Chapter 6
Channels and Tools

By the end of this chapter, the reader will be able to identify channels and tools for communicating the message by:

Step 1: Choosing the Channels That Are the Most Likely To Reach the Intended Audience:

- **Evaluate the best strategic approach for the channel mix.**
- **Evaluate each channel's capacity to reach the audience in the most cost-efficient manner.**
- **Select a lead channel and supporting channels, with a rationale for each.**

Step 2: Determining Tools

Step 3: Integrating Messages, Channels, and Tools

Overview

Your friend the architect, of course, does not actually build the school. He chooses a general contractor and, through him, subcontractors to do the job. For the architect, these skilled technicians serve as channels for him to achieve his objectives. In turn, these technicians use the tools of their trades to build the school: the carpenter uses his saws, hammer, and nails; the electrician strings wires and connects them to the main source of electricity and to outlets; the plumber uses his wrench to install and connect pipes.

Similarly, you will use channels and tools to reach your intended audiences, and this chapter shows you how to choose the tools and how to integrate them.

You will spend the bulk of your communication budget on creating materials and placing them in the most suitable channels and on using the most appropriate tools for communicating to audiences. This chapter will help you select the communication channels and tools that are most likely to move the strategic approach forward in the most cost-efficient manner.

In chapter 1, you listed the available communication channels and the audiences best reached by these channels (worksheet 1.3a). In subsequent chapters, you identified the primary and secondary audiences, set behavior change objectives, determined the overarching strategic approach, and developed key message points. Now it's time to put these pieces together by matching audience profiles with the channels of communication.

Step 1
Choosing the Channels That Are the Most Likely To Reach the Intended Audience

step 1 of 3
Channels and Tools

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Before you can decide what materials to produce, you must first decide what communication channels will best reach the intended audience. Health communicators have defined communication channels as modes of transmission that enable messages to be exchanged between "senders" and "receivers."

The various types of communication channels are:

- **Interpersonal Channels,** which include one-to-one communication, such as provider to client, spouse to spouse, or peer to peer.
- **Community-Based Channels,** which reach a community (a group of people within a distinct geographic area, such as a village or neighborhood, or a group based on common interests or characteristics, such as ethnicity or occupational status). Forms of community communication are:
  - — Community-based media, such as local newspapers, local radio stations, bulletin boards, and posters.
  - — Community-based activities, such as health fairs, folk dramas, concerts, rallies, and parades.
  - — Community mobilization, a participatory process of communities identifying and taking action on shared concerns.

- **Mass Media Channels,** which reach a large audience in a short period of time and include:

  — Television
  — Radio
  — Newspapers
  — Magazines
  — Outdoor/Transit Advertising
  — Direct Mail
  — The Internet

Table 6.1: Communication Channels

Channel	Audiences Reached	Advantages	Disadvantages
Interpersonal Channels			
Provider to client, spouse to spouse, peer to peer	Individuals	May be the most credible source because it is face-to-face communication. Most participatory. Highly effective.	Is difficult to control messages. Requires expert training by a communicator. Is costly to scale up. Takes a long time to build reach.
Community Channels			
Community media (Community newspapers, local radio)	Men, women, children	Participatory. May be more credible than mass media because it is localized. Low cost.	Costly to scale up. Low reach beyond the immediate community. Low frequency. One-way communication.
Community Activities (Folk drama, group meetings, rallies, community advocacy or mobilization)	Audience segments	Participatory. May have more credibility than mass or community media because they engage the audience. Stimulates institutionalization of community structures. Encourages sustainability of effort. Low cost.	Costly to scale up. Low reach. Low frequency.

Channel	Audiences Reached	Advantages	Disadvantages
Mass Media Channels			
Television	Households, families (men, women, adolescents, children)	Comes into homes-can spur family discussion. Reaches a large percentage of the intended audience. Delivers the maximum impact (sight, sound, motion). Cost-efficient.	Expensive production costs. Initially more urban than rural. May be too costly at certain times of the year. Prime time may be prohibitive; other time slots may not reach many audience members.
Radio	Individuals, families, adolescents	Used as a personal medium in many countries. Delivers frequency. May be used to build reach. Reinforces TV messages. Can be highly creative. Less expensive than TV. Can send messages in the local language.	Fragmented. Costly to build reach when there are many different stations covering one area. No visuals. Not always easy to buy in all parts of a country.
Magazines	Men, women, youth	Segmented to reach different audiences by lifestyle, demographics, and attitudes. Reproduction value/color. Pass-along readership. Prestigious.	Long lead time. Low frequency. For literates only. More upscale.
Newspapers	Well-educated men and women, policymakers	Mass medium. Timely. Message length. Influential. Flexible sizing.	For literates only. Reproduction quality. Poor photo reproduction. Short lifespan. May not be cost-efficient.
Outdoor/transit (Billboards, bus advertising)	Men and women	Good for identification or awareness building. High traffic areas. Very brief message. Reinforcement of other media messages.	Limited time of exposure. Limited message content. Is not very durable.

To start developing a channel strategy, write down opportunities (or openings) for sending your message during a typical day in the life of your audience. The example below, together with worksheet 6.1, identifies the various opportunities for exposure.

Example 6.1: A Typical Day in the Life of the Intended Audience Worksheet

Instructions: Fill out this chart to track a typical day in the life of the intended audience, which should include home, workplace, and leisure time activities. This information should be readily available through consumer-based research and by speaking with potential members of the audience. Indicate where opportunities exist for audience members to be exposed to communication channels.

Time of Day	Location, Activities	Communication Channel Opportunities
Early morning	Commuting to work by bus.	Opportunities could be billboards.
Midmorning	Office tea break.	Opportunities could be worksite activities.
Midday	Lunch at canteen in office compound.	Worksite activities, radio.
Early afternoon	In office.	
Late afternoon	Tea break in office.	
Early evening	Commuting home.	
Dinner	At home.	Radio, television.
Late evening	At home.	Radio, television, magazines.
Special events (List day, week, or month.)	Church gatherings, market days.	
Seasonal Opportunities (Harvest time, holiday season)	During holidays, I go back to my village by train.	

Worksheet 6.1: A Typical Day in the Life of the Intended Audience

Instructions: Fill out this chart to track a typical day in the life of the intended audience, which should include home, workplace, and leisure time activities. This information should be readily available through consumer-based research and by speaking with potential members of the audience. Indicate where opportunities exist for audience members to be exposed to communication channels.

Time of Day	Location, Activities	Communication Channel Opportunities
Early morning		
Midmorning		
Midday		
Early afternoon		
Late afternoon		
Early evening		
Dinner		
Late evening		
Special events (List day, week, or month.)		
Seasonal Opportunities (Harvest time, holiday season)		

Compare the above worksheet with worksheet 1.3a developed in chapter 1 that listed available communication channels. Are there matches between the list of available channels and the typical day? If so, you should concentrate on these channels. Circle the channels that you might use.

Definitions

These definitions may be helpful, especially when working with advertising agencies.

Reach: The number or percentage of members of a defined audience segment that will be exposed to a message at least once. Reach helps to build momentum quickly.

Frequency: The average number of times that one person is exposed to a message. Frequency helps ensure message penetration.

Gross Rating Points: In broadcast media, the combination of reach and frequency is measured as Gross Rating Points. Ratings are the percentage of a specified audience segment that is viewing or listening to a particular program at a specific time. The accumulation of ratings (based on the number of television or radio spots bought in these time periods) equals total Gross Rating Points. The percentage of reach multiplied by average frequency also gives total Gross Ratings Points. "Gross Impressions" is the term used when this is given in actual numbers instead of percentage points.

TIP: *If you are not sure whether rating surveys are available in your country, check with an advertising agency. If surveys are not available, consider collaborating with other organizations to fund a survey.*

Evaluate the Best Strategic Approach for the Channel Mix

Your next decision is to decide the focus of the channel mix. What is the best way to reach the intended audience, based on the objectives in chapter 3? Should you focus on building reach, building frequency, or maximizing both?

Build Reach Quickly

Do you want to reach as many different people in the audience segment as quickly as possible? If so, the channel mix will be based on reach. This approach means that the lead channels selected are ones that can reach a large number of people in a short period of time. In some countries, television is considered such a medium. In other countries, it is radio. Community events can reach a large number of people within a community, but the frequency of message exposure is limited to the timeframe of the event and to the number of events planned for a community.

Emphasize Frequency

Should the channel mix be one that steadily conveys a message to build recall over a long period of time? If so, emphasize frequency, and use a medium that may not reach as many people quickly but is affordable enough to repeat messages regularly over an extended period of time. Radio in many countries is a good example of a channel that helps to build frequency. Radio advertising is relatively inexpensive, and radio spots can be repeated over and over during a campaign. IPC at a health clinic is a way to build frequency by ensuring that different levels of health providers reinforce the messages and by repeating the messages at each provider visit.

Combine Reach and Frequency

To build reach, but not at the expense of minimizing frequency, consider using an equal combination of these approaches. You will reach a large number of people on an ongoing basis. In some counties, a combination of television, radio, community events, and IPC is a way to build both reach and frequency at the same time.

Evaluate Each Channel's Capacity To Reach the Audience in the Most Cost-Efficient Manner

A good channel mix balances a variety of factors, such as the size of the audience reached and the cost of reaching this audience. To compare each channel on a cost-efficiency basis, divide the cost of placing the message by the audience reached.

Example

The cost of a television spot is divided by the audience reached (in thousands) using the latest television program ratings data. The result will give you a cost-per-thousand to use for comparison purposes.

If a television program reaches 400,000 women ages 18–35 and if the cost of a television spot on the program is $500, the cost per thousand is $1.25.

You can do the same calculation for a magazine ad. Divide the cost of a page in a magazine by readership (in thousands) to obtain a cost per thousand. Cost-per-thousand comparisons are used to compare one television station with another, to compare one medium with another, and to compare one communication channel with another. Mass media will clearly reach more people more often in a less costly way on a cost-per-thousand basis. Conducting such an evaluation helps justify the use of different channels.

Example 6.2: Evaluating Each Communication Channel Worksheet

Instructions: Fill in the type of channel, the audience reached, and the estimated cost in the first three columns. In column 4, estimate the cost per thousand. In column 5, rate the channel's credibility. Check the boxes that offer both efficiency and credibility.

Example: Nicaragua[1]

1 Channel	2 Audience Reached (000) in a Typical Week	3 Cost USD (Typical Week)	4 Cost per Thousand (Divide Cost by Thousand Audience Reached)	5 Opportunity Rating (1–5) (5-Most Credible; 1-Least Credible)	6 (Check the Channels That Offer Efficiency and Credibility)
Television	2,195	$72,00	3.28	4	X
Radio	1,701	$2,821	1.66	4	X
Newspapers	126	$1,370	10.83		
Billboards	NA	NA	NA		
Community Media	100	$250	2.50	4	X
Community Event	2400	US $3,200	US$0.75 per person	4	
Group Meetings	240	US$1,263	US$5.26 per person	2	
IPC Materials	500 people a week (300 community agents and 12 clinics)	$.28	Less than one cent per person	5	X

[1]Typical week for "Juntos" campaign-data and costs estimated July 2002

Worksheet 6.2: Evaluating Each Communication Channel

Instructions: Fill in the type of channel, the audience reached, and the estimated cost in the first three columns. In column 4, estimate the cost per thousand. In column 5, rate the channel's credibility. Check the boxes that offer both efficiency and credibility.

