptance. **Clarity**: messages must clearly convey information to assure public understanding and limit chances for misunderstanding or inappropriate action. **Consistency**: conflicting views and even conflicting information appear in the media. Specialists will interpret new health data differently and consensus among government, industry, health institutions and civil groups is unlikely. Well-developed messages can take advantage of this seeming negative as an opportunity for debate and can be a value to the health communication programme. **Main points**: Stress and repeat these. **Tone and appeal**: a message can be designed to be reassuring, alarming, challenging, or matter-of-fact, depending on the desired audience and desired impact. **Public need**: messages must be based on what the target audience perceives to be important and what they want to know, not what is most important or interesting to the health communication team. **Credibility**: the spokesperson and source of the message must be believable and trustworthy.

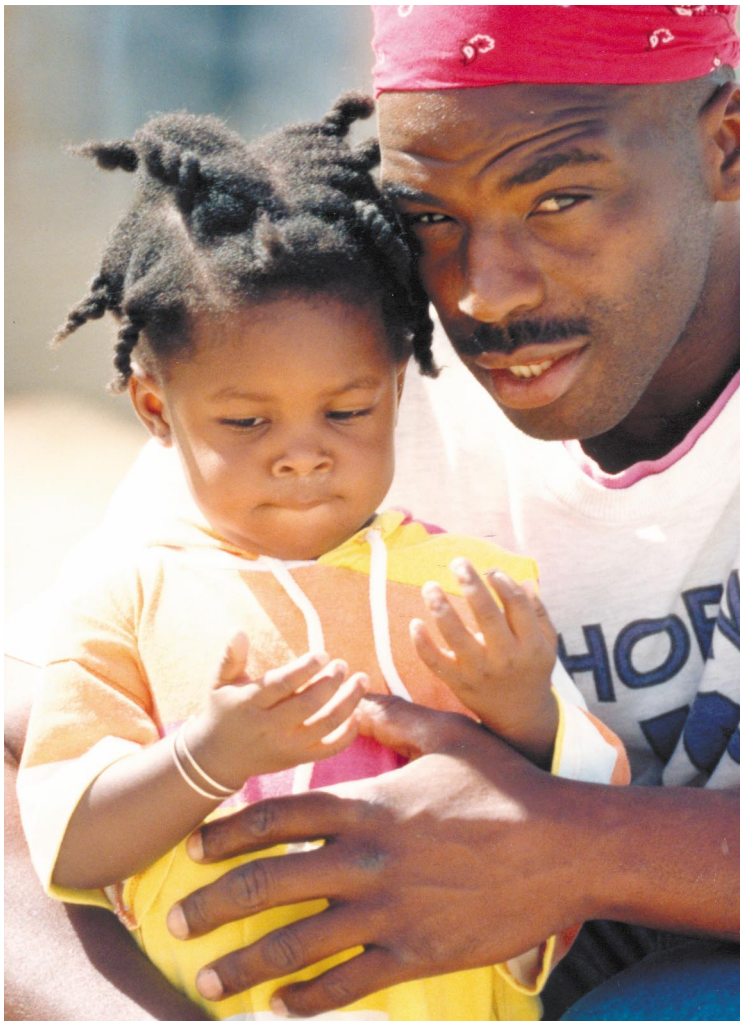
The right actor or celebrity personality to represent your campaign brings the message alive. Celebrities can be effective if they can be directly associated with your message by the audience (e.g. an ex-cancer patient, an ex-smoker). Be sure that the celebrity does not practice health-related habits or hold health-related opinions that contradict your messages and remember that celebrities live in the public eye. A change in their popularity or personal life-style could affect the acceptability of you message. A locally well-known figure may be more credible for some audiences than a national figure.

Questions for producing materials

1. **Has the message eliminated unnecessary information?**
2. **Can the message capitalise on public awareness of new data even if they are conflicting?**
3. **Have the main points been fronted or are they hidden within less strategically important information?**
4. **Is this message truthful, honest, consistent and complete?**
5. **Is it appropriate to the target audience?**
6. **Is the celebrity figure appropriate to the message and audience?**

Co-ordinator's guide – step 14

- Ensure that the message contains as few technical, scientific or bureaucratic terms as possible, unless it is specifically aimed at those target audiences.
- Ensure the team eliminates unnecessarily detailed explanations that the audience does not need to make necessary decisions.
- Ensure that the team has a firm agreement with the celebrity about his or her role and what he or she will and will not say.
- The wise co-ordinator, like any good navigator, is correlating the guide with what's down the road. That is, he or she is looking ahead to the steps required for implementation and evaluation. The team will need to be on top of the necessary preparations for events detailed in the programme plan. If for example, the health communication material includes support products such as press kits, or print or video material tailor-made for particular segment audiences, these should now be underway for presentation. These may include meetings with Ministry of Health officials, workshops for community organisers, health workers, and or other individuals and groups pivotal to dissemination and follow-up.



Different communication channels have different capacities
Photo: Ronnie Carrington

Message concept

Examples of pithy health messages developed by the Share Care marketing unit, MOH, Jamaica in 1993

HEALTH AND NATIONAL DEVELOPMENT

- Only a healthy worker can be truly productive
- Good health is an economic asset
- Health is wealth
- Health is everything

RESPONSIBILITY FOR HEALTH

- Your actions determine the state of your health
- The more health-conscious you are the healthier you will be
- Health knowledge is the first step to good health
- Family life is key to health

BEING PROACTIVE

- An infected child is an epidemic waiting to happen. Have your child immunised
- Sow a seed for health. Start a community health project
- Education and good health go hand in hand
- The air belongs to all of us. Keep it clean

HEALTHY LIFESTYLES

- Eating right is the first step to good health
- Eating right is not eating too much
- Regular exercise makes you physically fit, healthy, energetic and strong
- Too much sugar, salt, fats and oils are bad for health

VOLUNTEERISM AND HEALTH

- An hour of your time could be crucial to someone's health
- Health professionals need voluntary help. Please help
- There is no greater joy than helping someone back to good health
- Many lives have been saved, many made healthier, through the help of volunteers

6

Implementation

The delivery or implementation sites of a health communication programme in the Caribbean may include health fairs, radio and television programmes, and media house sponsored events such as The Nation Newspaper Healthy Lifestyle Extravaganza in Barbados. Agricultural events such as the annual Denbigh Show and Trelawny Yam Festival in Jamaica are popular venues with potential as delivery points for health messages. So are tourist attractions such as the Oistins Fish Festival in Barbados, or the St Lucia Jazz festival, or several annual sailing regattas in the OECS territories. Popular theatre groups like Ashe (Jamaica), and Pinelands (Barbados) are attractive and effective messengers in both rural and urban settings.

Some supermarkets promote good nutrition, incorporating health tips into promotional material. Service clubs and churches occasionally organise blood pressure and blood sugar screening at convenient venues. Religious organisations, schools, factories, and offices are portals to a variety of audiences with health problems common among particular social groups.

