The Substance of Health Communication Education

By Gabriel J. Bagui

Abstract

Health communication education has come to be appreciated as an important ingredient for the improvement of both an individual or a community's health status. This paper examines the substence of health communication education, its role in disease prevention and control, as well as the appropriate methodologies to adopt for greater effectiveness. The ultimate goal of this paper is to stimulate health communication education practitioners into coming up with ideas on how communication can be made to play a more effective role in effecting behaviourial change, and thus an overall improvement of people's health. Impediments to achieving this goal as well as known approaches that have been implemented with success are highlighted. Furthermore, the paper argues a case for the need to adopt a two-way approach in communicating health messages unlike the traditional system where the source was considered more important than the destination. The individual's needs, preferences and environment, argues the paper, count in determining the extent of success in a given health communication education campaign.

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L'essentiel de l'education de Communication Dans le Domaine de la Sante

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Résumé

La communication dans le domaine de la santé est considérée comme l'un des ingrédients importants dans l'établissement d'un bon état de santé, qu'il s'agisse d'un individu ou d'une communauté entière. Cette communication est centrée sur les aspects divers de l'éducation de la communication, dans le domaine de la santé. Ainsi on étudie son rôle dans la prévention et le contrôle, ainsi que dans la détermination des méthodologies les plus appropriées, qu'il faut adopter afin d'accroître l'efficacité. Le but principal de cette communication est l'incitation des praticiens dans la discipline de l'éducation de communication au domaine de la santé, pourqu'ils puissent contribuer à une meilleure utilisation de la communication, dans le but d'influencer le comportement social, et ainsi améliorer la santé publique. On expose également les obstacles majeurs, qui ont empêché la réalisation de ce but, ainsi que les approches qui ont été tenté avec succès. De plus, cette communication souligne la nécessité d'une communication à double sens, au contraire de l'approche traditionannelle, qui donnait beaucoup plus d'importance à la source, au détriment de la destination. Selon l'auteur de cet expoé, les besoins, les préférences et l'environnement individuels déterminent, largement, le niveau du succès de la compagne d'éducation de la communication dans le demaine de la santé.

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Introduction

The practice of health communication education is more than the use of mass communication to inform the public about health issues. Health communication draws from development communication theories and practices, with increased emphasis on social marketing principles and behavior analysis. It is a fundamentally purposeful effort designed to facilitate intended changes in health-related practices.

In the past, however, the practice of health communication education was characterized by a one-way approach, with little planning. In many developing countries, particularly in Africa, although we had our own traditional modes in population health communication, there is increasing use of modern approaches primarily aimed at satisfying the interest of what is known as the "source" in the linear model of communication (Yankah, 1992).

Furthermore, the channels used to convey ill-conceived messages to undefined audiences were often instruments of preserving the socio-political status quo. Windahl et. al. (1992) called this type of communication effort a " political lighting rod" because these were evidently a political splash that demonstrated a political responsibility of the government ministry.

In such a situation, the "source", represented by the government health ministry and/or its appointed department, simply assumes that it has discharged its responsibility, and that all that remains is for individuals and the public to play their part in changing their lifestyle and adopting healthy practices.

The activities and other intervention components of these efforts included:

- seminars and/or workshops on community mobilization or health-related topics directed to health or community workers who were too busy to give quality service to their clients;
- poorly structured home visits by the same health workers

who were too overworked to plan ahead;

- radio programs that did not reach the target audiences because of conflicting interest in the use of broadcast time schedules. More time is often devoted to political propaganda considered priority agenda items over health issues;

- culturally insensitive TV spots that failed to facilitate changes in health-related practices, but instead demonstrated to the public and government partners the pseudo-political and social responsibility of the ministry;

- posters which were developed without the grassroots input and which were never pretested;

- billboards that ornamented the country's highways, thus giving the impression that something was being done.

As preventable and controllable diseases began to take their toll among children and adults alike, health communication education practitioners, international health agencies and governments began to look for workable frameworks in which the practice of health communication education would have appreciable effects on the health of individuals and the community. Using development communication principles and methods, the practice began to shift its emphasis from knowledge and attitudes to "actual behavior change".

The 1978 United Nations Conference at Alma-Ata in the former Soviet Union, pointed out that in order to realize health for all, knowledge about protecting the health of children and adults alike "must be put at the disposal of the majority". The Conference further emphasized the role of the community as the focal point of the planning and implementation of health communication education programs.

