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The Mass Media Alone Are Not Effective Change Agents

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Abstract

The decade of the 1980s could, from a communications perspective, be typified as the period of 'social mobilisation'. Rather than expanding on the theoretical assumptions underlying the social mobilisation approach for development, this article discusses the consequences of the theoretical assumptions for the use of personal and mass media, as experienced in the African context.

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Les Masses médias tout seuls ne sont pas efficaces

Résumé

La décennie des années 1980 pourrait, vue dans la perspective de la communciation, être considérée comme la période de la mobilisation sociale. Au lieu de s'attarder sur les hypothèses théoriques sous-jacentes à l'approche de mobilisation des masses pour le développement, cet article évalue les conséquences des hypothèses théoriques dans le cas d'un usage personnel et celui des masses médias dans le contexte africain.

Introduction

Mass media alone are not effective tools in bringing about change in knowledge, attitude and practices (lifestyle) relating to health among widespread sectors of society in Southern Africa[1]. They could, however, play an essential role if directed specifically at training, and backing up the interventions of personal change agents.

This is the conclusion of recent research studies undertaken as part of social mobilisation or social marketing programmes for the promotion of health practices, particularly immunization and family planning. Cynically enough, it is these same social mobilisation experiments which draw heavily on the diffusion of innovations method of the 1950s, which promoted the myth of all-powerful mass media in the first place[2].

The realisation that media are not that effective is not a new notion. Already in the 1960s, critics of the diffusion of innovations theory contended that information does not simply trickle down from the mass media to the people. Rather, information reaches the people through the intermediary of change agents, such as agricultural extension workers, local readers and health workers. This process was called the two-step flow of information[3]. Even if, as a result of mass media information campaigns in the diffusion of innovations tradition, some impact was made in changing the knowledge and attitudes of people, their impact on practices lagged far behind — the so-called KAP gap[4]. Change agents were recognized as a key factor in bringing about change in people's practices, the idea being that the mass media are effective in arousing awareness and creating interest, while personal media, such as extension workers, are better in establishing the link with people's experiences and helping them to overcome resistance to adopting innovations through a process of trial and error and critical evaluation[5].

Social Mobilisation Programmes for Immunization

Over the last decade many African governments have implemented social mobilisation programmes aimed at the widespread adoption of 'new' health practices like immunization, family planning and oral rehydration therapy. These experiments could be seen as diffusion of innovation projects in a new 'marketing' jacket[6].

Following the laws of the marketplace, they concentrate on the wide scale distribution of specific health services, such as immunization, while simultaneously creating a massive demand for these 'products' to ensure their optimum utilization. This article will limit itself to a discussion of the immunization programmes.

This strategy greatly attracted African leaders and international donors, who could use it as a means to obtain political and financial support for their developmental programmes, particularly in health[7].

Contrary to the lengthy and cumbersome process of setting up structures to provide people all over the country with comprehensive primary health care services, the social marketing projects for the adoption of immunization, and to a lesser degree for oral rehydration salts and family-planning devices, promised quick and tangible results from selected measures. Indeed, within a few years after their introduction, several African countries, or rather African capitals, such as Mogadishu, Maputo and Dakar, experienced a leap in immunization coverage. Rates rose from about 20 percent to 70 percent[8].

This did not mean that African women, who, with their young children, were the main target groups for the immunization programmes, understood what they were being immunized against and why that was important. According to evaluation studies from Zambia, Angola and Mozambique, focusing primarily on knowledge aspects, levels of knowledge and awareness about immunization are significantly lower than adoption rates[9].

The social mobilisation tradition thus shows the KAP gap in a reversed form. Instead of high knowledge and low practice, we now find high practice and low knowledge. This should not be surprising altogether since the immunzation coverage has often been boosted as a result of short campaigns. The mass media limited themselves mostly to motivating people to visit the health centres: announcing the dates and places where one could be vaccinated rather than explaining the why and what[10].

The reversal of the KAP gap could also be attributed to the arrival of the political cadre as a new change agent on the scene. In one Party states, particularly in the socialist regimes, the Party and mass organisations for vigilantes, women and youth have an extension network of cadres, running from central, down to grassroots level. These mass organisations fall directly under the Party and have no autonomy whatsoever. Their key role is to extend the control, authority and ideology of the Party to all levels. The approach is one of top-down communication. The members of these mass organisations are to implement and promote directives and orientations issued from above. Their structural set up allows for little local creativity or for a flow of information from bottom up. The fact that the Party often supersedes State structures, facilitates the use of these same organisations to promote programmes or practices of a sectoral ministry, such as that of health, aiming to achieve a common good like immunization or birth control.

Indeed, most ministries of health managed to rally the political support of African leaders for their immunization campaigns. In various countries, the President, often also the leader of the Party, personally launched the campaign, thus, ensuring the massive participation of these structures[11]. But the very nature of the Party channels as vehicles for promotion of immunization limited the genuine, creative and active

participation and responsibility of people for these programmes. In some cases it even provoked a certain popular resistance to these programmes.