1 Channel	2 Audience Reached (000) in a Typical Week	3 Cost (Typical Week)	4 Cost per Thousand (Divide Cost by Thousand Audience Reached)	5 Opportunity Rating (1–5) (5- Most Credible; 1- Least Credible)	6 (Check the Channels ThatOffer Efficiency and Credibility)
Television					
Radio					
Newspapers					
Billboards					
Community Media					
Community Event					
Group Meetings					
IPC Materials					

The Multichannel Approach

Research has demonstrated that a multichannel approach has a better chance of changing behavior than a single channel approach (Piotrow, Kincaid, Rimon, & Rinehart, 1997). In addition, a multichannel approach, especially an approach that uses mass media, can achieve objectives more quickly. Using several channels enables you to reach more people and to reach people in different environments with more frequency. The combination of multiple channels also offers a synergy to the campaign and gives it more impact. It is important for the primary audience as well as for other secondary and influencing audiences, who will most likely be exposed to these same messages. This exposure will, in turn, help to reinforce in them the necessity of supporting the campaign.

Achieve a Seamless Channel Mix

The ideal multiple channel mix is one that reaches a large proportion of the audience segment efficiently. Messages delivered through these channels must be consistent and reinforce each other. This means, for example, that messages on television are consistent with messages delivered at health clinics.

The strategist should understand how the audience responds to each channel, so that the message is seamless. For example, when adolescents are at a village concert sponsored by a social marketing company, the messages that they are exposed to are reinforced with materials they receive through peer counselors and ones they hear on the radio.

Example

In Kenya, an FP campaign called Haki Yako used radio, community mobilization, and IPC, with radio being the lead channel. The conclusion in the Information, Education, and Communication (IEC) Field Report (December 1996) was that "using several communication channels . . . reached three-fourths of the adult population of Kenya. In fact, the overlapping coverage of various media increased the level of exposure and had a reinforcing effect on those exposed." (Kim, Lettenmaier, & et al., 1996)

Example

In the United States, the Department of Agriculture (USDA) School Meals Initiative for Healthy Children is a comprehensive plan that aims to ensure that children eat healthy meals at school. USDA established Team Nutrition as a way to ensure that schools are able to provide healthy meals to children and to motivate them to eat more healthful foods. The goals of Team Nutrition include eating less fat, eating more fruits, vegetables, and grains, as well as eating a variety of foods. A nutrition education program was delivered through the media, in schools, and at home, to build skills and motivate children to make healthful choices. The program was evaluated to determine the impact of multiple channels, and evaluation showed that the degree of behavior change was directly related to the number of channels that students reported being exposed to (Lefebvre, Olander, & Levine, 1999).

Example

In Bangladesh, the lead channel was "jiggasha,"* a Bangla term used to signify a community social networking meeting, because this was the channel capable of reaching women of reproductive age at a place where they would be most receptive and responsive to the messages. "Jiggasha" was reinforced by radio broadcasts and print materials.

* "A Bangla term, which means 'to inquire,' was selected by the Bangladeshi staff to represent the community network approach because it implies the active participation of village women in obtaining health and FP information, counseling, and supplies." (Kincaid, 2000)

Select a Lead Channel and Supporting Channels, With a Rationale for Each

You must determine which channel will be the lead channel and which ones will serve as supporting channels. Just as a locomotive pulls the other cars on a train, the lead channel will be the "engine" that pulls the other channels with it. Think about your worksheets as you answer the following questions:

- Which channel will reach the largest proportion of the intended audience?
- Which channel will fit the message brief most appropriately?
- Which channel will achieve the greatest impact?

Although a mass medium may reach more people, it may not always make sense to choose it as a lead channel.

Use the following worksheet to determine the lead channel and supporting channels. Write a rationale for each channel.

Example 6.3: Summary of Communication Channels Selected Worksheet

Example: Ghana's 'Life Choices"

In Ghana, a demand generation strategy for FP was designed to encourage the use of modern contraceptives among several audience segments: young sexually active unmarried adults, young married adults who wanted to space the number of children that they planned to have, and more mature married adults who wanted to limit the number of children that they had. Since the strategic approach was to associate FP with the ability to achieve life goals and since the messages were designed to focus on specific characters, television became the lead channel to help deliver the story of each character's life goal and subsequent FP choice.

My Lead Communication Channel Is:	Because…
1. Television	Television reaches a vast majority of all audience segments and has the dynamic of sight, sound, and motion to relate each character's story. Television enables each story to come to life.
Other Communication Channels Are:	**Because…**
2. Radio	Radio can support the story that is relayed in the television spots and also can reach audience segments unreached through television. It can also help to tell other stories using different characters in local languages.
3. Outdoor Billboards	Outdoor billboards can remind the audience of the characters being portrayed on television and can reinforce the simple tag line: "It's Your Life. It's Your Choice."
4. IPC Materials	Materials can reach those specifically interested in learning more about FP methods and can reinforce the "Life Choices" theme.
5. Community Outreach	Satisfied users will support the "Life Choices" theme through outreach events and seminars, will relate their "Life Choices" story, and at the same time will advocate for their FP method of choice.

Example 6.3: Summary of Communication Channels Selected Worksheet

Example: Uganda

My Lead Communication Channel Is:	Because. . .
1. Radio	Wide reach (73% of women and 87% of men in DISH districts, excluding Kasese, listened to the radio at least once a week, per the 1999 DISH Evaluation Survey)
Other Communication Channels Are:	**Because. . .**
2. Interpersonal—CHW to Couple	They are more influential.
3. Video	It can "show" procedures, internal anatomy, and satisfied users.
4. Print	It can reinforce IPC and can remind clients of information once they leave the clinic.

Worksheet 6.3: Summary of Communication Channels Selected

My Lead Communication Channel Is:	Because. . .
Other Communication Channels Are:	**Because. . .**

Step 2
Determining Tools

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Channels and Tools

Suppose you want to visit your relatives in another town. You have many ways of getting to the town. You can go by river and take a ferry or hire a small boat. You can go by rail and take the express train or the local train. You can go by road and take a taxi, take a bus, or drive your own car. The river, rail, and road serve as the route to get you from one place to the other—they serve as the channel. The ferry, small boat, train(s), taxi, bus, or car serve as the tools that you will take to access the channel. It is the same with communication channels and tools. For example, television and radio are mass media channels, while advertising and publicity are tools. Channels enable you to reach the audience, while tools are what you use on those channels.

Tools are the tactics used to send messages through the channels and include advertising, publicity, entertainment education, advocacy, community participation, provider training, events management, and private partnership development.

A communication strategy team has a bag of tools or a toolkit to choose from. The challenge is to choose the best combination of tools to follow the strategic approach and achieve the objectives.

Your team needs to understand how the tools work, what tools will work best to achieve objectives, and when to use them. Advocacy, for example, can help to establish an environment that supports a behavior before an audience is exposed to messages. A campaign of advocacy to religious leaders in Jordan paved the way for an adolescent reproductive health campaign. A mass media advertising and PR campaign can help dispose policymakers to support a policy change. In Romania, the launching of a nationwide multichannel campaign on women's health was the impetus for the MOH to move ahead with a program to ensure that providers of FP were being compensated for their work.

Eight Tools of Strategic Communication: Definitions and Examples

1. Advocacy: a set of tools used to create a shift in public opinion and mobilize necessary resources and forces to support an issue, policy, or constituency.
2. Advertising: a set of tools to inform and persuade in a controlled setting through paid media, such as television, radio, billboards, newspapers, and magazines.
3. Promotion: a set of tools for providing added incentives to encourage the audience to think favorably about a desired behavior or to take some intermediate action that will lead toward practice of the desired behavior, such as coupons, free samples, contests, sweepstakes, and merchandising.
4. IPC Enhancement: a set of tools that can enhance personal interaction between clients and providers, including discussions within and outside the clinic. It includes not only training the information providers, but also enhancing the place where the communication takes place.
5. Event Creation and Sponsorship: developing and/or sponsoring events for the purpose of calling attention to and promoting a desired behavior, such as a news conference, celebrity appearance, grand opening, parade, concert, award presentation, research presentation, or sporting event.
6. Community Participation: a set of tools for helping a community to actively support and facilitate the adoption of a desired behavior.
7. Publicity: the use of nonpaid media communication to help build audience awareness and affect attitudes positively.
8. Entertainment vehicles, such as television or radio programs, folk dramas, songs, or games, provide entertainment combined with educational messages.

The major questions to ask are:

- What tools do we need to support the strategic approach?
- How will they be used?
- Why should these tools be used?
- How will these tools fit into the overall picture?
- How will these tools work together?

Other questions to ask are:

- Do our partners have the ability to manage these tools?
- Do we have the resources to finance these tools?

If advertising, for example, is a viable option, it is best to hire an advertising agency to handle materials development and media placement. (See "How To Select and Work With an Advertising Agency.") For more on managing tools, see chapter 7.

Table 6.2: Eight Tools: Advantages, Disadvantages, and Appropriate Uses

Tools	Definition	Advantages	Disadvantages	Appropriate Uses
Advocacy	To create a shift in public opinion and mobilize necessary resources and forces to support an issue, policy, or constituency.	Builds support among policymakers. Can build coalitions at grassroots level. Creates a positive environment. Counters opposition.	Limited in reach. Requires very specific skills. Requires a knowledge of system and contacts. Can take a long time to see change.	To create or change legislation or policy in support of a health program. To change the legal, social, or political environment related to health issues. To avoid negative responses to a health program.
Advertising	To inform and motivate in a controlled setting through paid media (such as television, radio, billboards, newspapers, and magazines).	Ability to control message content, media placement, timing, and length of message.	Initially expensive, although cost-efficient in the long run. Need to use an advertising agency. Limited space. Less credible.	National communication programs. When message control is necessary. When audiences have access to mass media.
Promotion	Provides added incentives to encourage the audience to think favorably about a desired behavior or to take some intermediate action that will lead toward practice of the desired behavior (such as coupons, free samples, contests, and sweepstakes).	High response rate. Activates audience. Produces action.	Action is immediate but usually short-term. Can be expensive to produce and distribute.	When encouraging the trial of new behavior or introducing new product or service. To stimulate use.

Table 6.2: Eight Tools: Advantages, Disadvantages, and Appropriate Uses (continued)

Tools	Definition	Advantages	Disadvantages	Appropriate Uses
IPC	Enhances personal interaction between individuals. Includes discussions in and outside the clinic, training and managing counselors, including peer counselors, and enhancing the place where the communication takes place.	Reaches the audience at the individual level. Two-way communication. Reinforces behavior at provider setting. Builds provider or counselor and client relationships. Lends itself to effective feedback process.	If a provider or peer counselor fails to deliver on his/her promise, the audience may be discouraged from return visits. Materials have to be understandable, attractive, and accessible. Limited reach. Inconsistency from one situation to another.	For any provider/facility promotion. Any program where service provision exists.
Events Promotion and Sponsorship	Develops or sponsors events for the purpose of calling attention to and promoting a desired behavior (e.g., news conference, celebrity appearance, grand opening, parade, concert, award presentation, research presentation, or sporting event).	Generates publicity and goodwill.	Short-term; can be costly. Labor-intensive. Sponsors have to be pursued, receive a benefit, and be socially compatible with program.	During a campaign launch. Create awareness. Promote logo or slogan. Build a brand-client relationship.