This paper examines the conditions under which "knowledge about protecting health" can achieve appreciable impact on both

individuals and the public. As the title indicates, it is an attempt to present the characteristic components of health communication education. In other words, the paper will try to answer a basic question: What are the essential elements needed to make health communication education efforts more effective?

While attempting to present these characteristic elemants, a purposive definition of health communication will be given, in addition to briefly describing two well-known theoretical approaches to communication planning. This will guide the substance of health communication education practice.

As mentioned earlier, today's practice of health communication education puts emphasis on actual behavior as the health variable of interest, and on the consumer- audience as the centre of all the activities. Three fundamental concepts and techniques namely social marketing, behavioral analysis and anthropological methods provide the basis for this evolution. These technical tolls underlie health communication education as a major strategy that contributes to the creation and distribution of health products and services.

Though health communication education originated in the West, a number of related programs have successfully been carried out in developing countries, including Africa. Notable examples include the Honduras and the Gambia Communication and Marketing for Child Survival Project (Rasmuson et al., 1992), and the Zaire Mass Media Entertainment for AIDS Communication Project (Convisser, 1992).

Despite a number of successful health communication education programmes, developing countries continue to face unique problems in setting up development communication efforts. Besides lack of skilled personnel and resources, the mass media (radio, television and print media) in many developing countries are still controlled to a large extent by central governments. Unlike their European and American counterparts, the media in developing countries and particularly in Africa, do not entirely rest on a commercial foundation which advertisers and health professionals must operate (Atkin & Wallack, 1990).

However, there are new trends towards the commercialization of national broadcasting agencies and the introduction of private channels in several African countries. These developments are likely to introduce new challenges to health communication education efforts using the mass media. Public health communicators must, therefore, look into new and innovative strategies such as social marketing and health advocacy to face these new challenges.

It is within the context described above that the paper attempts to present strategies that can stimulate African development and health communication education practitioners to rigorously employ strategic communication principles with a view to increasing the success and effectiveness of their efforts.

Health Communication and its Role in Disease Prevention and Control

Health Communication

Before proposing a purposive definition, it is proper to briefly describe some commonly held misconceptions about health communication education. Health communication education practice has long been perceived as evolving around three basic models:

1. An information model in which message transmission was the in-thing with little attention paid to how the message was received and whether it was acted upon.
2. An instruction model that treats health content as a school syllabus. Lectures were basically the method used to communicate health issues to the potential target groups, who in turn were expected to be attentive and receptive and comply to the prescriptions."
3. A medical model that compels the health communicator to give prominence to the scientific accuracy of the message and totally neglets his role in demystifying the complexity of

health knowledge for a better comprehension by the target group.

This is evidently the frame of reference of health communication education as traditionally practised in the past. However, the definition that follows points to the new direction health communication has taken. Health communication can be defined as the systematic process of packaging and distributing accurate risk factors and behavior change information, with a view to influencing positively the health practices of individuals and groups of people. This is realized through a strategic design that draws from principles and methods of social marketing, behavior analysis techniques and anthropological methods (CCS, 1988:7).

By systematic process is meant a step-by-step process which does not imply a planning checklist or a ready-made formula. Communication is a dynamic effort and as such, every communication situation is different with unique problems and solutions. In fact, the effectiveness of a communication effort will greatly depend on how best the planner or designer understands his/her target group and its environment.

Health Communication Role in Disease Prevention and Control

The goal of health communication education efforts is to improve the health status of individuals and communities by facilitating changes in health-related practices. For example, results from the Zaire Mass Media Project for AIDS Prevention, carried out by the Washington D.C.-based Population Services International, showed increased positive attitudes and intention to practice safer sex through the use of condoms, abstinence or mutual fidelity among the target population.

The success indicator of that project in terms of change was the 1000 percent increase in annual condom sales. The findings showed that condom sales rose to 18.3 million in 1991 from the 900,000 condoms sold in 1988. According to a measurement

scale developed by Family Health International's AIDSTECH Project, the 18.3 million condoms sold in 1991, if actually used properly, translated into the prevention of close to 7,200 cases of AIDS in Zaire that year alone (Convisser, 1992)

A careful analysis of the findings of the Zaire Mass Media Project (Convisser, 1992), the Honduras and the Gambia Projects (Rasmuson et al., 1992) the North Karalia Project (Baker et al., 1992) and many more, showed that health communication programs serve many other functions in addition to the creation of demand and motivation for increased use of products and health services. Health communication education programs can therefore help to increase awareness of a particular health issue; influence attitudes and beliefs to create support and build alliances for individual and community action; facilitate the acquisition of specific skills to solve specific problems; and sustain these skills and knowledge to maintain newly adopted behaviors (MHCPW, 1989).