A health communication programme selects credible spokespersons to deliver its messages. The popular storyteller Paul Keens-Douglas and calypsonian Colin Lucas have promoted nutrition, exercise, dengue fever control, HIV/AIDS prevention, and reproductive health and rights. Sports personalities, musicians are effective publicists for both civic and commercial products. Audience sampling may indicate that a target audience is more likely to respond to messages that do not use mass media.

Step 10 requires that the team has set up the components for implementation described in the programme plan. Contacts with people in health centres, NGOs, village councils, media houses are in place.

Two steps to Implementation

WITH HCP WORKSHEETS 15 and 16

Aim:

To launch the health initiative.

Method:

Follow-up, check-up, double check, apply creative flexibility.

Tools:

HCP WORKSHEETS 15 &16, programme plan, programme checklist.

HCP steps 15-16:

15. Readiness for the health communication launch.

16. Active measures to ensure implementation.

Interpersonal communication allows for personal exchange between people over a message.
Photo: Ronnie Carrington

To achieve step 15: preparing for the launch

The team has in hand its communications materials and knows the channels it will use to deliver them. At this stage a number of actions must occur simultaneously for a successful public launch of the health communication material.

Key concept = plan

Expect the unexpected. Even with the best advance planning communication interventions are likely to need last-minute modifications or emergency decisions[1]. Team members should keep their (dog-eared) programme plans handy and stay awake at the wheel! At each team meeting members are well advised to consult the co-ordinator and HCP guide to track lines of progress on individual objectives by identifying and recording problems, flaws, or oversights regarding material, implementation strategies or channel selection *before* they become nightmares.

Questions for introducing the programme to audiences:

1. **Does the team have before it a list of all the relevant publicity outlets contacted and the contact names?**
2. **Does every organisation that should be involved in the HCP know about the programme?**
3. **Has the team prepared stakeholders and all those people who have conducted and participated in surveys, assisted in research, or otherwise contributed to the realisation of the programme for the event?**
4. **Is staff of agencies and related organisations, celebrities and others being called upon to speak for the programme prepared to respond to queries from the public?**
5. **Are health professionals in the community aware of the timing of the launch and prepared to respond to queries from patients and clients?**
6. **Are the materials in place, ready to be released into supermarkets, doctors' offices, churches, community centres, night-clubs, at television and radio stations? Is finished copy, audio-tape, video-tape on newspaper, magazine, radio and television production on editors' desks?**

[1] A Toolbox for Building Health Communication Capacity AED 1995 p 23-2

Co-ordinator's guide – step 15

- The programme plan contains all the elements of planning including the timetable. Referring to this blueprint, track progress as per the items above on the **production checklist (HCP WORKSHEET 15).**

- Record problems identified by the team.

- The team must be prepared to alter specific activities when needed. Help the team to keep the goal in mind. A programme with the potential to respond creatively to unexpected developments is likely to benefit from surprises.

Process evaluation includes assesments of whether materials are being distributed to the right people and whether programme activities are working
Photo: Ronnie Carrington

To achieve step 16: active measures to ensure implementation

Dissemination of materials alone will not ensure implementation of the programme. You need back-up measures. Working relationships developed between team members and stakeholders and contacts within the communications channels come into play at this moment of delivery. Call on them. Once it is "out there" the programme may attract new players to the team and that will require more decision making as to whether or not to expand and involve other groups and media outlets.

Key concept = assess

This is an exciting time for the team. Your health communication programme is likely to use some combination of mass media, interpersonal and community channels. You will want to make maximum use of your resources to spread the health message and you will want to capitalise on every opportunity to stimulate choices for behaviour change among target audiences. Guided by the programme plan and timetable (step 10), the team has been working with organisations that are part of the communication strategy such as community centres and radio stations. If pre-scheduled, arrangements for sensitisation workshops and presentations must be finalised.

Once your programme is visible others may be drawn to help. The team must ensure that the resources and energy infused by new intermediaries give credibility to the programme. Locating a new agency within a health communication programme can be time consuming and in cases where co-sponsoring is desired, the programme may need to be altered to accommodate the structure and needs of the partner organisation. The original team may have to relinquish control over certain parts of the programme in exchange for the benefit to be gained by exposure to wider target audiences.

The team should be aware of these possibilities and be prepared to give and take without disrupting the direction of the programme. Private sector organisations with an interest in health information may offer funds, channels for distribution, even technical assistance in tracking, evaluation and follow-up.

Whatever its composition and altered arrangements a team must continue its commitment to the tasks of the final stages of the programme plan.

Questions for periodic assessment of the implementation phase:

1. **Are activities (sensitivity workshops, press kit presentations, and meetings) with targeted individuals ongoing?**

2. **Are all implementation activities in the programme plan on track and on time?**

3. **What revision or elimination is required?**

4. **Are time schedules being met?**

5. **Are resource expenditures acceptable?**

Questions for negotiation with a new organisation:

1. **Who will manage the new working relationship?**

2. **Are parties clear about the integrity and direction of the programme?**

3. **Are there differences and can they be negotiated? How?**

Co-ordinator's guide – step 16

- Ensure the team refers to components in the programme plan when implementing the programme *as per* tasks and accountability.
- Record revisions and deletions from the plan.
- Record feedback on programme implementation from the team.
- Review with the team the follow-up and monitoring tasks in preparation for the next meeting date *as per* programme plan and timetable.
- Ensure that the team has thanked individuals and intermediaries assisting in the implementation.
- If the team is willing to bring on board a new agency for a co-operative venture, ensure that the team records an outline for the terms of the new joint arrangement *re* planning, resources, implementation and promotion, monitoring and evaluation.
- Make sure the new terms have adequate arrangements for the continuation of the documentation process.

7

Evaluation / Reporting

Outward looking, opinionated and media oriented, our small developing societies willingly endorse the visible ‘message’ end of health communication programmes. Yet few Caribbean-made programmes go that extra mile to measure the end product. That is, to investigate exactly who these messages reach and whether programmes have brought changes in the target group’s behaviour.

Section 7 describes two steps for evaluation drawing on different methods. Monitoring communication objectives during and after the implementation steps is one type. Beyond that an evaluation of the programme as a whole should be considered.

There are several good reasons to evaluate your intervention. The first is accountability. People engaged in a programme (team members, on the ground participants, and sponsors) feel a sense of achievement when they have an opportunity to evaluate the experience. This reinforcement of commitment and motivation may extend well beyond the launching of a programme and this matters for sustainability (see Introduction 5.3).

Also, an evaluation report may be required by funding agencies.

Certain types of evaluation provide evidence of the impact of the programme on a health problem and record improvement in the information on priority issues in the health problem.

Finally, evaluation enhances the credibility of the work. It is the documented outcome of a programme that breaks new ground or becomes a benchmark for programmes to follow[1].