Table 6.2: Eight Tools: Advantages, Disadvantages, and Appropriate Uses (continued)

Tools	Definition	Advantages	Disadvantages	Appropriate Uses
Community Participation	To assist a community to participate and actively support and facilitate the adoption of a desired behavior.	Involves and engages the community as a whole. Supports collective and individual behavior. Helps change community norms.	Time intensive. Takes a long time to scale up. Communities may not always be homogeneous.	To develop sustained participation from the community as a whole.
Publicity	The use of nonpaid media communication to help build audience awareness and positively affect attitudes toward the desired practices.	Provides an objective, more credible source. Generates awareness quickly. Inexpensive. Enhances advertising campaign.	Lack of control of message and media placement. Can take time to foster media relationships.	Introduces a new product or service. When there is something newsworthy about the subject.
Entertainment	TV or radio programs, folk dramas, songs, and games that provide entertainment interspersed with educational messages.	Audiences are very receptive. Program content can be engaging. Messages can be persuasive.	Can be costly to produce. Requires careful design.	Ties in with national advertising campaigns. Can be a strong focal point for a national strategy. Can mix different messages to promote integrated health.

Examples of Channels and Tools

Table 6.3 shows the relationship between channels and tools and some of the materials used for each category. For example, mass media as a channel is a way to transmit messages. However, messages can be conveyed through designing fully produced programs, paid advertising spots, or news items as a result of a publicity campaign. All of these tools are using the same channels of communication but require different skills and/or organizations (advertising agencies, PR firms, production companies) to help you implement them.

Table 6.3: Relationship Between Channels and Tools

Channels	Tools Used on the Channels	Materials/Activities
Interpersonal Communication (IPC)	Peer Counseling	Training, support materials
	Provider Counseling	Training, support materials
	Health Clinic Enhancement	Posters, pamphlets, videos used by client without personal interaction with provider
Community Channels	Community Participation	Group meetings, guides, rallies, advocacy activities, speaker kits, press kits
	Community Media	Community newspapers, local radio, hoardings, criers, miking
	Community Activities	Folk drama, road shows, health fairs
Mass Media TV, Radio, Newspapers, Magazines, Billboards, Transit	Advertising	Print advertisements, TV spots, radio spots, outdoor posters, transit cards
Mass Media TV, Radio, Newspapers, Magazines, Billboards, Transit	Publicity	Press releases, video releases, articles, radio press releases, press conferences, public service announcements, journalist training
Media, Community, Interpersonal	Advocacy	Kits containing pertinent facts and compelling stories to garner support for a policy, issue, or constituency; meetings; mailings
Media, Community, Interpersonal	Promotion	Coupons, free samples, contests, sweepstakes, either through media or at community and store level
Media, Community	Event Creation and Sponsorship	News conferences, celebrity appearances, grand openings, parades, concerts, award ceremonies, research presentation, sporting events
Media, Community	Entertainment Education Vehicles	TV programs, radio programs, folk dramas, songs, games

Review the example for worksheet 6.4, and then fill in the worksheet to select the tools that you will use.

Example 6.4: Summary of Tools Selected Worksheet

Example: Nigeria's Democracy and Governance Communication Strategy

A communication effort was developed with the objective of encouraging Nigerian citizens of voting age to become involved in civic affairs and especially to work within existing groups that may already belong to advocate for social change. A combination of tools was used to encourage Nigerians to get involved.

I Choose the Following Tools:	Because . . .
Training local organizations to advocate for social change by partner NGOs.	To help organizations work with their local government and/or political officials to methodically and effectively convince them to affect the desired change.
PR activities	To get media coverage to help encourage local groups to act and to encourage individuals to work within groups.
Advertising campaign	To reach individuals through television, radio, and outdoor billboards and to show examples of successful local group advocacy efforts.
Community mobilization	To encourage local organizations to help their communities.
Events promotion	To stage contest for "local heroes"—individuals that convinced groups to advocate for change that results in successful changes.

Example 6.4: Summary of Tools Selected Worksheet

Example: Uganda

I Choose the Following Tools:	Because . . .
Advertising	To inform audience about methods, availability, or services and to persuade audience to use them.
IPC enhancement	To improve the quality of information about these methods provided by health workers and to train a cadre of CHWs who can explain the methods to interested couples.
Entertainment vehicles	To show satisfied users, demonstrate how the procedures are done, demonstrate spousal discussions about the methods, and stimulate public discussion about these methods.

Worksheet 6.4: Summary of Tools Selected

I Choose the Following Tools:	Because . . .

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Step 3
Integrating Messages, Channels, and Tools

Example: A Nutrition Campaign on Breastfeeding

The intended audience is young mothers and the key issue is to encourage exclusive breastfeeding for the first 6 months of a child's life. The strategic approach is to convince pregnant women during the antenatal period that they should exclusively breastfeed their newborn child. The message is based on the woman's desire to keep the baby healthy during infancy. Channels are IPC, community communication, and radio. Tools used are training providers to counsel pregnant women during antenatal visits, IPC materials to support counseling efforts and reinforce positive behavior at the provider site, group meetings at marketplaces on market days, and an entertainment education radio program that focuses on nutrition. All of the efforts mentioned are planned together, so that messages are consistent and reinforce each other, while the timing of all efforts falls within the same period for maximum impact.

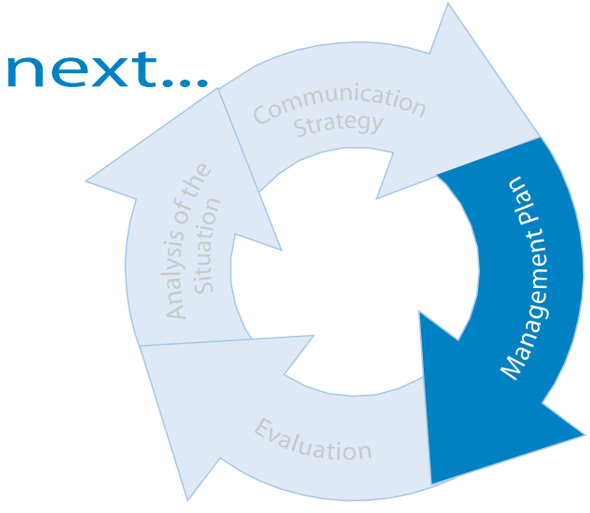
The advantage of strategic communication is that the planning process allows you to see a whole picture of how to use messages, channels, and tools to maximize communication efforts, as described in the following example.

Example: Integrating Channels and Tools

The Zambia Integrated Health Program (ZIHP) was designed to move forward the implementation of health reform in selected districts in the country. It focused on the needs of various audiences and offered specific integrated packages of health services to each audience. ZIHPCOMM was designed to communicate to the four basic audiences: women, men, caretakers of children, and youth, and focused on four technical areas: malaria, HIV/AIDS, integrated reproductive health, and child health and nutrition. ZIHPCOMM had three major objectives: to increase demand for population, health, and nutrition interventions; to change knowledge and attitudes about health behaviors; and to increase knowledge about when and where to go for services. Within ZIHPCOMM, sets of interventions were developed that corresponded to different communication channels. The Better Health Campaign became the mass media application and included radio and television messages about health behaviors. The Neighborhood Health Committee package became the community partnership component that included training of CHWs and print materials to support their training and ongoing community work. A radio program provided distance education to support community partners. This became the glue for the whole community partnership package. It provided updates on the health interventions as well as the community mobilization techniques.

The interpersonal intervention package complemented the mass media and community intervention packages. The package included a set of clinic-based activities, including counseling kits, training materials, and other clinic support materials, such as posters, wall paintings, and leaflets. All of the elements of the interpersonal package contributed to enhancing the experience that clients and patients have at the clinic for any of the health-related areas: FP services, maternity services, child health care, reproductive tract infections, or other HIV-related services.

The Better Health Campaign, the Neighborhood Health Committee package, and the clinic package complement each other to ensure that all levels of the system receive appropriate materials with consistent messages from a credible source. Each package is flexible enough to accommodate changing program foci yet offers a consistency and a credibility that increases the level of impact.



Next Steps

You are getting closer to developing an implementation plan. You have an overarching strategic approach, key message points, and now a channels and tools mix. The next step is to determine how to manage this strategy, that is, who will implement the strategy, who will collaborate, how this effort will be coordinated, what timeframe to use, and what financial resources you will need.

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Chapter 7
Management Plan

By the end of this chapter, the reader will understand the importance of management for strategic health communication and the elements of successful management by completing the following steps:

Step 1: **Identifying the Lead Organization and Collaborating Partners**

Step 2: **Defining the Roles and Responsibilities of Each Partner**

Step 3: **Outlining How the Partners Will Work Together**

Step 4: **Developing a Timeline for Implementing the Strategy**

Step 5: **Developing a Budget**

Step 6: **Planning To Monitor Activities**

Overview

The architect, the builder, and the subcontractors constitute the team that will build the school. Together, the architect and the builder manage the project: they draw up agreements for working together, determine a schedule, and prepare a budget. Specifically, they will determine how and when the team members—engineers, electricians, plumbers, painters, and decorators—will do their work. In addition, the architect and the builder specify how they will monitor progress and plan for solving problems and maintaining quality control.

Likewise, you will need to manage all the elements of your communication efforts, most importantly your coworkers and any collaborating agencies. This chapter will show you how to develop a management plan.

Successful management requires leadership, clearly defined roles and responsibilities, close coordination and teamwork between all the participants, and adherence to a timeline and budget. This chapter explains the strategic considerations inherent in each of these elements and discusses how to develop a management plan.

Step 1
Identifying the Lead Organization and Collaborating Partners

step 1 of 6
Management Plan

To distinguish the lead organization from collaborating partners, start by identifying the key functional areas and skills that need to be in place to carry out the strategy. Typically, these roles include management coordination, policy, research, advertising, media planning and placement, PR, community-based activities, training, monitoring, and evaluation. Some of these may not apply to the particular communication strategy at hand, and often functions not listed above may be relevant. Plan only for those roles that are appropriate to the situation.

The Lead Organization

The group designated as the lead organization is often responsible for the overall coordination of the strategy design and implementation. Within this organization, one manager is typically designated as the contact person through whom all information should flow. The contact person often makes sure that all activities are on strategy, within budget, and on schedule and that all partners are involved and kept up-to-date. This organization will write the management plan, coordinate with other groups to implement the plan according to an agreed-upon timeline and budget, and keep the management plan on track. The lead organization is usually responsible for obtaining all necessary approvals for activities. It often serves as a focal point for issuing status reports and for alerting other groups to problems and issues that require attention. This organization should always have a clear, "big picture" notion about why various activities are taking place and how these activities interrelate. Also, this group should work collaboratively with other partners in establishing clear timelines that include decisionmaking approval points. The lead organization often helps build the capacity of the collaborating partners through the day-to-day work of implementing the communication strategy.