Conceptual Models of Communication

The Linear Model

Development communication practitioners use conceptual models of communication to guide their work. Perhaps the best known model of communication process is the SMCR - Source, Message, Channel and Receiver - commonly called the linear model. This model has for long influenced development communication efforts that were conceived only as project support tools.

The linear model is basically characterized by the source as the initiator of the communication process, who has the ability and knowledge to interpret and influence his receivers (audience) through the choice of messages that are perceived as right and the use of channels that are believed to be effective (Atkin and Wallack, 1990; Worall, 1977; Windahl et al., 1992). Quite often, the receivers who are supposed to be compliant, are neither consulted/nor educated or mobilized for the programs

that have already been designed.

By consulting the target populations who are to be reached by the program activities, the communication planners seek convergence of ideas, thoughts, feelings, understanding and meanings about the subject matter. Through education, both partners namely the audience and the communication planner(s), - seek to clarify some existing misunderstanding and misconception about the programs content. The target population needs to be mobilized so that alliances are built for the realization of the program's objectives. Such alliances that include partnership-seeking with representatives of the target population and strategic community members and key leaders, can indeed contribute to the success of the program.

The Convergence Model

The convergence model of communication - that is, our own understanding of how development communication must operate includes all that has been said on consulting, educating and mobilizing the target population and key members of the community. Rogers and Kincaid (1981) who have offered comprehensive presentations of this model, define communication not in terms of source and receiver, but in terms of participants or partners engaged in a meaningful relationship to "create and share information with one another in order to reach a mutual understanding".

In our view, the convergence model enhances the underlying approaches of social marketing, behavior analysis and anthropological techniques of health communi*cation education* practice. It puts emphasis on the audience and the communication planner as equal partners who are seeking a mutual understanding on a specific issue.

In the linear model, the primary participant - the source - projects his/her attitudes and beliefs on the receivers waiting for a "feedback" that is often a resistance-to-change feedback because there has never been a mutual understanding. The

convergence model on the contrary allows the participants to forge alliances with a view to seeking understanding and meaning. This mutual understanding is usually arrived at after both partners, through their own perceptions and frame of reference, have interpreted the subject matter.

Since each communication problem is essentially unique, it would appear that the convergence model offers a suitable and highly dynamic conceptual framework to health communication education planning. The convergence model is, thus, far from being an assembly-line-like model.

Approaches to Health Communication Education

Social Marketing

According to Kotler (1982), social marketing is the "design, implementation and control of programs seeking to increase the acceptability of a social idea or cause in a target group." It represents the state-of-art in public health communication education practice today. The use of advertising and marketing principles to sell positive health behaviors, however, has its own limitations (Atkin and Wallack, 1990).

Nevertheless, social marketing has significantly contributed to health communication efforts in positioning the consumer-audience as the focal point. This is a clear departure from traditional health communication education practices where target groups were not consulted before the programs were planned. By incorporating social marketing principles in health communication education activities, the planners benefit from the target group's input at the program formulation and planning stage.

The understanding of the target audience and subsequent design of strategies based on their wants and needs is crucial to communication efforts (Windahl, 1992, Atkin and Wallack, 1990; MHCPW, 1989). Formative research, including pre-testing helps in the knowledge and understanding of the target group.

It is a primary research tool that is used to identify perceptions, attitudes and beliefs of relevant target audience that can benefit from the program activities. The process, known as audience segmentation, makes it possible to analyze and assess knowledge of socio-demographic characteristics, psychological profile and behavioral characteristics that reach each target group through the media.

The knowledge and analysis of the audience, as well as the assessment of its media habits serve to develop appropriate messages that can be "placed in the proper media at the proper time" to promote products and services that the program intends to promote (Atkin and Wallack, 1990: 157). This will further serve as a basis to create the ideal marketing mix of right product, price, place and promotion.

The product as perceived in health communication can be an idea, a commodity, a behavior practice, or even a service that the individual or the audience is called upon to accept by acting upon the message received.

The concept of price refers to what the individual must give up in order to receive and enjoy the benefits of the program (MHCPW, 1989). Other than monetary expenditures, the price can be in terms of time and energy, lifestyle and psychological costs associated with the exchange of the product.

Place on the other hand refers to the channel through which the product is made available to the individual or audience. It is not enough for the product to be available; it has to be accessible and the channel used must also show support in motivating the target audience.