[1] Rockefeller Foundation's Communication and Social change Network. Communication Initiative Forum

Two steps to Evaluation and Reporting

WITH HCP WORKSHEETS 17 AND 18

Aim:

A working understanding of formative and summative evaluation, and format for documenting an evaluation of the communication objectives, and possibly the long-range results of the programme.

Method:

Feedback, check-back, distinguish, monitor.

Tools:

HCP WORKSHEETS 17 & 18, programme plan, selected measurement methods.

HCP steps 17-18:

17. A suitable evaluation methodology with a documentation format for evaluation.

18. 'Learnings'.

To achieve step 17: an evaluation methodology

The wise team has been here before! A special welcome to those looking ahead from step 10. However, if you are driving up for the last time, hang on, you are on the home stretch! Step 17 gives you concepts to guide your decisions about evaluating communication objectives, and to prepare you for the programme evaluation that comes after the team has implemented the health communication.

Evaluations have different purposes. The team had early experience of evaluating its materials and strategies before launching the health communication (pre-testing). You have also been monitoring the implementation (step 16). Now that "word is out" you are ready to investigate further. Did your message get to the intended audience? This step will help you find out if communication objectives were met and determine the effectiveness of the intervention. Did your health programme make a difference in people's behaviour? This level of evaluation speaks to the overall goal of the programme. Evaluation is too often a hasty afterthought or skipped altogether. This will not be the case with the team using the methodology outlined in this manual. You have wisely built the elements of an evaluation system into the programme plan (step 10) and are ready to act on the plan.

Key concept = select

The terms **formative** and **summative** distinguish between two types of evaluation relating to the two general purposes of evaluation[3]. Formative evaluation is designed for monitoring and assisting the conduct of programmes during their early stages. Pre-testing is an example of formative evaluation. It assesses the strengths and weaknesses of materials or communication strategies allowing for necessary revisions *before* implementation of the full effort.

At this stage, the team wants to assess procedures and tasks involved in implementing the programme. The programme plan (step 10) has a built-in monitoring mechanism (formative) to keep you on track throughout the **process**. This is evaluation based on the communication objectives and indicators formulated during planning (step 5). At the very least the team will want to record these findings for posterity. The manual suggests and provides a flexible format for this purpose.

Summative methods evaluate long-range results, measuring changes or improvements in health status (against purpose and goal indicators). These comprehensive **impact** evaluations involve extended commitments, are often costly, and may depend on other strategies in addition to communication. The team would have already considered evaluation options (formative and summative) in step 7 and consulted experienced evaluators. Limited resources may require the team to choose between formative and summative methods in final programme evaluation (APPENDIX E-1) but both should be done if at all possible. The updated programme plan must specify the methodology selected and the components to be evaluated must be itemised.

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[2] This manual does not entertain the technical fine points and exacting definitions from the science of evaluation. However, the terms in bold typeface are concepts used in such fields and the interested reader may wish to investigate them further in other sources. Some of these are defined in the glossary.

Questions for establishing evaluation objectives and indicators (for a formative evaluation exercise):

1. **What are the team's objectives for the evaluation? (Remember these must relate to the communication objectives and strategies)**
2. **Which of these possible evaluation objectives are the most useful and practical?**
3. **Review the funds and other resources required for meeting these evaluation objectives. Does the team possess these?**
4. **Is it possible to evaluate all the chosen objectives? If not, simplify your design by reducing the number of evaluation objectives to be measured and/or by cutting down your sample size.**

Questions for determining evaluation design:

1. **What is the team's best advice on the appropriate evaluation methods and tools?**
2. **Who is designing or verifying the authenticity of the design?**
3. **Who on the team is responsible for arranging the evaluation process?**
4. **Who on the team is responsible for arranging the analysis of evaluation findings?**
5. **What are the timelines on these tasks?**

Co-ordinator's guide – step 17

Evaluation objectives and indicators

- Have the team's communication objectives at hand.
- Record evaluation objectives and indicators by ensuring that the team states clearly why it is conducting the evaluation, what it hopes to measure and demonstrate, and who the audience for the evaluation is anticipated to be.
- Make a priority list based on the team's assessment of the most "do-able" and useful evaluation objectives that can be measured.
- Ensure the team selects and names the evaluation methodology or methodologies it chooses.

Evaluation report design

- Ensure that the report format for analysis of evaluation results will state some or all of the following depending on the evaluation objectives selected by the team. Key findings; communication objectives; (hoped for) feasible behaviours to be adopted; (hoped for) knowledge and attitudes to be changed; and the health status to be measured.
- Ensure accountability and timetables are recorded on the evaluation plan.
- See the report outline (**WORKSHEET 18**)

To achieve step 18: 'learnings'

The ideal application for the team's evaluation findings is to improve an ongoing programme. If the team's programme is continuing, or if there is an opportunity to advise others planning health communication interventions, an evaluation report is the best tool you can have. The co-ordinator's guide traces the trajectory of the team's process including decisions and the reasons for which these were made. Combined with data gathered from various research phases and from evaluations, the team has the basis for many documents. An evaluation report is an appropriate way to end this journey. Tales of adventure are entertaining, but a report gives many more people access to what the team has learned.

Key concept = assess

The evaluation report will take the shape of the evaluation methodology used. However, all good reports provide the theoretical framework for analysing the results of the evaluation and the opportunity to suggest what or how things could be done differently. Pre-testing and other evaluation tasks require an investment of scarce programme time and funds. This is why the team built this component into programme design in step 10.

Questions for reassessing goals, objectives, strategies and activities:

1. Has anything changed?
- **With the target audience**
- **With the community**

2. Is there any new information about the health problem that should be incorporated into the health programme messages or design?

3. What objectives were not met?

4. **What strategies appear the most successful?**

5. **Were some objectives met as a result of successful activities?**
   - **Should these be continued because they appear to work well?**
   - **Should they be considered successful and completed?**
   - **Can they be expanded to apply to other audiences and situations?**

Questions for assessing costs:

6. **What were the relative costs including paid (e.g. staff) time, unwaged (e.g. volunteers') time in terms of different aspects of the programme?**
7. **How does the comparative success of activities relate to their cost in terms of time and money (cost-effectiveness)?**

Questions for continued support or termination of a programme:

1. **Does the evaluation offer evidence of the programme's effectiveness with regard to the health problem?**
2. **Is the team in a position, based on the evaluation, to seek support for continuation, to entertain the involvement of other organisations, or if the programme is complete, to document the programme for dissemination?**
3. **Should the programme end now?**

Co-ordinator's guide – step 18

- Note any new information the team has about the health problem.
- Note the relative performance of particular objectives and strategies.
- Note the distribution of time and money costs.
- Indicate whether the evaluation shows any effect on the health problem.
- Determine the future of the programme, whether it achieved its stated goal, whether it ends, whether it continues.
- Arrange the writing of the evaluation report according to the recommended format.