Potential Collaborating Partners

For Policy Matters. Facilitating the implementation of the strategy according to plan may require policy changes, either in the public or private sector. For example, perhaps the local government has never before allowed mention of prescription contraceptives on television, or perhaps a privately owned radio station is reluctant to allow programming that includes references to STDs. To change such obstacles may require various advocacy tactics at the highest levels. Roles may include individuals with appropriate influence serving on an advisory board or coordinating committee that oversees the communication effort. This approach will ensure that a management mechanism is in place to deal with policy obstacles.

For Research, Monitoring, and Evaluation. If there is a research component in the strategy or if there are plans for monitoring and evaluation, several options exist for choosing who will carry out the research. Although expertise may exist within the lead organization, staff members are often committed to other responsibilities and may not be able to get information as quickly as required. Chapter 8 contains several suggestions for identifying research firms and provides additional information on this topic. Once the research partners are selected, make sure that they have all of the background information they need and that they have a chance to meet with all partners.

For Advertising. An in-house group rarely has the skills and experience to develop and implement a comprehensive communication campaign that includes creative materials development, production, media buying, and other advertising agency functions. Experience has demonstrated the advantage—almost always—of having the lead organization select and contract with an advertising agency to carry out this work (Greenberg, Williams, Yonkler, Saffitz, & Rimon II, 1996).

For Media Placement. The advertising agency will typically take care of buying media time and ensuring that messages are delivered according to the media plan. If the advertising agency is unable to provide this service, you may have to engage an individual or company whose specialty is media buying.

For PR. PR is another area that the advertising agency may or may not be able to manage. Depending on the country, the scope of the communication strategy, and the level of PR expertise within the country, you may find it worthwhile to engage a PR agency or consultant to help implement the strategy. PR staff work with high-level decision-makers at the lead organization and other collaborating agencies to train these individuals as spokespersons and to prepare them in the event that the program comes under criticism. This type of work requires strategic management decisions and close collaboration with other partner agencies.

For Community-Based Activities. Although a communication strategy may not necessitate working with community-based groups to ensure smooth implementation, engaging the services of a grassroots organization can sometimes be helpful in disseminating messages to the intended audience. In other instances, the program may benefit by enlisting support from women's groups, health groups, or local opinion leaders. Identify the community-based activities that are key to the strategy, and then decide whether it is appropriate to forge a collaborative partnership with community members or whether it is preferable to subcontract to one or more organizations for this purpose. See the resource book titled *How to Mobilize Communities for Health and Social Change,* published by JHU/PCS in collaboration with Save the Children, for ideas about how to work with communities.

For Training. Identify any areas where gaps in skill or knowledge might prevent the management team from achieving the objectives of the strategy. For example, if the strategy includes developing a campaign to promote clinic use, the plan may need to provide for the training of clinic workers to increase their counseling skills prior to launching the campaign. Decide which training needs are most critical and whether you can justify the costs of meeting those needs in light of the overall budget.

Example

The HEART Campaign in Zambia is managed by a Design Team consisting of about 10 different people representing different organizations. Given the focus in this campaign on promoting safer sex among young people, HEART is guided by a Youth Advisory Group (YAG), which is comprised of 35 young people from 15 youth-serving organizations around the country. The YAG developed the behavior change objectives and message points for each audience segment. Strong linkages were developed among all of the partners in the campaign. These partnerships proved to be critical when controversy arose and the television spots were pulled off the air. The youth representatives were able to come together quickly and present a united front in expressing their objection to the cessation of the television spots. This spontaneous and unified response on the part of the young people enabled the Design Team to effectively negotiate for the reintroduction of the campaign, which occurred within 2 months of the ads being stopped.

step 2 of 6
Management Plan

Step 2
Defining the Roles and Responsibilities of Each Partner

Once the lead organization and collaborating partners have been identified, the next step is to delineate respective roles and functions to ensure successful implementation of the program. As these roles are determined, try to establish ways of working that will benefit the partner organizations as well as support the communication strategy. For example, a group of health professionals may be willing to advocate for government support of the strategy because that will help them forge closer ties with host country officials. Partner organizations must derive a benefit from participating in the strategy; otherwise, they are unlikely to collaborate.

Use worksheet 7.1 to help you map out how the participating groups will work together.

Example 7.1: Identify Key Functional Areas and Skills Required Worksheet

Example: Country X

Functional Areas	Skills Required	Who Has These Skills?
Research	Qualitative, evaluation	Lead organization, several private companies
Policy	Relationship with high government representatives	Former Minister of Health
Advertising/PR	Creative, spokesperson training	Several private agencies
Community-based activities	Local advocacy	Women's cooperative
Training	Clinic-based counseling skills, IPC	Family Planning Association (FPA)

Worksheet 7.1: Identify Key Functional Areas and Skills Required

Functional Areas	Skills Required	Who Has These Skills?

step 3 of 6
Management Plan

Step 3
Outlining How the Partners Will Work Together

Write a brief memorandum of understanding (MOU) for all parties to sign outlining how day-to-day management will be handled. Summarize who the players are, what their functional roles will be, and how they will coordinate their activities. To get started, answer the following questions:

- Will there be an advisory body consisting of the collaborating partners?
- Will the advisory body meet on a regular basis?
- What decisionmaking authority will the advisory body have?
- Will the lead organization handle day-to-day coordination and provide the collaborating partners with regular written updates of activities?

Many different ways of managing and coordinating exist, and it is important to select a set of tools that makes sense for all of the partners involved. For example, if the partners are not located in the same geographic area, you may find it more practical to rely more on telephone calls and written reports than face-to-face meetings. Keep the management guidelines simple, and revisit them regularly to see if you need to change them.

For examples of how to delineate roles and responsibilities, see the sample management descriptions for the Ghana Long-Term Family Planning Methods IEC Campaign and the regional West Africa project known as SFPS at the end of this chapter.

Step 4
Developing a Timeline for Implementing the Strategy

step 4 of 6
Management Plan

If the communication strategy is to be implemented in phases, establish a timeline that shows when the major activities of each phase will take place and where the key decision points are. Since communication efforts are usually tied to service delivery, training, and other areas, it is important to create a timetable with appropriate linkages to these other functions.

Several commercial software programs designed to aid in project management decisions are available, or it may be sufficient to use a simple grid format on a piece of paper. The focus should remain strategic—that is, identify only the major milestones at this point. A detailed management implementation plan should follow later.

Use the timeline as a guide to ensure that implementation activities stay on track. Make adjustments as needed, and be sure to communicate the status of activities to all relevant partner organizations.

To help develop your timeline, review worksheet example 7.2, and then complete worksheet 7.2.

Example 7.2: Timeline Worksheet

Example: Country X Phase 1 Timeline ~~as~~ of January 1, 2003

Task	Who Is Responsible?	By When?
Establish advisory body.	Lead organization.	3/1/2003
Identify audience(s).	Lead organization.	3/15/2003
Conduct a quarterly meeting of advisory body.	Lead organization plans; others participate.	3/31/2003
Conduct formative research.	Research firm.	4/30/2003
Set behavior change objectives with indicators.	Lead organization, with input from partners.	4/30/2003
Select advertising agency.	Lead organization, with input from partners.	5/15/2003
Decide on strategic approach.	Lead organization, with input from partners.	6/15/2003
Conduct quarterly meeting of the advisory body.	Lead organization plans; others participate.	6/30/2003
Develop a creative brief.	Lead organization, with input from partners.	7/15/2003
Identify and prepare spokespersons.	Lead organization, with PR experts.	7/03–10/03
Decide on communication channels.	Advertising agency with input from lead organization.	7/31/2003
Develop and test concepts.	Advertising agency, research firm.	8/31/2003
Develop and test messages.	Advertising agency, research firm.	9/30/2003
Conduct quarterly meeting of advisory body.	Lead organization plans; others participate.	9/30/2003
Finalize and produce communication materials (mass media and community-based activities).	Advertising agency, with input from lead organization.	10/31/2003
Launch communication strategy in three pilot areas.	Advertising agency, lead organization, others.	11/2003
Conduct quarterly meeting of advisory body.	Lead organization plans; others participate.	12/2003
Monitor pilot implementation.	Lead organization, research firm.	11/03–1/04
Decide phase 2 activities.	Lead organization, advisory body.	1/2004

Worksheet 7.2: Timeline

Task	Who Is Responsible?	By When?

step 5 of 6
Management Plan

Step 5
Developing a Budget

Developing a budget ensures that you have available the financial resources that you need to carry out your communication strategy in all its parts. Although the strategy team may use several different approaches for developing a budget, one of two situations usually prevails and will drive the process:

- The amount of funding is fixed, and the strategy team must allocate these funds across all activities for a finite time period and must justify these allocations.
- The team conducts an analysis of the situation, identifies the intended audiences, sets objectives, and then obtains funding commitments from one or more sources to continue designing the communication strategy and to implement it. In this instance, opportunities for leveraging funds from other organizations or programs are usually also explored.

To estimate the actual amount of funding needed for each category in the budget, you should research comparable costs in your country and obtain quotations from contractors for services, such as research and advertising. Review worksheet example 7.3, and complete worksheet 7.3 to guide you and your team in developing your budget.

Example 7.3: Budget Worksheet

Example: Country X

This example provides an illustrative Year 1 budget (January through December). As such, there is no funding allocated for evaluation. The media launch is projected for November of Year 1.

Labor and Direct Costs	Estimated Cost (Year 1) U.S. $ (Use the appropriate currency.)
ADMINISTRATION	
Project manager	40,000
Program officers (2)	25,000
Support staff	15,000
Advisory council meetings (time and travel costs)	10,000
Conference calls	1,000
Mailing costs	1,000
Meeting materials	1,000
RESEARCH and EVALUATION	
Formative (qualitative and quantitative)	50,000
Evaluative (usually quantitative)	
ADVERTISING	
Creative development (mass media and other media)	50,000
Media buying	30,000 (November–December)
PR	
Spokesperson training Other services (e.g., press kits, press events)	10,000
COMMUNITY-BASED ACTIVITIES	
Entertainment education activities, advocacy events	10,000
TRAINING	
Workshops	
Study tours	5,000
Total Estimated Cost	248,000

Worksheet 7.3: Budget

Labor and Direct Costs	Estimated Cost (Year 1) (Use the appropriate currency)
ADMINISTRATION	
Project manager	
Program officer	
Support staff	
Advisory council meetings (time and travel costs)	
Conference calls	
Mailing costs	
Meeting materials	
RESEARCH and EVALUATION	
Formative (qualitative and quantitative)	
Evaluative (usually quantitative)	
ADVERTISING	
Creative development (mass media and other media)	
Media buying	
PR	
Spokesperson training Other services, e.g., press kits, press events	
COMMUNITY-BASED ACTIVITIES	
Entertainment education, advocacy events	
TRAINING	
Workshops	
Study tours	
Total Estimated Cost	

Step 6
Planning To Monitor Activities

step 6 of 6
Management Plan

Monitoring is an important, but often overlooked, function in strategy execution. A good management plan contains a clear process for tracking the implementation of campaign activities. For example, how will you know if clinic materials, such as handouts, are in all of the appropriate places and are being distributed to the intended audience? How will you determine whether community events have occurred according to the strategy? Who will track the advertising to make sure that it is aired or published on schedule? Who will be responsible for ensuring a continuous supply of campaign materials? Who will collect client service statistics?