Promotion goes beyond simple publicity. It involves the individual or audience education so that the product promoted is properly used. Windahl (1990) conceives promotion as "actively reaching out to the right people with the right message at the right time in order to obtain the right effects".

Behaviour Analysis and Anthropological Methods

The second approach to an effective health communication education program is the behavior analysis method which usually involves a four-step planning model. In the model, the educational and organizational diagnosis phase is of interest as it represents a framework of a thorough behavioral change analysis of environmental events, or determinants that maintain or change behavior patterns. Accordingly, whenever an individual responds to a situation, this is seen to be the result of an interwoven complex set of predisposing, reinforcing and enabling factors.

These factors cannot, however, be easily understood unless they are considered in a cultural context. Behavior analysis helps us to break down this complex set of behaviors into components that can then be diagnosed with more ease.

Predisposing factors refer to those determinants that can either prevent or stimulate the individual or the community to adopt and accept a new practice. Knowledge, attitudes, beliefs, values and specific behaviors have to be analyzed in order to determine these factors.

When we talk of reinforcing factors, we essentially seek to establish if the consequences of adopting and accepting a new pattern of practice are favourable to the continuation and maintenance of that practice.

Enabling factors on the other hand, refer not only to the community and environmental structure and the individual's own situation conducive or capable of presenting obstacles to change but also to how people relate to each other in that community. The interaction is likely to influence each of the members who share the same cultural values and meanings. The analysis of enabling factors can be well realized by the use of ethnographic techniques of observation, interviews and methods of evaluation. Ethnographic techniques are research tools in anthropological study. This is the third approach that can contribute to an effective health communication education

effort. The techniques, if properly applied, can provide a wealth of information about a community's perceptions, beliefs and practices with regard to health issues.

Furthermore, the way people understand a health issue in terms of its concept and how it affects them is a big step forward in gaining support for health promotion (Atkin and Wallack, 1990). The communication education planner must, therefore, seek to understand the health issue and practice as perceived and understood by the target population.

Health Communication Methodology

The premise of this paper is how knowledge about protecting health can achieve an impact on individuals and the public alike. What then are the characteristic elements that make health communication education work? So far we have heard that health communication education more than before, now operates on a good conceptual framework that includes social marketing, behavior analysis and anthropological methods.

The participation of target group and strategic members of the population is of great importance and necessity in this effort. All this makes public health communication a purposeful activity designed to facilitate intended changes. We say purposeful because the communication effort follows a strategic method with clear and measurable objectives.

Over the years, health communication education efforts have seen many innovative methodologies. For example, the Honduras and Gambian projects operated on a 5-step methodology: Assess Plan, Pretest, Deliver and Monitor. Other projects pioneered three broad stages: Plan, Intervene and Monitor/Evaluate. Each of these stages consists of a several other steps. Some other projects have worked on a 6-stage methodology: Plan/Select strategies, Select channels and materials, Develop/Pretest, Implement, Monitor and Evaluate.

Though health communication education and other development communication practitioners may use their good judge-

ment as planners to decide on what suits them best, they must never forget that at the heart of the process is one central concern: the consumer comes first (Rasmuson et al., 1992). However the methodology one chooses can be constructed around four basic principles that have proved to be good indicators of effective development communication efforts. The principles are: good audience knowledge and health problem, good context, good messages, and good channel use (Hornik, 1992).

Whatever methodology one uses the process is a circular one and is fundamentally interactive. The last stage feeds back to the first in a continuous process of re-shaping the planning, that in turn leads to re-defined interventions. Monitoring of these new interventions will lead to possible new changes in the planning stage, because of the reaction among the larger target population to the action taken. This is the dynamic aspect refered to earlier.

For purposes of this paper, a user-friendly methodology that works on a 4-step process namely Assess and Plan, Develop and Pretest Materials, Implement, and Monitor/Evaluate, will be illustrated.

Assessment and Planning

This stage is the foundation of the entire health communication process. The program must carefully assess the problem and analyze the target audience and its perceptions of the problem. The program must be client-centered to the extent that the program manager must be able to step in the "shoes" of the audience. This demands that a thorough epidemiological analysis and assessment of the behavioral dimensions of the targeted health problem are made. It also calls for the collection of relevant information related to the prevalence and principal causes and risk factors associated with the health problem.

Information that is likely to help in the understanding of the target audience and their media habits must also be collected. Research methods such as existing baseline studies, ethno-

graphic studies, focus group discussions in-depth interviews, etc. can provide valuable information about the target audience. A good knowledge of the audience, including its behavior is likely to provide a basis for realistic strategies and measurable objectives for the communication program.