In the Well-Baby Clinic: promoting health, preventing disease
Photo: Ronnie Carrington

8

Conclusion

Congratulations! You have arrived! Here's your gold cup!
The HCP team can feel a sense of satisfaction. Even if all objectives weren't met, the planning, implementation, and evaluation process has allowed the team to tailor the programme to meet the needs of the stakeholders, including the target audience,
to document the process and to learn valuable lessons
that can be used to good effect next time.
Here's to better communication for health!

_____THE END_____

HCP Worksheets

Each worksheet is designed for its corresponding step.
Tailor it to the health problem you are working on.

_____HCP WORKSHEET 1_____

Methodological Steps

Team members (organisation, contact numbers/addresses):

HCP Chairperson _____
HCP Co-ordinator_____
_____
_____
_____
_____
_____
_____

Features of health problem:

Review of methodological steps 1-17:

References for a resource directory:

_____HCP WORKSHEET 2_____

Health Problem Statement [1]

1. **Epidemiology of health problem (mortality, morbidity, prevalence, geographic location). Include how this problem is affecting people (where and when, to whom, with what personal and social effects, as a result of what possible causes)**

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

3. **What service, supply issues are part of this problem?**

4. **What are the problems anticipated?**

   a) **Social**

   b) **Economic**

   c) **Cultural**

   d) **Other**

[1] Adapted from Toolbox for Building Health Communication Capacity 1995 USAID, HealthCom, AED 2-7

_____HCP WORKSHEET 3_____

Stakeholder Analysis[2]

Take close look at the groups and institutions with a stake in the health problem (i.e. who are affected by it, or who can influence for better or worse the proposed HCP).

Categorise these stakeholders as interest groups, individuals, agencies, etc. and discuss their interests and views.

Select those stakeholders to be given priority.

Make a more detailed analysis of these groups in terms of:

PROBLEMS

The main issues stakeholders must contend with or which define their social space (i.e. economic, political, environmental, gender issues; cultural realities; social power/social dislocation etc.)

INTERESTS

The main needs and interests as seen from each stakeholder's point of view.

POTENTIAL

The strengths and weaknesses of stakeholders.

LINKS

Conflicts of interest, patterns of co-operation with or dependency on other groups.

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[2] Logical Approach to Project Management in PAHO Instructor's Manumal 1994. Team Technologies Inc. p24

_____HCP WORKSHEET 4_____

Situational analysis[3]

First:

Categorise issues/barriers in terms of least to most important.
In the case of breastfeeding promotion examples of issues or barriers may be: convenience factor, discomfort, cost, skill, information.
These should be categorised according to which are the most, or least, important in the context of your health promotion objectives, and easiest, or hardest, to achieve.

Second:

Rank these issues/barriers on a scale of easy to hard to do.

The Problem

What is it?
Whom does it affect, primarily and secondarily ?

Epidemiology

Previous
Current research

Resources – expertise, money

Local

National

Regional

[3] Applying Precede – Proceed Model. See APPENDIX B

_____HCP WORKSHEET 5_____

HCP Title:

Goal:

Purpose:

Output(s):

_____HCP WORKSHEET 6_____

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 –

   - Organisers?
   - Researchers?
   - Analysts?
   - Documentalists (Report writers)?

   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, financial sources, and logistics involved?

_____HCP WORKSHEET 7_____

Programme evaluation options

Review formative and summative evaluation methods in step 17:

Anticipated length of HCP run:

Projection:

Measurable objectives:

Prioritise programme components:

Management support and accountability:

Evaluation methodology suggested:

_____HCP WORKSHEET 8_____

Determining resources

Expectations HCP:

Priority areas of need:

Activities as per needs:

Resources available (including: financial, institutional, community):

Barriers to HCP:

Reviewed activities as per constraints:

_____HCP WORKSHEET 9_____

Coming to a communication strategy statement

HCP objectives (from step 5):

Primary and secondary audiences (from step 6):

Specific target information:

Audience benefit:

HCP activities (from step 7):

Write the HCP strategy statement:

_____HCP WORKSHEET 10-A_____

Programme Plan Outline & Timetable

HCP tasks as per objectives:

Related implementation tasks as per above:

Related evaluation tasks as per above:

Accountability per evaluation tasks above:

Names _____

Names _____

Names _____

_____HCP WORKSHEET 10-B_____

Title of HCP:

Goal:

Output:

Sponsoring Organisations:

Description of Need:

Primary Target Audiences *per* gender, age, ethnic group, etc:

Key Strategies *per* each target audience:

Secondary Target Audiences:

Key Strategies *per* each secondary Audience:

Key Dates:

Estimated Costs:

Other Resources required *per* staff, computer time:

Potential Problems *per* country clearances, or political opposition etc:

Methods of evaluation *per* formative, process and summative evaluation strategies:
(The wise co-ordinator will look ahead to section 10 Evaluation/Reporting)

_____HCP WORKSHEET 10-C_____

Health Communication Programme Report Outline

(Review Section 10 Evaluation/Reporting)

Title of HCP:

Team Members:

Responsibility for Evaluation:

Type/s of Evaluation being used in this HCP:

Responsibility for Report(s) production:

Frequency of Evaluation Reports and/or projected date of final Programme Report:

What is being reported on:

Report(s) are intended for:

Format of Report(s):

_____HCP WORKSHEET 11/12_____

develop simultaneously with 12

Channels selected:

Rationale for selection(s):

_____HCP WORKSHEET 12/11_____

develop simultaneously with 11

Before the Pre-test

ORGANISATION	TO BE COMPLETED BY	COMPLETED
1. Design/pre-test Guides/questionnaires According to technique		
2. Determine samples of Pre-test		
3. Prepare field logistics: Obtain clearances Arrange participants Organise logistics		
4. Select and train Interviewers		
5. Prepare materials: - Make sufficient copies of questionnaires and materials to be pre-tested - Obtain and check equipment to be used		
6. Distribute all pre-test Materials and forms to Teams		
7. Do pre-test		

_____HCP WORKSHEET 14_____

The message(s):

The medium/media:

The audience(s):

_____HCP WORKSHEET 15_____

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/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) colours 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 colour 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 music and voices are clear and (2) tapes are of agreed-upon quality, length, and content.

____10. Been to the studio and checked.

_____HCP WORKSHEET 16_____

Revised schedules:

Resource allocations:

What's been dropped?