You and your team will want to avoid situations such as the one in which a large number of posters were printed and then were stored indefinitely in a warehouse because no instructions had been given to the health clinics about why the materials were important and how the clinics should use them.

You and your team should plan to monitor such activities. Decide what organization will be responsible for each activity. For example, your advertising agency will likely conduct media tracking; the lead organization or one or more collaborating partners may perform other monitoring tasks.

Example

In Zambia, phase 2 television spots for the HEART Campaign were not aired in adherence to the media plan, which resulted in television spots discussing condom use among young people being shown during the news hour when families typically watch television together. Incorrect broadcasting of the spots contributed to an already sensitive environment in which certain Government, religious, and community leaders had expressed concerns about the appropriateness of mass media messages directed at young people that dealt with sex and condom use.

Conclusion

A good management plan includes a clear description of the roles and responsibilities of the partners involved, a realistic timeline, a feasible budget, and a description of monitoring tasks. It takes strong leadership, organizational skills, and collaboration to work in a team environment that builds local capacity and generates effective communication strategies.

When developing a practical management plan, remember these guidelines:

- Keep management tasks simple. Refer to the strategy's behavior change objectives, and ensure that management activities support these objectives. Stop doing what does not need to be done, and focus on getting results.
- Empower people by offering effective leadership, training and retraining of staff, and job aids or tools to help staff do their jobs well.
- Improve the organizational climate by setting forth clear plans, strengthening the commitment to excellence, and building capacity through structural and systems improvement.
- Monitor progress, make changes when necessary, and provide feedback in a timely manner to those who need it.

Use worksheet 7.4 to summarize who will be involved, what roles each partner will play, the timeline, estimated budget, and monitoring functions. Next, read chapter 8 to understand the key issues in planning for evaluation.

Example 7.4: Summary of Management Plan Considerations Worksheet

Example: Country X

Questions	Answers	
1. The lead organization is:	Community-based NGO	
The lead organization is responsible for:	Management coordination, communication i.e., liaison with partners, stay on schedule and within budget, management of subcontracts, Advisory meetings, technical input on all aspects of strategy development and implementation	
2. The collaborating partners are:	MOH, FPA, local university, advertising agency, PR company, strategic communication firm, women's cooperative, and medical association	
The collaborating partners are responsible for:	MOH—provides policy and program guidance FPA—provides service delivery and community activities University—provides research Advertising Agency—provides creative materials PR Company—provides spokesperson training and press kits Strategic Communication Firm—provides technical guidance on all aspects of health communication strategy Women's Cooperative—provides community activities Medical Association—provides service delivery	
3. The strategy will be implemented over the following time period and will include the following milestones:	Phase 1: March 2003 Through December 2003	
	1. Design of Strategic Approach 2. Development and Production of Creative Materials 3. Plan for Tracking Studies	
4. The total estimated cost for the time period is:	Time Period	U.S. $ (Use the appropriate currency.)
	Year 1: 2003	248,000
5. Activities will be monitored in the following ways:	Audience research (Year 1) Media tracking studies (Year 2)	

Example 7.4: Summary of Management Plan Considerations Worksheet

Example: Uganda

Questions	Answers	
1. The lead organization is:	DISH	
The lead organization is responsible for:	Funding, providing technical assistance, monitoring, implementation, and preparing media materials	
2. The collaborating partners are:	District Health Services, NGOs, MOH	
The collaborating partners are responsible for:	Training CHW, organizing doctor/nurse teams for outreach, and ensuring good quality services	
3. The strategy will be implemented over the following time period and will include the following milestones:	August 2001–September 2001 June 2001: All outreach facilities selected. July 2001: CHWs selected and trained. August 2001: Print and radio materials distributed, and outreach began.	
4. The total estimated cost for the time period is:	Time Period	U.S. $ (Use the appropriate currency.)
		100,000
5. Activities will be monitored in the following ways:	Service statistics from sentinel sites Media monitoring Omnibus tracking survey	

Worksheet 7.4: Summary of Management Plan Considerations

Questions	Answers	
1. The lead organization is:		
The lead organization is responsible for:		
2. The collaborating partners are:		
The collaborating partners are responsible for:		
3. The strategy will be implemented over the following time period and will include the following milestones:		
4. The total estimated cost for the time period is:	Time Period	U.S. $ (Use the appropriate currency.)
5. Activities will be monitored in the following ways:		

Sample Management Plans

The following descriptions of management roles and responsibilities use different formats, yet they are each valid ways to depict how specific tasks will be managed. As with all components of a good strategic communication strategy, there are different approaches that can be used, and strategic designers should use their creativity, technical skills, and cultural sensitivity to ensure that the management plan developed is appropriate for the situation.

Sample Management Plan I
Ghana's Long-Term FP Methods IEC Strategy

Background: A workshop held in Achimota, Ghana, in May 1996, brought all of the stakeholders together for the purpose of developing a national communication strategy to encourage the use of long-term FP methods. The lead organization was the MOH of Ghana. Collaborating agencies were:

- National Population Council (NPC)
- Planned Parenthood Association of Ghana (PPAG)
- Ghana Registered Midwives Association (GRMA)
- Ghana Social Marketing Foundation (GSMF)
- Lintas Advertising
- Cooperating agencies (CAs), such as JHU/PCS and Engender Health, formerly known as the AVSC
- USAID
- Religious organizations

Project Implementation: Workshop participants decided to set up a coordinating committee of key organizations: MOH, AVSC, JHU/PCS, NPC, PPAG, GRMA, and GSMF. In addition, they issued a request for proposals from advertising agencies to develop creative materials and handle media placement. Lintas won the contract.

(Yonkler, 1997)

Sample Management Plan I (Continued)

The coordinating committee approved materials developed by Lintas and coordinated regional launches in 5 of the country's 10 regions. Each organization had responsibility for a specific aspect of the strategy: AVSC trained providers, MOH contracted with the ad agency and was the main liaison, NPC coordinated the regional launches, PPAG trained local drama groups to provide entertainment education programs, GRMA trained midwives, and GSMF disseminated brochures and posters.

Campaign Roles of Each Coordinating Committee Member

- **MOH/Health Education Unit (HEU)**

  - Serves as the contact point for Lintas Advertising.
  - Provides liaison with Lintas and the IEC Campaign Committee.
  - Issues request for services (RFS).
  - Approves budgets and tracks payments.
  - Monitors timetables to ensure that work is on schedule.
  - Provides input to Lintas and assists Lintas in getting input from other committee members.
  - Helps set up meetings between Lintas and the IEC Campaign Committee.
  - Assists with the regional incentive campaign.
  - Participates on the training subcommittee.
  - Distributes client materials and provider materials to public health facilities.

- **Lintas**

  - Develops, designs, and produces print materials, such as posters, client leaflets, question-and-answer brochures, press kits, campaign slogans, and regional campaign kits; radio spots and four to six radio programs for regional use; PR services, such as assistance with launch events and media training for key spokespeople; and other creative materials.
  - Submits status reports, budgets, and conference reports in a prompt fashion.
  - Makes MOH/HEU aware of adjustments in schedules and budgets.
  - Prepares cost estimates.
  - Obtains competitive bids for production activities.

- Documents and completes invoices.
- Develops media schedules, when appropriate.
- Recommends radio stations, timing, number of spots, costs, and rationale.
- Trains journalists, correspondents, and other media personnel.

- **Engender Health (formerly AVSC)**

  - Furnishes input on provider training, provider sites, and expert lists; updates committee and agency on sites.
  - Participates on the training subcommittee.
  - Serves as one of the key informants for Lintas creative staff in developing question-and-answer brochures.
  - Trains and works with satisfied clients—several from each region—to appear on radio and television shows, hold press interviews, and participate in community activities.
  - Helps with regional launch events.

- **PPAG**

  - Helps with community mobilization efforts
  - Manages small grants programs with local drama groups.
  - Provides training in IEC counseling.
  - Participates on the training subcommittee.
  - Refers clients to service sites when appropriate.
  - Assists with the distribution of print materials.

- **NPC**

  - Coordinates regional campaigns.
  - Sets up meetings with regions.
  - Assists in providing input on provider training; updates committee and agency on latest activities.
  - Serves as one of the key informants for Lintas in developing question-and-answer brochures.
  - Helps with regional launch events.
  - Helps coordinate the training of media personnel.

Sample Management Plan I (Continued)

- Serves as the resource for regional activities, collects materials from each region, and serves as the liaison between agency and regional committees.
- Assists with the regional incentive campaign
- Coordinates training and counseling materials.
- Coordinates the activities of the training subcommittee.
- Assists MOH/HEU with the day-to-day management and scheduling of ad agency materials development.

- **GSMF**

  - Distributes posters and client leaflets to pharmacies, hairdressers, barber shops, and other retail outlets, either through merchandise runs or through sales representatives in four regions (Greater Accra, Eastern Region, Central Region, and Western Region); uses another form of distribution in Ashanti Region.
  - Assists with launch event funds.
  - Assists MOH/HEU as needed with the creative and media development process.
  - Refers clients to service sites.

- **JHU/PCS**

  - Guides the coordinating committee and ensures adherence to the strategy.

- **GRMA**

  - Assists with the distribution of print materials.
  - Refers clients to service sites.
  - Participates on the training subcommittee.

- **MOH/MCH-FP**

  - Participates on training subcommittee.
  - Assists MOH/HEU with resource mobilization.
  - Refers clients to service sites.
  - Coordinates and disseminates the list of service provider sites to other organizations.

Sample Management Plan II
Management Approach for the SFPS Project

Background: Declining resources forced USAID to close nearly half of its bilateral missions in West and Central Africa (WCA). At the same time, health officials recognized that major public health problems in the region were common to the region and transnational in nature. Efforts to address some of the most pressing health concerns in WCA were no longer effective when carried out only through isolated country programs. Programs could be more cost-effective when implemented on a regional basis.

In 1995, USAID authorized a Family Health and AIDS program in West and Central Africa (FHA–WCA). With an 8-year timeline, FHA–WCA is responsible for achieving regional impact on FP, HIV/AIDS prevention, and child survival through a combination of country-level and regional programming.

The main implementing program of FHA–WCA is the SFPS project. This project does not use the traditional model of prime contractor with subcontractors but rather an innovative procurement and management approach that created equal partners who share responsibility for program management, coordination, and implementation. SFPS consists of five separate cooperative agreements between USAID and five U.S. private voluntary organizations: JHU/CCP, Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), Population Services International (PSI), Tulane University, and most recently Family Health International (FHI). JHU/CCP works in the area of behavior change communication. JHPIEGO specializes in service delivery, training, and finance and administration. PSI is a social marketing organization that sells health products through the private sector. Tulane's role is to conduct operations research and to monitor and evaluate activities. FHI provides support in the area of HIV/AIDS.