During this stage, the program planners must as clearly as possible, also define the audience - those who will primarily benefit from the program as compared to those who are likely to influence this primary audience and enhance the success of the program. They must define in specific terms, the product to be promoted. As we said above, the product in health communication can be an idea, a tangible commodity such as a condom or Oral Rehydration Therapy (ORT) or simply health services to be used by the target audience.

Although the product may be available, it may not be accessible to the targeted audience. The distribution strategy must, therefore, be clarified and stated. For a tangible product, this may include public sectors, wholesale networks, private retail outlets, professional health providers or/and volunteers.

Developing and Pre-testing of Materials

After knowing the audience, the product to be promoted and the distribution system, the program planners are now ready to develop the communication tools that include message and materials design, and choice of channels. These tools are interdependent. Before designing any new material, it is the responsibility of the planners to look around and see whether or not there are some existing communication materials where the program is being implemented. The planners must use their own judgement to decide to choose among these existing materials and adapt them to the target audience.

The decisions about what material formats (print or audiovisual) to use, will largely depend on several factors that include:

- the message characteristics: Is it complex? Is it sensitive? What is the style and the purpose of the message?

- the audience and the channel preference: Whether the audience prefers to read about the subject matter or watch a videotape on the same subject; what are the channels likely to reach more people; is it the media, private physicians, school system or a combination of these?

- the budget and other available resources such as skilled personnel.

After the development of material strategies and message design, the planner must embark on pre-testing all materials before they are delivered to the larger target population. Pre-testing is a type of formative evaluation used to ensure that communication materials will work and produce the desired effects. The purpose of pretesting therefore is to have materials that are understandable, relevant, culturally sensitive and credible, as well as attractive and acceptable to the target audience.

This is usually achieved through various methods, including focus group discussions, that involve few people who are representative of the target group; self-administered questionnaires; theatre testing; readability test; and gatekeeper review.
The common message delivery channels include:

- face-to-face communication (individual patient education, peers counselling and family members interaction);

- organizational communication: professional or voluntary association;

- mass media: radio, television, newsletters, billboards, newspapers, posters, etc;

- community network: community workers, churches, women groups, opinion leaders, youth clubs;
- a combination of the above.

Implementation

This is the stage whereby the program planners introduce the program to the larger audience. Before this is done, it is advisable that materials produced are available in sufficient quantities and that enough time is devoted to prepare the "kickoff" (MHCPW, 1989). Depending on the budget, promotional activities related to the program may include: press releases; briefing with key leaders of the community, including gatekeepers in media organazations; press conferences to introduce the program; as well as TV and radio spots to advertise the big event. The program implementation must indicate when specific events will occur. This may entail training of those who will interact directly with the target group.

Monitoring and Evaluation

A monitoring mechanism must be built into the program. This will help detect flaws and oversights in some of its components (MHCPW, 1989; CCS, 1988). However, there are no universally agreed upon mechanisms for effective monitoring. Each program must find the best way to carry out this activity. Nevertheless, there are elements of the program that are of importance for monitoring activities. These include: materials and distribution systems for products; tracking of audience levels of knowledge, acceptance and practices and adherence to work schedule and budget.

The following are some of the common strategies used in the monitoring process:

- Broadcast monitoring to ensure that planned program schedules are met;
- Regular audits of materials at designated distribution points;
- Focus group discussions to investigate the impact of promotional messages and to detect possible confusion;
- Management reviews to assess the impact on the implementors.

While monitoring measures the process outputs of the program, summative evaluation is the use of systematic research techniques to measure outcomes and impact of the overall programm effectiveness. Program managers must decide on the type of evaluation to be carried out. Outcome evaluation is basically used to describe some relevant data of the project and to record short-term results: changes in knowledge and attitudes; intentions to do something by the target audience; actual behavior variables demonstrated, etc. Impact evaluation on the other hand, relates to the long-term results like changes in morbidity and mortality, or maintenance of desired behavior. It refers to the overall health status of the exposed audience.

Conclusion

This paper has examined principles and characteristic components that contribute to the effectiveness of health communication practice. The planning of this effort is not a ready-to use formula that can be applied to all health communication situations. However, with careful assessment and planning, it is possible to draw on the methodology as described in this paper.

It is, therefore, recommended that health communication education planners and practitioners strive to know their audiences, including their wants, needs, and media preferences, as

well as the environment where the program is to be introduced, before they proceed to implementating it. Through innovative approaches of formative research, they must empower the target audience to have ownership of the program with a view to realizing maximum success.

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