_____HCP WORKSHEET 17_____

Evaluation objectives as per HCP objectives

Areas to be assessed: **Time line:**

- _____ _____
- _____ _____
- _____ _____

Relevant indicators:

Methods of evaluation/assessment:

Degree of achievement:

(none) _____

(partial) _____

(complete) _____

Suggested revisions/ Recommendations

_____HCP WORKSHEET 18_____

Evaluation report format

1. **Make it readable.**
2. **Keep it clear, simple, and as short as possible (The secret is to make each sentence say something).**
3. **Attach questionnaires, other materials as appendices to the report document.**
4. **Share the report with stakeholders, interested NGOs, programme implementers, etc.**
5. **Share the report with clearinghouses for health communication materials and media.**

Name of HCP:

Background purpose and objectives of HCP:

Description of what was evaluated:

Purpose of evaluation:

Evaluation methodology:

How conducted
With Whom
When and where
Methods used

Obstacles:

Problems in designing and conducting the HCP

Results:

What has been learned?
Application of this learning to this or future HCPs

Glossary

A/B design or **baseline intervention** A simple comparison of behavioural data taken at two different points during an intervention. For example, an immunisation monitoring drive asks mothers of children under 5 years of age attending a clinic to have their cards checked. The percent of children fully up to date on immunisation was graphed at the beginning of the drive and again after 5 weeks. Such measurements base your evaluation on points of comparison. Area-to-area comparisons measure basic statistical differences between groups in different locales. Before-and-after (the programme) statistical reports measure change over time. Remember to look carefully for alternative explanations for change that may be caused by other factors. Exposed or not-exposed measurement compares performance of health personnel trained in community relations with that of an untrained group[1].

Baseline data Information on the situation/conditions *before* programme implementation or *before* a specific intervention/activity is carried out.

Baseline study The collection and analysis of data regarding a target audience or situation *prior* to intervention.

Audience tracking A survey method built into a long term HCP that involves: baseline activities (finding out what the target audience knows, thinks and does before the HCP); periodic assessment (of progress and the need for modification); change in status (among the target group at the completion of an HCP).

Caribbean Charter for Health Promotion Modelled on the Ottawa Charter for Health Promotion, the Caribbean Charter was designed in 1993 and adopted by CARICOM Ministers Responsible for Health in 1994. It identifies six strategies for achieving goals of health promotion: formulating healthy public policy; reorienting health services; empowering communities to achieve well-being; developing/increasing personal health skills; creating supportive environments; and building alliances, with special emphasis on the media.

Central location interviews ("theatre testing") A large group of respondents are gathered together at a central location (church, community centre) where an audience's comprehension, attentiveness to and recall of, a message are assessed.

Channel Means of delivering messages. May be mass media, community or interpersonal. Different communication channels have different capacities. Certain channels are more effective in transmitting information while others are better at creating an image or atmosphere. Newspapers and brochures are a good way to reach an audience who will take the time to read about an issue and will take the time to find out how to do something. Newspapers are easily carried into the home, clippings stuck on the fridge where they serve as a reminder. Other graphics and audio display materials such as billboards, slide presentations, videos, flip charts can reach particular segment audiences. Interpersonal face-to-face communication lends credibility and confidence because there is

[1] Adapted from A Tool Box for Building Health Communication Capacity USAID HealthCom AED 1995 p8-3,4

a personal exchange between people over the message. Popular theatre and radio are well suited for communal messages where the individual may relate personal behaviour with a wider social situation dramatised through these channels. Television is the atmosphere and image-generating medium[2]. Ultimately decisions about channels must be based on the media preference of the target audience.

Co-ordinator's guide Comprehensive notes on conclusions of the health communications team. An overview of the decisions and trajectory of the health communications programme. As a source of more refined information (eg stakeholder analysis, situational analysis, strategy statement, definition of goals, purpose, outputs, etc) the co-ordinator's guide is useful to the step by step monitoring and evaluation of the process.

Epidemiology The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems[3]**.**

Formative research Evaluative research conducted during programme development. May include state-of-the-art reviews, pre-testing messages and materials, and pilot testing a program on a small scale before full implementation.

Goal The overall improvement a programme strives to achieve.

Health communication Aimed at the modification of human behaviour and environmental factors related to that behaviour which directly or indirectly promote health, prevent illness or protect individuals from harm[4].

ICPD International Conference on Population and Development. At this United Nations Conference held in Cairo, Egypt in 1994, global women's health networks worked with Caribbean and other governments to change the conference agenda. An example of a successful health communication strategy advocating that the issue of population be re-conceptualised from an emphasis on demographics to a new framework of health rights and empowerment.

Indicator A statement defining achievement of an objective in terms of: quantity (what/who/how much?); quality (to what standard?) and time (by when?).

KABP (study) Knowledge, attitudes, beliefs and practice.

Lifestyle The behaviour in daily life that differentiates us as individuals from one another[5].

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[2] Marshall McLuhan describing this phenomenon said "The medium *is* the message"

[3] Last, J.M. A Dictionary of Epidemiology. 2nd ed. Oxford University Press, 1988

[4] Elder, Geller, Hovell & Mayer

[5] Strid 1988: 4

Message Text of information to be disseminated. Packaged and transmitted according to distribution channel, mass or interpersonal.

NGO Non-governmental organisation.

Objectives Brief but specific operational statements of desired results i.e. what the HCP team would like to achieve.

Output What an HCP will do, or leave in place, to achieve the purpose; the tangible products or services that the program will deliver e.g. research evaluation data, project report.

Pre-test A type of formative research designed to facilitate a programme's accomplishments and effectiveness. Pre-testing is used to answer questions about whether a test audience perceives materials as understandable, relevant, attention getting, credible and acceptable to the target audience.

Primary target audience That group of people within a population whose attitudes or behaviour the HCP team wants to affect with the intervention. There may be more than one primary target audience in a given HCP. If so, the team should set priorities among them for sound planning and resource allocation. (See secondary audience)

Process evaluation Studies the functioning of components of programme implementation. Includes assessment of whether materials are being distributed to the right people and in what quantities, whether and to what extent programme activities are occurring, and other measures of how the program is working.

Purpose Impact that an HCP will have on the beneficiary in terms of change in behaviour, systems, or performance.

Qualitative research A research technique of subjective data (i.e. about feelings, and impressions) usually with small numbers of respondents (e.g. in focus groups) The information gathered usually is not described in numerical terms and generalisations about the target population should not be based on research of this type. Advantage: gives the researcher a deeper understanding of what people think, feel and do, and therefore offers insights into why people in a target audience act the way they do[6].

Quantitative research A survey with large, statistically representative sample of respondents with results that can be projected to the whole target audience. Usually structured questions (questionnaires) and administered through face to face interviews. May also take other forms such as collecting vital statistics data. Advantage: provides an estimate of what percentage of the population is aware of an issue, a valuable baseline for tracking changes as a result.

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[6] A Tool Box for Building Health Communication Capacity USAID HealthCom AED 1995 p 8 -5

Readability testing Health information materials such as pamphlets, flyers, newspaper and magazine articles are designed for distinct target groups. A readability test will indicate if a printed piece is written at a level that most of the audience can understand. Readability formulae use counts of language variables such as word and sentence length. Assessing the readability of a printed message, however, is not an indicator of the effectiveness of the message.

Risk factor A circumstance or condition that increases the likelihood of occurence of a particular disorder or situation.

Resource directory Compilations of persons/agencies/institutions/documentation that can assist the HCP team to achieve the programme objectives.

Secondary audience An HCP target audience with influence on the HCP primary audience, or those who must do something in order to help cause the change in the primary target audience e.g. fathers of adolescents, passive smokers.