Project Implementation: The cornerstone of collaboration between the project's partners is its Unified Management Team (UMT), which consists of professional staff members from each partner agency and is based in Côte d'Ivoire. Team

(Shereikis & Wyss, 2000)

Sample Management Plan II (Continued)

members meet regularly to ensure that the various activities are in harmony with the objectives defined in the results package and the overall vision for SFPS. All of the partners work together to prepare the annual work plan, and each organization is responsible for preparing its own budget.

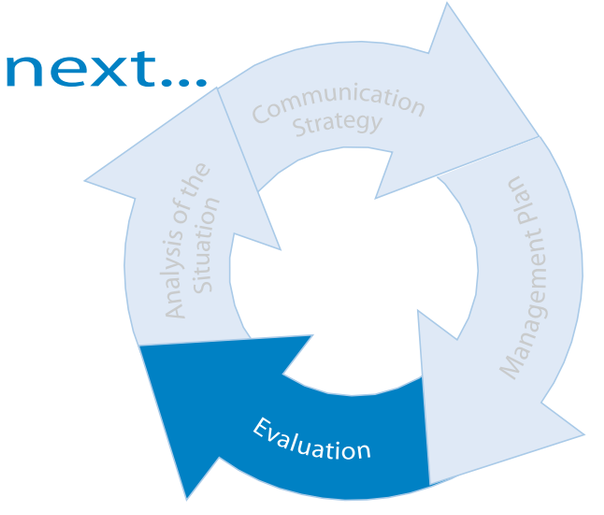
The core UMT consists of the Chiefs of Party (COPs) from each of the collaborating agencies. A MOU provides details regarding how the team approaches issues, such as deciding on program priorities, coordinating component activities, and developing work plans. The MOU specifies that, to help facilitate consensus building, to promote collaboration, and to coordinate program activities across organization lines, the JHPIEGO COP will serve as the team leader (TL). The MOU includes specific directions regarding how the consensus decisionmaking process shall work. Similarly, communication systems and procedures are outlined in the MOU, and provisions are included for collaborating with other donor agencies.

Decisions typically requiring consensus among UMT members include any decisions with funding implications for individual CAs, initiatives outside the work plan, revision of project strategies or the results package, and decisions with political or corporate implications. All decisions are resolved within the UMT without requiring outside mediation. This attests to the strong collaborative spirit of the UMT, which has ensured close collaboration among CAs without compromising clinical and behavior change communication expertise.

The UMT is supported by three collateral units that enhance the project's operational coherence:

- *Leadership Unit*—This unit has a TL responsible for articulating and keeping up the program vision, coordinating program activities, and facilitating consensus building.
- *Finance and Administration Unit*—This unit is responsible for budgeting and disbursement of joint operational costs in the Abidjan office and the four country offices.
- *Monitoring and Evaluation Unit*—This unit has a regional monitoring and evaluation coordinator who works closely with each country office, program information manager to monitor and assess the progress and performance of SFPS.

SFPS uses a performance-based management approach tied to a results framework for its main project areas: FP, child survival, HIV/AIDS, and capacity building. For each result, intermediate results and indicators are set. Performance is assessed and reported semiannually to USAID. A consistent project-reporting mechanism and review schedule help the team to focus on project objectives and keep track of progress. Every quarter, progress on activities is reported to USAID against milestones preset in the project work plan for each component.



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Chapter 8
Evaluation Plan

By the end of this chapter, the reader will understand the importance of evaluation for strategic health communication programs and the key elements of monitoring and impact assessment by completing the following steps:

Step 1: **Identifying the Scope and Type of Evaluation**

Step 2: **Planning for Monitoring and Impact Assessment**

Step 3: **Identifying the Evaluation Design and Sources of Data**

Step 4: **Tailoring the Evaluation to the Specific Situation**

Step 5: **Deciding Who Will Conduct the Evaluation**

Step 6: **Planning To Document and Disseminate Evaluation Results**

8

Overview

When conceptualizing a design for a new school, your friend the architect must think ahead to how the teachers, students, and staff will actually use the school. At every stage of the planning and execution of the building process, he and his team must consider the impact of the school design on the ability of the users to maximize its utility.

Similarly, evaluation plays a key role in a communication strategy because without it no one can judge whether the strategy was either applied or effective. Planning for evaluation occurs from the very beginning of the strategy design process. Ideally, an evaluation plan is generated in participatory fashion with input from various stakeholders, such as program staff, community groups, research experts, and donor organizations. The communication specialist does not need to be an expert in research methodology but does need to play an active role in developing the evaluation plan to ensure that it focuses on the appropriate communication issues.

Step 1
Identifing the Scope and Type of Evaluation

step 1 of 6
Evaluation Plan

Determining the appropriate scope and type of evaluation that is both needed and possible is a key element in strategic design. At the basic level, evaluation serves the purposes of:

- Finding out whether the implementation activities spelled out in the work plan were actually carried out (process evaluation or monitoring)
- Determining whether the objectives set forth in the strategy (see chapter 3) were achieved (impact assessment).

Evaluation, like research, must be addressed at the beginning of any strategic communication project. The initial definition of strategic communication objectives guides every stage of evaluation. Thus, an objective of changing individual behavior requires an evaluation that will measure individual behavior over time; a policy objective of passing specific legislation will require a means to determine whether or what part of that legislation became law; and an objective of stimulating community activism will require from the start measures or indicators of community activism.

The evaluation design must focus on the intended unit of analysis as well as expected changes. Therefore, those who carry out the evaluation should ideally participate in helping to set SMART objectives in such a way that those objectives and the process of achieving them can be accurately and precisely measured throughout the project.

At a more complex and strategic level, evaluation should also:

- Assess the adequacy of the strategy selected
- Highlight areas of high and low impact
- Identify not only individual or community behavior change, but also measure population-based health and social outcomes, such as birth and death rates, education levels, and voting registration

TIPS for an Effective Evaluation Design:

1. **Evaluation must be introduced, understood, and planned from the start of a program and must be based on the program objectives. It cannot be a last minute addition. To measure change, it is essential to have baseline data before an intervention takes place as well as postinterventiondata.**

2. **Program evaluators need to assist program personnel in articulating objectives in measurable terms consistent with behavior change theory and in using research methodologies that are practical and appropriate to the situation.**

3. **Evaluations should avoid overly sweeping claims of impact from pre- and postdata alone. Cross-sectional data can document correlation between variables but not causality.**

4. **The use of different types of data and more extensive analysis can strengthen the probability that a specific communication intervention caused a measurable change in behavior or contributed an identifiable amount to the change.**

- Highlight ways to improve the program
- Measure cost-effectiveness per person reached or per any measure of behavior change

Without a documented evaluation, policymakers, program planners, funders, and participants will not know what happened, why, when, or with what effect. Within a few years, for all practical purposes, a program that is not evaluated will not have existed.

The following chart summarizes the ways that evaluation can be used in public health programs.

Selected Uses for Evaluation in Public Health Practice by Category of Purpose

Gain Insight

- Assess needs, desires, and assets of community members.
- Identify barriers and facilitators to service use.
- Learn how to describe and measure program activities and effects.

Change Practice

- Refine plans for introducing a new service.
- Characterize the extent to which intervention plans were implemented.
- Improve the content of educational materials.
- Enhance the program's cultural competence.
- Verify that participants' rights are protected.
- Set priorities for staff training.
- Make midcourse adjustments to improve patient/client flow.
- Improve the clarity of health communication messages.
- Determine whether customer satisfaction rates can be improved.
- Mobilize community support for the program.

Selected Uses for Evaluation in Public Health Practice by Category of Purpose (continued)

Assess Effects

- Assess skills development by program participants.
- Compare changes in provider behavior over time.
- Compare costs with benefits.
- Find out which participants do well in the program.
- Decide where to allocate new resources.
- Document the level of success in accomplishing objectives.
- Demonstrate that accountability requirements are fulfilled.
- Aggregate information from several evaluations to estimate outcome effects for similar kinds of programs.
- Gather success stories.

Affect Participants

- Reinforce intervention messages.
- Stimulate dialogue, and raise awareness regarding health issues.
- Broaden consensus among coalition members regarding program goals.
- Teach evaluation skills to staff and other stakeholders.
- Support organizational change and development.

(Centers for Disease Control and Prevention, 1999)

Step 2
Planning for Monitoring and Impact Assessment

Chronologically, once objectives have been established, evaluation must address:

- First, monitoring of program activities and outputs
- Second, impact assessment

Each of these types of evaluation requires different action and skills.

Monitoring

Monitoring requires attention to process, performance, and, to a lesser extent, outcomes:

- **Process monitoring—**Here evaluators must measure whether activities occurred with the planned frequency, with the planned intensity, with the appropriate timing, and as directed to reach the intended audience. Ideally, monitoring begins at the start of the program activities and continues throughout the length of a program or campaign. Retrospective monitoring is less reliable than ongoing monitoring.

- **Performance monitoring**—The quality, quantity, and distribution of communication outputs must be closely followed. For example, were the expected number of posters printed and distributed to the designated locations? Were the expected number of health care providers or others trained in the proper use of communication materials? Did all members of the management and communication team carry out their functions as planned? Were the quality and volume of the outputs, whether posters, serial dramas, or community events, at the expected and desired levels? In what ways did the performance of the management team meet expectations and work plan requirements? These measures of both process and performance monitoring should be as specific and as quantitative as possible, since it would be impossible to determine the success of the strategy if, in fact, it was not carried out as planned.

- **Outcome monitoring**—Here the evaluation focus shifts from activities and actions back toward original objectives. If the objectives were increased attendance at certain specific clinics, increased purchase of certain products, or increases/decreases in a specified behavior, such as partner reduction or condom use, to what extent did these changes take place? During the monitoring process, extensive surveys may not be possible, but onsite observation and interviews are important to ensure that expected outcomes are beginning to take place. Unintended outcomes, different from those identified as original program objectives, would immediately call for close attention, feedback to program directors, and, if necessary, changes in either implementation or strategy.

In short, monitoring is essential to be sure that the program is being carried out as planned and that no unintended, unforeseen, or unexpected events or shifts are taking place. Whether the planned activities are in fact responsible for producing whatever changes may be observed (for example, the question of causality) usually cannot be determined at this stage during the progress of a campaign.

Impact Assessment

More difficult, but essential for any large-scale communication strategy, is some form of impact assessment. Impact assessment seeks to answer the question "Did the communication strategy achieve the specified objectives?" Impact assessment then goes on to look at the difference that the strategy made in the overall program environment.