Frequently, the Party and mass organisations, even the military in the case of Somalia, were largely responsible for mobilizing the people to attend immunization services. Equipped with maps of the area and lists of names of all inhabitants, they went from house to house to round up defaulters who had not completed the immunization schedule. In this, they were effective. It is not unlikely though that the massive concurrence of the population to vaccination facilities emanated from the people's experience with vigilantes and Party members in their role as law enforcers. Little research has been done in understanding the people's perception of health services and immunization — the attitudinal aspects. Because of this, one should not be surprised to find neutral or even negative attitudes towards immunization, even among those immunized[12].

The new change agents have been shown to be stronger in mobilization than in education[13]. As a result, the changes brought about by the massive immunization efforts seem rather superficial, because the people's adoption of immunization was the result of temporary social pressure and control, rather than the outcome of a conscious decision or evaluative process. The concentration of the campaign approach itself on achieving quick results among large groups of people, reinforced a tendency to impose ideas on the people, rather than allowing them time to incorporate these new ideas into their existing framework of thoughts[14].

The significant increases in coverage rates can only rarely be maintained. It often proved too costly for government ministries to maintain the special facilities of transport, mobile vaccination centres and allowances for health personnel and mobilizers, created during campaigns, on a longer term, not mentioning the disruptive effects the campaigns often had on the provision of other health services through the regular mechanisms. Special co-ordination structures which were set up for the campaigns often fell apart after a short period, once different sectors reverted to their regular programme of activities.

As a result, coverage rates dropped in many countries to almost pre-campaign levels, when the high-profile, politically-backed campaigns were abandoned, special incentives were no longer provided and immunization services were really being delivered through the regular health package. For example, the coverage rates in the Somali capital, Mogadishu, rose from 22 percent to 70 percent in 1985, but within a year dropped again to a mere 8 percent above the original level, a position it has maintained since[15].

The experience of some West African countries, such as Nigeria, Senegal and Togo with the use of regular mini-campaigns, is slightly better. These mini-campaigns are a recurrent feature of the Expanded

Immunization Programme (EIP) and constitute a high peak in the regular provision of immunization services, enabling impressive support from non-health sectors, like the business and political community, to be rallied. The highly visible mini-campaigns also shake up the population and rejuvenate awareness and interest of the health sector and the population at large, while minimizing the disruptive effects or wasting of resources through bad planning. Data from 1989, a year after the last round of campaigns, showed that vaccination coverage rates in these countries had settled roughly at 10 percent above their original levels, a result achieved at a relatively low price[16].

Social Mobilisation and Health Information Activities

We have so far discussed the use of social mobilisation programmes for the promotion of health services, particularly immunization. Special emphasis was given to the function of a new category of change agents: the political activists. We will now try to establish the role of more traditional health information channels and identify ways to strengthen their effectiveness.

Arguments will be based on data drawn from studies done in Botswana, Kenya, Lesotho, Malawi, Mozambique and Zambia over the last four years. These so-called social mobilisation analysis or health education studies aimed to identify the major channels of information used by the population in health matters and assess the impact of information and social mobilisation activities undertaken. For Angola, data are drawn from a national EPI survey.

Health Information Activities

National health education programmes were widely initiated on the African continent by the ministries of health in the last decade. These programmes generally focus on two lines of activity: training of health and para-medical personnel, and production of health educational materials through print as well as audio-visual media.

(Para) Medical Personnel as Communicators

Although group dynamic skills and health education techniques have been introduced in the national training curricular for nurses in many countries, this has not led to a significant improvement in their human relations skills. A Kenyan study of 1983 concluded that 73 percent of health workers in Kisumu District in the western part of the country never advised their clients and a larger number (82%) were even incompetent to do so[17].

Overall, bad treatment by health staff has been a recurrent cause for

failure of mothers to return to health centres to complete the immunization schedule[18]. Data also confirm that lectures, advice and demonstrations are the most common health education technique, even though a fair number of health staff is aware that lectures are not effective[19]. The boost in programmes to equip and train community health workers has not led to a wider use of these village volunteers in disease prevention through health education. Data suggest that village health workers are mostly involved in practical activities, such as latrine construction or well-digging, or render curative services[20].

Studies show that 'the clinic', and, in the clinic, 'the nurse', are the major source of health-related information, particularly among women aged between 15 and 45 from lower income groups (the target group of many health interventions). Scores for clinics as source of information ranged from 60 percent to 90 percent, while village health workers were seldom indicated as a source of information[21]. Most clinics (nurses) fail to systematically involve community volunteers, whether village health workers or members of mass organisations and church groups[22]. This has impeded the development of a stronger relationship between population and health services through health education programmes in the communities.

The Mass Media

Virtually all African radio and television networks have introduced regular health programmes, produced jointly with the ministries of health, and targetted at the population at large. The seven studies confirmed the limited role of TV as a source of health information due to lack of purchase power, foreign currency restrictions and limited access to electricity supply.