Segment audience A distinct population group separated from the general population. The HCP team goes through a process identifying whom it wants to reach and what it knows about them. The team may elect to reach several distinct population groups. When the team is confident whom the HCP is intended to reach, further decisions (setting audience priorities, selecting more and less critical audiences) are made easier by segmenting. For example, mothers of urban teenagers as distinct from the general population of mothers, or teenagers.

Situational analysis A determination of priorities in the context of the whole planning environment of the proposed health communication. It is the product of research by the health communications team, an analysis of skills, knowledge, information, and of institutional and financial resources.

Social communication Is for a social cause, usually aimed at community groups.

Social marketing The use of commercial marketing methods and techniques in promoting social products, e.g. breastfeeding, fruit and vegetable consumption, iron supplementation, food safety, immunisation.

Stakeholder A person, institution or representative of a social group who can benefit from, or who may present obstacles to, the health communication programme. Through the research process by which the heath communication team creates an analysis of these, the team builds shared knowledge of the complexity of factors, forces and mechanisms involved in carrying out the health communication programme.

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Appendices

APPENDIX A

Resource directory

In the development of a programme, each resource compilation is tailored to a particular HCP according to speciality, location, scope and reach (local, national, regional, and global) and each requires discussion and selection by the team. The HCP co-ordinator is advised to consult with the HCP team to get as broad-based, yet streamlined and professionally-supported a directory as possible. Many NGOs, agencies and ministries are internet-connected. This can assist the HCP team to keep down its research and communication costs. Some agencies associated with HCP development are noted here, but the list is by no means comprehensive.

CARIBBEAN COMMUNITY (CARICOM) SECRETARIAT BANK OF GUYANA BUILDING, PO BOX 10827, GEORGETOWN**,** GUYANA. TEL (592) 2-51960/51964/51968

CARIBBEAN DEVELOPMENT BANK (CDB) WILDEY, ST MICHAEL, BARBADOS TEL (246) 431-1600

CARIBBEAN ASSOCIATION FOR FEMINIST RESEARCH AND ACTION (CAFRA) PO BAG 442, TUNAPUNA, TRINIDAD & TOBAGO TEL (868) 663-8670

CARIBBEAN HUMAN RIGHTS NETWORK (CHRN) 5 3RD AVE BELLEVILLE, ST MICHAEL, BARBADOS TEL (246) 436-9456

CARIBBEAN POLICY DEVELOPMENT CENTRE (CPDC) PO BOX 284, BRIDGETOWN, BARBADOS (246) TEL 437-6055

CARIBBEAN ORGANISATION OF INDIGENOUS PEOPLE (COIP) CARIB COUNCIL, SALYBIA, DOMINICA TEL (767) 445-7336

UNITED NATIONS DEVELOPMENT PROGRAM (UNDP) BARBADOS & THE ORGANIZATION OF EASTERN CARIBBEAN STATES) BRIDGETOWN, BARBADOS TEL (246) 429-2521

UNITED NATIONS CHILDREN'S FUND (**UNICEF)** HASTINGS, BARBADOS TEL (246) 436-2119

UNITED NATIONS FUND FOR WOMEN (UNIFEM) CARIBBEAN OFFICE STE 27, BECKWITH MALL, BRIDGETOWN, BARBADOS TEL (246) 437-3970

Health Education Offices: (TEL NOS OF SOME ORGANISATION OF EASTERN CARIBBEAN STATES & BARBADOS GOVERNMENT MINISTRIES)

Anguilla: Min.of Social Services, The Valley (264) 496-2541

Antigua and Barbuda: Min. Health & Civil Affairs, Cecil Charles Building, Cross St, St Johns' (268) 462-1600
Barbados: Min.Health & Environment Jemmotts Lane, St Michael (246) 426-5080
British Virgin Islands: Min. Health and Welfare, Roadtown, Tortola (284) 494-3701
Dominica: Min. Health & Social Security, Govt. Headquarters, Roseau (767) 448-2401
Grenada: Min. Health Housing & Environment, Carenage, St Georges (473) 440-4955
Montserrat: Min. Health, Education, Welfare & Culture (664) 491-2552
St Kitts and Nevis: Min. Health, Women's Affairs & Labour, PO Box 33, Basseterre, (869) 465-2521
St Lucia: Min.Health, Human Services, Family Affairs & Women, Chaussee Rd, Castries (758) 452-2611 / 452-6730
St Vincent and the Grenadines: Min. Health & the Environment, Kingstown (784) 456-1111

CARIBBEAN REGIONAL MEDIA HOUSES:

Caribbean News Agency (CANA) Beckles Rd, St Michael, Barbados Tel (246) 429-2903
Caribbean Broadcasting Union (CBU) Waterford Main House, Waterford, St Michael, Barbados Tel (246) 430-1000

MEDIA AND MEDIA LITERACY/EDUCATION ORGANISATIONS:

Barbados Women's Media Watch
c/o CGDS see: Centre for Gender & Development Studies, UWI
Caribbean Media Workers Association (CAMWORK) Bertram Niles, c/o Nation Newspaper, Fontabelle, Bridgetown, Barbados. Tel (246) 436-6240
Jamaica Women's Media Watch PO Box 344, Stony Hill, Kingston 9, Jamaica Tel (876) 926-0882

REGIONAL PUBLIC HEALTH AND NUTRITION RESOURCE CENTRES:

Caribbean Epidemiology Centre (CAREC) 16-18 Jamaica Boulevard, Federation Park, PO Box 164 Port of Spain, Trinidad and Tobago (868) 622-4261, -2 www.carec.org
Caribbean Food & Nutrition Institute (CFNI)
PO Box 140, Mona, Kingston 7, Jamaica (876) 921-1540, -1 www.cfni.paho.org

POPULAR THEATRE (AND PRODUCTION) ORGANIZATIONS:

Pinelands Creative Workshop: Wildey Great House, St Michael, Barbados
Sistren: 20 Kensington Crescent, Kingston 5, Jamaica
Banyan Productions Ltd., 15 Cipriani Boulevard, Port of Spain, Trinidad & Tobago

PAHO OFFICES:

Caribbean Regional Office PO Box 508, Bridgetown, Barbados
Tel (246) 426-3860 Fax (246) 436-9779 www.pahocpc.org
PAHO: Nassau, Bahamas Tel (242) 326-7390, -7299, -325-0121 Fax (242) 326-7012
Bridgetown, Barbados (246) 426-3860 Fax (246) 436-9779
PAHO: Belize City, Belize Tel (501) 2-448 85/2-448-52, -2-455-36
Fax (501) 2-309-17
PAHO: Georgetown, Guyana Tel (593) 2-544-642, -2-551-460, -2-528-405
Fax (593) 2-502-830
PAHO Port-au-Prince, Haiti (509) 458-666, 458-695 Fax (509) 451-732
PAHO: Kingston, Jamaica Tel (876) 967-4626/-4691/-1992 Fax (876) 967-5189
PAHO: Paramaribo, Suriname Tel (597) 471-676 Fax (597) 471-568
PAHO: Port of Spain, Trinidad & Tobago Tel (868) 624-7524, -4376, -5624
Fax (868) 624-5643
PAHO Division of Disease Prevention & Control,
Washington, DC, USA (202) 974-3306 Fax (202) 974-3625 www.paho.org