Indicators

As discussed in chapter 3, the first step in impact evaluation is to determine the indicators you will use to determine whether your objectives have been achieved. Examples of individual-level indicators for the behavior change communication strategies include (Bertrand & Escudero, 2002):

- Percent of audience with a specific attitude (toward a product, practice, or service)
- Percent of audience who believe that their spouses, friends, relatives, and community approve (or disapprove) of a product, practice, or service
- Percent of non-users who intend to adopt a certain practice in the future
- Percent of audience who are confident that they can adopt a particular behavior

At a broader social level, the indicators listed below can be used to measure social change. Some of these indicators are measured qualitatively and others are more appropriately measured through quantitative techniques:

Indicators of Social Change

- Leadership
- Degree and equity of participation
- Information equity
- Collective self-efficacy
- Sense of ownership
- Social cohesion
- Social norms

For detailed explanations of these terms and for guidance on how these indicators can be used within an integrated model of communication for social change, see (Figueroa, Kincaid, Rani, & Lewis, 2002).

A key issue in impact assessment is the research design or plan for the evaluation, which must be determined early in the project. Traditionally and particularly in biomedical research, the so-called Gold Standard for impact assessments is an experimental design in which individuals or communities are randomly assigned to be involved or not to be involved in a specific intervention. After the intervention is complete, the difference between those involved in the intervention and those not involved determines the impact of the project.

Experimental Design

Experimental design is not feasible for many communication programs and certainly is not appropriate for large-scale communication projects. The major problems that arise in applying experimental design to strategic communication are as follows:

- The control group and the experimental group must be the same in all key characteristics that might influence the outcome.
- No differing events or activities, apart from project activities, must take place among either those exposed or those in the control group.
- There must be no contamination or shared activities or information between the control and the experimental group.

Not only is it almost impossible on a large scale to select comparable communities, but also, and even more important in communication projects, it is almost impossible to prevent contamination from one audience to another. Since the goal of an effective communication project is to disseminate information, ideas, and advice, a strong communication project will almost inevitably spread beyond its original boundaries. The only types of strategic communication projects that can be considered for an experimental design are those that relate to facilities that may be widely dispersed geographically or geographic areas that are not close to one another but otherwise similar—both unlikely possibilities. In other words, while experimental design is valuable—and indeed essential—in evaluating the impact of drug treatments on individuals where individuals are randomly assigned and do not know their own status, experimental design is not conceptually appropriate for most strategic communication interventions.

Quasi-Experimental Designs

A substitute for a pure experimental design in some communication projects is a quasi-experimental design in which a randomized selection of control and intervention groups does not take place. Instead, an effort is made to identify both control and intervention areas or units that are as comparable as possible and to limit the strategic communication program to certain areas while measuring changes in both areas. Even in such quasi-experimental designs, problems frequently arise as to the similarity of the controls, differing events in different areas, and, above all, contamination between the two groups. The degree of exposure is a key element of most communication programs, and unlike interventions consisting of specific drug treatments, exposure is determined not by the provider but rather by the reactions of the audience. Therefore, it is clear that exposure to a strategic communication intervention cannot be controlled in the same way in which exposure to a new or experimental medication can be controlled by dispensing physicians. Therefore, even at best, quasi-experimental designs with measurements before and after intervention may not be convincing.

Use of Statistical Analysis To Account for Population Differences and Contamination

Since exposure to strategic communication cannot be managed as accurately as exposure to different medications, various statistical techniques can be used to compensate for differences in control and intervention populations and, to a lesser degree, for contamination, that is, exposure in the control group and nonexposure in the experimental group. Weighting one or another population to be similar can control these differences. Various other forms of analysis can be used after pre- and postdata are collected.

One commonly used technique is bivariate analysis, in which researchers determine whether there is a correlation between two variables by examining the strength and directions of the relationship. For example, in a positive relationship, if the value of one variable increases, so does the value of the second variable. In a negative relationship, as the value of one variable increases, the value of the second variable decreases. However, bivariate analysis does not assume a causal relationship between the two variables.

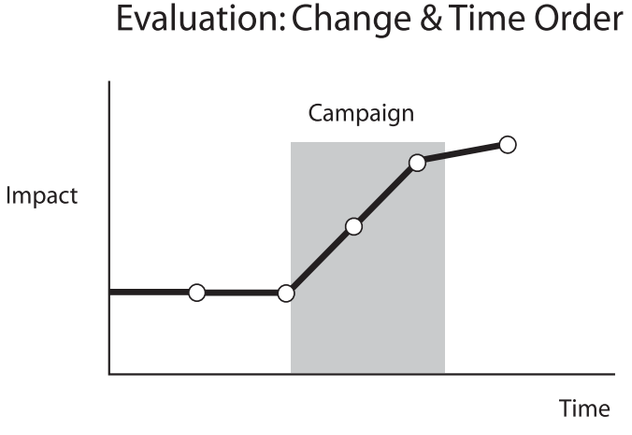
Regression analysis is used when one or more variables are assumed to predict or explain changes in another variable. When multiple variables are used to predict the dependent variable, regression analysis allows the impact of each variable to be evaluated separately, holding all other variables constant. For example, analysis of a communication campaign might determine that audience receptivity to a message (the dependent variable) can be predicted by measuring related variables, such as the believability of the message and media weight.

Establishing a Causal Relationship

In all strategic communication programs and in almost all evaluations of the impact of a communication program, skeptics may question the degree to which communication alone contributed to changing behavior. To strengthen the causal inference that the communication project was indeed responsible for the behavior changes measured, programs should seek to establish eight key points. From the start of the evaluation, therefore, data must be collected relating to each of these points (JHU/CCP, 2001).

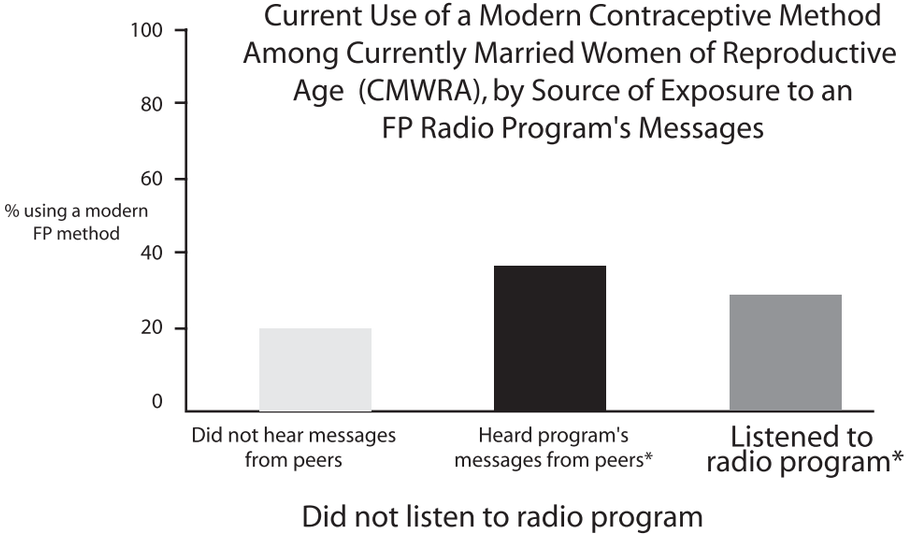
- **Evidence of a change in the desired behavior from time 1 to time 2.** See graph 1, below, for an illustration of a change in behavior that took place after a hypothetical campaign.
- **Evidence that the change occurred during or after the intervention took place.** Graph 1 also indicates that the change clearly occurred after the strategic communication took place. A major issue in evaluating changes in behavior following communication interventions is selectivity bias in the audience. Were those who recalled the material previous users, already predisposed, or self-selected to respond to that issue? This cannot be measured in a single survey that offers only cross-sectional data. However longitudinal surveys, which analyze the same or very similar groups over time and ask about current practice, can identify more clearly which came first: certain knowledge, experience and attitudes, or exposure to the strategic communication.

Graph 1



- **Evidence that greater change occurred among those exposed to the strategic communication campaign than among those not exposed.** A strategic communication program should document from the start how many and what segments of the population were exposed to the communication intervention, so that their behavior change, if any, can be compared with and hopefully will exceed that of those who were not exposed to the campaign. One problem in determining exposure is that exposure may be *direct* by actually seeing, hearing, or participating in a communication intervention, or exposure may be *indirect* through discussions with others who have been directly exposed. In order to include such indirect exposure to campaigns, specific data may be collected on IPC relating to strategic programs as well as, for example, direct viewership of a television serial. Graph 2, below, illustrates the difference in the use of modern contraceptive methods between (1) those directly exposed to a radio program, (2) those who heard the radio messages from peers, and (3) those who did not hear messages from either the radio or their peers.

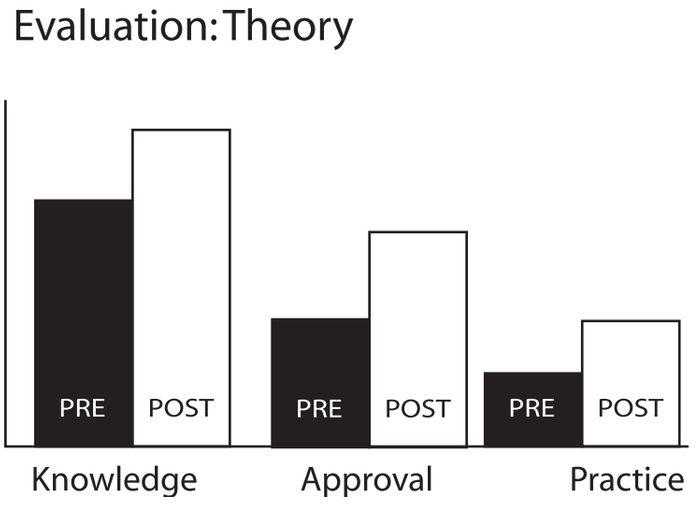
Graph 2



Source: JHU/PCS and Save the Children, 1997
*Significantly different ($p<0.001$) from Did Not Listen/Did Not Hear Group
Did Not Listen/Did Not Hear (n=210); Did Not Listen/Heard from Peers (n=119); Listened to Radio Program (n=338)

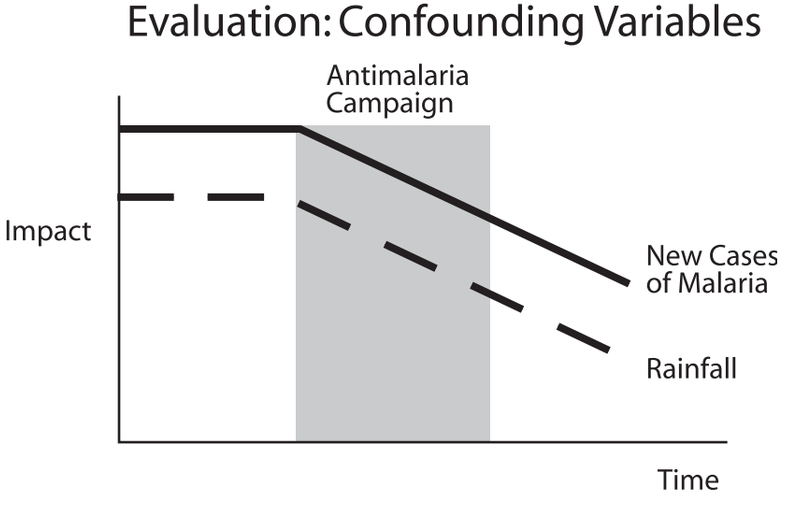
- **Evidence of scientific plausibility.** To strengthen claims that a strategic communication program caused behavior change, it is important to build campaigns upon an appropriate theory of behavior change and to document not only the final results, but also the intermediate or other preliminary steps to such behavior change. For example, if knowledge and approval of a specific practice declined, while at the same time the practice itself seemed to increase, this would cast validity upon the findings. Graph 3, below, illustrates how collecting data on intermediate indicators, based upon a theory of behavior change from knowledge to approval to practice, lends further validity to the inference that a strategic communication program caused the change.