Literacy rates and distribution problems are the major constraints impending wide access to the print media. The role of radio in imparting health related information is small, particularly so outside the capitals. Ownership of a radio set is still insufficient (Zambia 47%; Zimbabwe 30%), although scoring significantly higher in Lesotho and Botswana[23]. This difference could be explained by the high import duties on radio sets in most African countries, against the subsidized prices for commodities in those countries which are members of the South African customs union. Secondly, a large number of available radio sets appeared non-operational, with percentages running as high as 75 percent in Zimbabwe, 65 percent in Lesotho, and 50 percent in Botswana[24], probably due to unavailability and high prices of dry-cell batteries. Zimbabwean data between 1984 and 1988 show a marked decline in the number of people with a working radio set in the home from 33 percent in 1984 to 9 percent in 1988[25]. This could well be the trend in most African countries.

However, economic difficulty does not affect media use of all groups in the same way. In Lesotho and Botswana it was found that most people with more education (and, therefore, better-paid jobs?) have their radio sets in working order, against only a third of the lesser educated[26].

On the whole, health education programmes on the radio are frankly unpopular. Less than 20 percent of respondents overall listen regularly to health education programmes. The potential outreach of these programmes to the middle class seems higher, because this group uses the media for specific information purposes. The poorer and non-educated segments of the population turn to the mass media to be entertained and talk to nurses, village health workers and political leaders, in that order, for health information.

There is, however, the feeling that these people are not transmitting information well enough, nor often enough[27]. The health programmes transmitted by the radio are not attractive because the dominant format used is the interview with the expert and the lecturer. Drama, role-play and counselling, poorly used in real life, do not feature regularly in these programmes either[28].

Another Focus Needed

In spite of all health education activities undertaken, knowledge levels about issues related to immunization, and equally to other health subjects, like diarrhea, nutrition and family planning, are largely insufficient. While vaccination coverage stood at 19 percent in the Angolan capital, Luanda, a mere 5 percent of 232 respondents to a national evaluation of the Expanded Programme for Immunization in May 1989 could name the immunizable diseases, or was aware of the immunization schedule[29]. A Zambian study of 1986 revealed that only 5 percent of 2,200 respondents from rural and urban areas knew which diseases children and women could be vaccinated against[30]. At the same time, immunization coverage rates stood at around 50 percent.

Data from other countries show similar trends, with the exception perhaps of Zimbabwe. In 1986 three-quarters of respondents to a survey in this country were aware that immunization prevented disease and most could indicate measles as an immunizable disease. Few, nonetheless, were aware of all immunizable diseases or the immunization schedule[31]. Even in those cases where knowledge levels appeared relatively high at first sight, knowledge was limited to awareness about immunization as 'prevention of disease'. In general, knowledge about the reasons for follow-up visits, possible side-effects, preferred age for vaccination and diseases, was low.

Health education activities are still largely unsatisfactory. The inadequacy of present health education projects of ministries of health is

caused by a series of factors, ranging from lack of interest of decision-makers within the ministries and insufficient human and material resources to lack of central planning and co-ordination of production of materials for different health programmes and poor integration of health education activities in regular health programmes. Health education activities planned through the (para) medical system are completely separate from those involving the mass media. Evaluators, while recognizing many of these flaws, tend to make recommendations for change in either the ministry of health or the media, depending on their background.

Evaluators of health education programmes, recruited through the ministry of health, stress the need to improve the communication skills of health personnel through more adequate training. The media experts on the other hand suggest a more frequent use of the drama format in health education programmes in the mass media and a shift in broadcasting hours to the early evenings, which is shown to be the preferred listening time[32].

It is about time to draw on some of the lessons learned by the diffusion of innovation studies in the 1960s. According to these, the change process involving adoption of a new idea can roughly be subdivided into five phases: awareness, interest, information, trial and acceptance or rejection. Mass media are mostly influential in the first two phases, from where the personal change agents are to take up the ball[33]. The social mobilisation experiences have confirmed this trend. But few countries have as yet developed special media health programmes targetted to the health staff and mass organisations.

If mass media alone are not effective tools in bringing about change in KAP of widespread sectors of society, why not try improving the communicative skills and health knowledge of health and political cadres through the use of mass media programmes? They, in turn, will then relay this information to the masses which have already been warmed up to some of the issues by open broadcasts for the general audience[34].

One of the few countries where this approach has been tried is Ethiopia. Here, two projects are currently underway and underscore the role of the mass media in the training of health and paramedical personnel and in reinforcing the involvement of mass organisations in health education activities. Establishment of radio listener groups among the members of the mass organisations, use of community research as a basis for development of radio programmes, training of health workers in communication skills and involvement of creative artists in the production of materials, in conjunction with the health staff, are the major components of these two interlinked projects[35].

Although it is too early to assess the concrete results of these interventions, yet the approach used seems to be valid and worth repeating. After all, only trained and equipped members of political and

mass organisations and health cadres will be able to complement their capacity to mobilize the people, with a dialogue with the communities, and thus influence people's knowledge and beliefs in such a way that high adoption rates of, for example, immunization, services can be sustained.

Notes and References

[1]In South-East Asia and South America mass media have considerably more influence because of a complex of factors like higher levels of ownership of radio and television; better coverage by national stations; existence of local stations; a high level of experience in use of media in the context of development projects and more imaginative formats used.

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