UNIVERSITY OF THE WEST INDIES (UWI):

Caribbean Institute for Mass Communication (CARIMAC) Mona Campus, Mona, Kingston 7 Tel (876) 977-0898/927-1841 Fax (876) 977-1597
Centres for Gender & Development Studies (CGDS)
Cave Hill (246) 417-4490
Mona (876) 977-7365
St Augustine (868) 662-7076
Institute Of Social & Economic Research (ISER)
Cave Hill (246) 424-7291
Mona (876) 927-1020
St Augustine (868) 645-6329
School of Clinical Medicine & Research
Queen Elizabeth Hospital, Barbados (246) 429-5112
Faculty of Medical Sciences
University Hospital of the West Indies, Mona, Jamaica (876) 927-1620/-1627/-1629
Faculty of Social Sciences
Department of Economics, Health Economics Unit, St Augustine (868) 662-9459

UNIVERSITY OF GUYANA
Turkeyen Campus, Georgetown, Guyana (592)222-3586

UNIVERSITY OF SCIENCE & TECHNOLOGY (UTECH)
237 Old Hope Rd., Kingston 6, Jamaica (876) 927-1925

APPENDIX B

Theories of health behaviour

Adapted from J.A. Graeff *et al*
Communication for Health and Behavior Change: A Developing Country Perspective
A Publication of the HealthCom Project, Academy for Educational Development, USAID

Health Belief Model (Rosenstock) – behaviour is determined by knowledge and attitudes (i.e. by whether individuals believe they are susceptible to a health problem, regard it as serious, are convinced that treatment or prevention activities are effective and inexpensive and are prompted to take action).

Communication/Persuasion Model (McGuire) – changes in knowledge and attitudes are preconditions for behavioural change. The effectiveness of a given communication effort will depend on input variables (i.e. source, content, channel, receiver and destination of message) and output variables (i.e. changes in knowledge, attitudes and decision making).

Reasoned Action (Fishbein & Ajzen) – emphasises the role of personal intention in determining whether behaviour will occur. These intentions are influenced by 'normative' beliefs (i.e. what people think others, particularly influential people, e.g. peers would do in a similar situation.

Transtheoretical (or Stages of Change) **Model** (Prochaska) – identifies four stages: precontemplation, contemplation, action and maintenance. This model is the subject of many public health research efforts in chronic and infectious disease control.

Precede/Proceed Model (Green) – Analyzes a community's health needs by five 'diagnoses': social, epidemiological, behavioural, educational, and administrative/policy. The health planner focuses on community rather than individual, thus avoiding 'victim blaming'. Behavioural and educational diagnoses stress behaviour-environment relationships (i.e. the educational phase of Precede emphasises 'predisposing' and 'enabling' skills, while 'reinforcing' factors are synonymous with consequences).

Diffusion of Innovations (Rogers and Shoemaker) – the role of change agents in the social environment. Focussing attention away from the target individual, the relative, neighbour, health worker or other may help produce behaviour change (e.g. by developing a need for change, establishing the necessary interpersonal relationships, identifying the problem and its causes, specifying goals and solutions, motivating someone to attempt and maintain action.

Social Learning Theory (Bandura; Rotter) – bridges rational, decision making models with behaviour theory. SLT stresses process between 'person' (thinking), behaviour, and environment. While environment largely determines behaviour, the individual uses cognitive processes to interpret both the environment and his/her behaviour, and also behaves in ways to change the environment and meet with more favourable behavioural outcomes. A person responds to a question 'Can I do it and how well?' by judging his/her level of skills (a process of 'self efficacy assessment'). Through recollection of outcomes experienced personally or by others, the person also responds to the question "Will it pay off?' if the response to both is 'yes' behaviour is likely to occur. Reinforcement (environmental reaction to the behaviour) will help determine whether the behaviour will occur again.

Variables of Behaviour

The following are some variables underlying behavioural performance drawn from the more commonly applied theories in health promotion. They can serve to drive a team's communication outcomes:

- **Intention** For a person to perform the desired behaviour (e.g. to eat differently; to maintain healthy body size) he or she must form a strong intention
- **Environment** The conditions that make it possible to perform the behaviour must be in place (e.g. healthy foods must be accessible, recreational facilities must exist)
- **Skill** The person must have the skills necessary to perform the desired behaviour (e.g. access to recipes, aerobic guidelines)
- **Belief** The advantages benefits, and positive outcomes must be believed by the person to outweigh the disadvantages (inconvenience)
- **Readiness to change** The person's emotional reaction to performing the behaviour is more positive than negative
- **Self-perception** The person must perceive that he or she has the capabilities to perform the behaviour under a number of different circumstances. (e.g. eating right at home, at work and at play)

APPENDIX C

Different Channels, Different Benefits

The **mass media** transmit news quickly to a broad audience, but alone cannot be expected to motivate people to change their behaviour. Mass media are generally the public's primary source of information but may be less trusted than more intimate sources and are constrained by time, space, cost, newsworthiness and other factors in their ability to explain complex information. Media may focus too much attention on new information or information affecting limited segments of the population, may increase the chances for miscommunication or may communicate incomplete information (most crucially, leaving out information to explain what can be done to alleviate a health problem). Loss of control over how information is communicated may be a HCP team's trade-off for broad and rapid transmission.

Whether mass media are selected as channels, or whether a health issue appears as news, remember that the mass media are usually commercial, i.e. their purpose is to inform and entertain, not educate. There are few public service channels and commercial advertising almost exclusively finances Government-owned television and radio. News programmes may select health messages if they are considered newsworthy and attractive. If the complete message is too complicated or simply not considered interesting enough for use by the media, the team will be obliged to redesign the message to appeal to media professionals and their perceptions about what their audience wants. Working with media professionals will help assure that messages are interesting as well as accurate, and may help you obtain greater exposure for your programme.

In addition to news, mass media offers other opportunities for messages if the team is **innovative**. For example, radio audience call-ins or interview shows, even soap operas can publicise health issues such as testing for cervical cancer. Health columns in newspapers and magazines are another opportunity. Each format offers a particular advantage for communicating messages, and each format may reach a different audience.

Interpersonal channels put health messages in a more familiar context. These channels are more likely to be trusted and influential. Developing messages, materials, and links into interpersonal channels is best done through the many community and non-governmental organisations that exist throughout the region. Community channels, including schools, employers' and community organisations, can also reinforce and expand upon media messages and offer instruction. Establishing links with community organisations can offer support for action. These two-way links allow for discussion and clarification, encourage motivation and reinforce action.

Using several different channels will increase the repetition of the information, incrementing the chance that the audience will be exposed frequently enough to absorb and remember it. **Channel selection and mix** of channels should be determined prior to materials production since message format will differ for various channels.

(From Making Health Communication Programmes Work in Latin America and the Caribbean: a Manual for Action. HPP PAHO 1991)

APPENDIX D-1

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 Oral Rehydration Solution (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 you child from dying from dehydration).
  To do:
  Demand (the ORS packet)
  Look for (the logo of ORS packet)
  Go to (nearest health centercentre)
  Prepare (one packet in one litre of clean water)
  Add other behaviours (if needed).

- If the feasible behaviour is related to a product, specify this in your message:
  What it is (oral rehydration salts)
  How to use if (one packet in one litre of water)
  What benefits it has (takes away worrisome signs of dehydration)
  Where it can be obtained (health centres/community distributors)
  How much it costs (free)
  Who recommends it (doctor/nurse/health worker)
  How to recognise it (the ORS child logo)

- If the feasible behaviour(s) is related to a service, specify this in your message:
  Where to obtain it (at health centre 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. You need to find one principal message that will serve as the 'umbrella' theme for your communications and distribute the message content among the best channels of communication.

The above ORS programme example suggests one main message that would cover the other messages: "Dehydration during diarrhoea is the child's enemy. Dehydration can kill your child. Prevent that by using ORS."

APPENDIX D-2

Changing a main message

The team promoting the Caribbean Measles Initiative wanted to define and qualify 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 immunised (or, in many cases, re-immunised)?" 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 immunising and getting our children immunised, we are still not measles-free. Just last year, there more than 4,000 cases of measles in the Caribbean and several deaths caused by measles-related illness. With this final measles shot, which is to be given to every child 9 months through 15 years of age, whether or not they have previously been immunised 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 impressively high rates of immunisation already achieved, the Caribbean is the first region in the world with the capacity to be measles-free. We are already so close. This is a tribute to the Caribbean health worker, teacher, parent, teen, and child, without whose efforts and co-operation we never could have come this far.

In the concept test stage both 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 and for the communications "call to action" across all channels, "MAKE MEASLES HISTORY".

APPENDIX D-3

Components of a Delivery System[1]

The delivery system synthesizessynthesises the following components:

COMMUNICATION MATERIAL PRODUCTION

MEDIA PLAN

PRODUCTION SUPERVISION

DISTRIBUTION CHANNELS

MATERIAL PRODUCTION includes supervising the production process. The supervisor's knowledge of the production process will avert mistakes at key moments: contractual issues, deadlines, production, concerns on format, colour, editing, first version, order of pages, font/type, and number of copies.

MEDIA PLAN includes rationale, budget, format, length, number, timing, frequency, broadcast, and distribution channels.

'AUDIENCES BEHIND THE AUDIENCE' are public image creators, moulders of public opinion, specialists, and communicators for whom special material and events may be organised.

COMMUNICATION MATERIALS include information kits and press briefings.

CRITERIA FOR FLEXIBLE DECISIONS WHEN SOMETHING GOES WRONG The audience must be able to complete the promoted behaviour. Product must be as promised in the media. Communication strategy must be intact. Results must be on time. Delay can affect credibility.

[1] A Tool Box for Building Health Communication Capacity 1995 USAID HealthCom AED 23-12

APPENDIX E-1

Evaluation Options Based on Available Resources

Process / Outcome	Minimal	Modest	Substantial
Formative	Readability Test	Central Location Intercept Interviews	Focus groups Individual In-depth Interviews
	Record-keeping	Programme Checklist	Management Audit
	Activity Assessments (#of health screening audience response programme attendance)	Progress in Attaining Objectives Monitored (calculation of % of target audience aware and participating)	Assessment of Target Audience for Knowledge Gain Pretest Post-test
Impact	Print Media Review (monitoring of content of articles appearing in newspapers)	Public Surveys (surveys of self-reported behaviour)	Studies of public Behaviour/Health Change (data on changes In public health status)

Research designs most commonly used to carry out programme evaluations are descriptive designs for **process** evaluation and **time series** or **A/B** models that rely on comparison for **outcome/impact** evaluation.[2] (See Glossary)

[2]A Tool Box for Building Health Communication Capacity 1995 USAID HealthCom AED p 25-10

APPENDIX E-2

Elements of an Evaluation Design[3]

Every formal design, whether formative, process, outcome, impact or a combination, must contain certain basic elements. These include:

1. ***A statement of communication objectives****:* Unless there is an adequate definition of desired achievements, evaluation cannot measure them. Evaluators need clear and definite objectives in order to measure programme effects.

2. ***Definition of data to be collected:*** That is the determination of what is to be measured in relation to the objective.

3. ***Methodology:*** A study design if formulated to permit measurement in a valid and reliable manner.

4. ***Instrumentation:*** Data collection tools are designed and pre-tested. These instruments range from simple tally sheets for counting public inquires to complex survey and interview forms.

5. ***Data collection***: The actual process of gathering data.

6. ***Data processing***: Putting the data into usable form for analysis.

7. ***Data analysis***: The application of statistical and other techniques to the data to discover significant relationships.

8. ***Reporting:*** Compiling and recording evaluation results. These results rarely pronounce a programme a complete success or failure. To some extent all programmes have good elements and bad. It is important to appreciate that lessons can be learned from both if results are properly analysed. These lessons should be applied to altering the existing programme or as a guide to planning new efforts.

[3] From Making Health Communication Programmes Work in Latin America and the Caribbean: A Manual for Action HPP Washington DC p 76, 77.

APPENDIX E-3

Types of Evaluation[4]

Formative including pre-testing, designed to assess the strengths and weakness of materials or strategies before implementation. It permits necessary revisions before the full effort goes forward. Its basic purpose is to maximize the chance for programme success before the communication activity starts.

Process examines the procedures and tasks involved in implementing the programme, and may assess the administrative and organizational aspects of a programme.

Outcome used to obtain descriptive data on a project and to document results. Task-focussed, its results describe the output of the activity (e.g. the number of public inquiries received as the result of an announcement). Short-term results describe the immediate effects of the project on the target audience (e.g. the % of the target audience showing increased awareness on a subject). Information that can result from an outcome evaluation includes: knowledge and attitude changes; expressed intentions of the target audience; short-term or intermediate behaviour shifts; policies initiated or other institutional changes made.

Impact most comprehensive evaluation type, focuses on the long-range results of the programme and on changes or improvements in health status (related to programme goals). Impact evaluations are usually costly, involve extensive commitments and may depend on other strategies in addition to communication. Also, results often cannot be directly related to the effects of an activity or programme because of other external influences, which occur over time, on the target audience. Information obtained from an impact study may include: changes in morbidity and mortality; changes in absenteeism from work; long-term maintenance of desired behaviour.

[4] Adapted from Making Health Communication Programmes Work in Latin America and the Caribbean: A Manual for Action p78