Graph 3



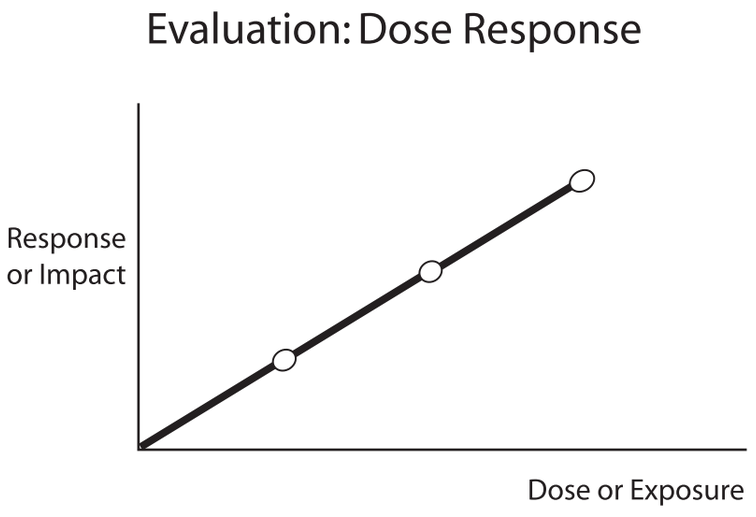
- **Control of confounding variables.** To ensure that any changes observed were the result of the communication intervention rather than some external event, such as opening or closing of facilities, increases or decreases in price, changes in weather, civil disorder, political change, or other factors, it is essential to control to the degree possible for such confounding variables. To control for such variables means to identify those variables at the start, to collect data regarding those variables to the extent possible, and to weigh the final analysis accordingly. Graph 4, below, shows the relationship between new cases of malaria and a decrease in rainfall, given the context of an antimalaria campaign that occurred during the same time period. The graph suggests that reduced rainfall rather than the campaign may be the major cause of the decline in new malaria cases.

Graph 4



- **Evidence of a dose response.** One type of measurement derived from medical and clinical studies that can often strengthen causal inference regarding the impact of communication activities is the use of dose response measurements. It is hypothesized that increased exposure to communication will increase the likelihood of behavior change. Therefore, measurement of exposure should consider exposure not as a "yes" or "no" variable but rather as a cumulative variable in which the extent of exposure, either to different interventions or repeatedly to similar interventions, can be collected and evaluated. Graph 5, below, indicates how a typical dose response effect might operate.

Graph 5



- **Evidence of magnitude and direction of changes.** Clearly the greater the behavior change in the desired direction, the more convincing is the case that the communication intervention was effective.
- **Evidence of replicability.** The final test of causality in scientific experimentation is the ability to replicate results by other investigators and/or in other projects. While this may not always be possible in communication interventions, every effort should be made to repeat interventions and to evaluate to confirm the validity of initial data. To the extent that interventions are designed along similar lines and with comparable research designs, the existence of a number of different studies increases the inference that a specific intervention not only was effective in one setting, but also can be effective in different settings. The ability to predict future results is a key element in causal inference. To the extent that multiple studies confirm a similar result, this replication adds to the validity of the individual studies.

In short, impact analysis in the field of communication will always be controversial and may be questioned by skeptics. For that very reason, it is important that the evaluation of strategic communication programs seeks to document impact and to strengthen causal inference in as many different ways as possible.

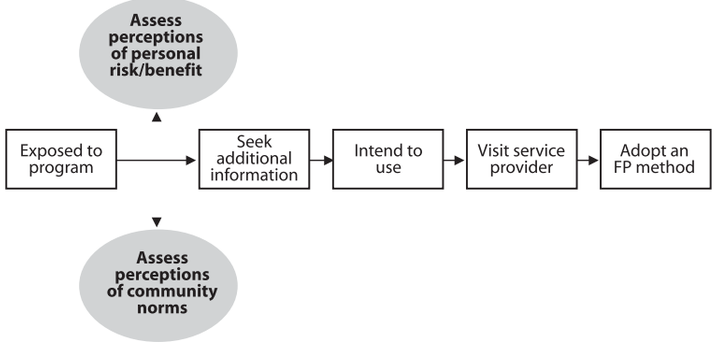
step 3 of 6
Evaluation Plan

Step 3
Identifying the Evaluation Design and Sources of Data

When considering how the evaluation of a communication effort should be designed and which sources of data will be used, it is helpful to keep the conceptual framework to the left in mind.

This framework can be adopted to fit other health behaviors in addition to the adoption of a FP method. The variables in this framework can be analyzed in different ways to measure changes at the individual, program, and outcome levels. It is important to note that the audience's process of weighing the personal risks and benefits of adopting the behavior and the audience's perception of community norms impact an individual's decision whether to pursue the proposed behavior change.

Conceptual Framework for Adoption of an FP Method



Source: The Johns Hopkins University Center for Communication Programs, 2002

Levels of Measurement

The evaluation of strategic communication depends upon the collection of data at different levels relevant to the objectives of the program. The two major levels of measurement for communication evaluation data are:

- Population-based
- Program-based

Population-based measurement is useful in tracking initial, intermediate and long-term outcomes. For example, surveys among the intended audience measure self-reported exposure, knowledge, attitudes, emotions and other factors that are often precursors to behavior change (known as initial outcomes). Surveys can also track changes in behavior or practice over the life of a project (i.e., intermediate outcomes). These intermediate outcomes in turn influence the long-term outcomes related to health status, such as fertility or mortality rates. The following example on Zimbabwe measured both initial and intermediate outcomes. The one from Bolivia also included the long-term outcome of infant mortality.

Example: Promoting Sexual Responsibility Among Young People in Zimbabwe

In 1997–98, a multimedia campaign promoted sexual responsibility among young people in Zimbabwe while strengthening their access to reproductive health services by training providers. Baseline and followup surveys, each involving approximately 1,400 women and men ages 10–24, were conducted in 5 campaign and 2 comparison sites. Logistic regression analyses were conducted to assess exposure to the campaign and to assess its impact on young people's reproductive health knowledge and discussion, safer sexual behaviors, and use of services. The results showed that the campaign reached 97 percent of the youth audience. Awareness of contraceptive methods increased in campaign areas. As a result of the campaign, 80 percent of respondents had discussions about reproductive health—with friends (72 percent), siblings (49 percent), parents (44 percent), teachers (34 percent), or partners (28 percent). In response to the campaign, young people in campaign areas were 2.5 times as likely as those in comparison sites to report saying no to sex, 4.7 times as likely to visit a health center, and 14.0 times as likely to visit a youth center. Contraceptive use at last sex increased significantly in campaign areas (from 56 percent to 67 percent). Launch events, leaflets, and dramas were the most influential campaign components. The more components that respondents were exposed to, the more likely they were to take action in response.

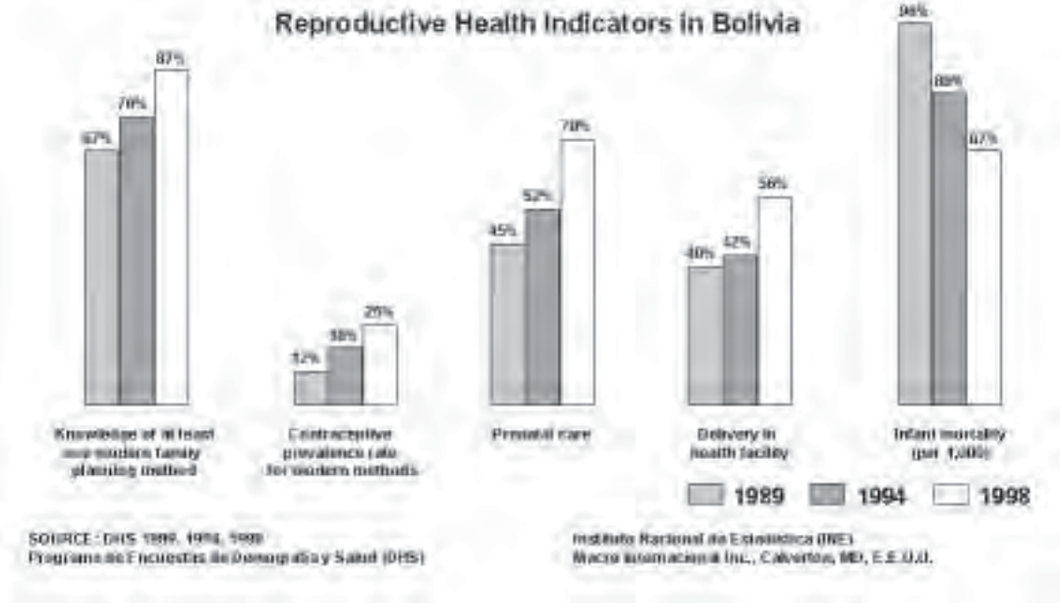
(Kim, Kols, Nyakauru, Marangwanda, & Chibatamoto, 2001)

Example: Bolivia's National Reproductive Health Program

In Bolivia, a series of carefully designed and well-executed reproductive health campaigns contributed significant improvements in the health status of Bolivian mothers and their children. (See appendix 3—Bolivia Case Study.) From 1994 to the present, the National Reproductive Health Program has implemented a strategic communication effort to address specific audience needs using a variety of communication channels. This program has been research-driven, and the key outcome results—an increase in contraception use and a reduction in infant mortality—are noted in graph 6, below.

(The Johns Hopkins University Center for Communication Programs, 1999)

Graph 6



Program-based measurement depends upon the collection of service statistics, sales data, client exit interviews, interviews or observations within clinic or service settings, and possibly a review of organizational and management factors relevant to program performance.

Example: Length of Counseling Sessions and the Amount of Relevant Information Exchanged: A Mystery Client Study in Peruvian Clinics

Time constraints have been implicated in FP providers' inability to offer comprehensive counseling to their clients. It is important for providers to know whether lengthening counseling sessions increases the amount of relevant information imparted to clients. Using the mystery client technique, 28 women were trained to pretend to solicit an effective method and to opt for the injectable contraceptive at 19 clinics in urban areas from a national sample of MOH facilities in Peru. Each clinic was visited on different days by 6 of these "simulated clients," for a total of 114 cases. For each visit, the woman recorded on a 46-item checklist the topics discussed by the provider and estimated the duration of the counseling session. Providers dedicated anywhere from 2–45 minutes to counseling. The amount of information given that was relevant to the client's choice significantly increased, by 43 percent, when the session length went from 2–8 minutes to 9–14 minutes. However, further improvements in the amount of useful information exchanged were trivial and nonsignificant when session lengths extended beyond 14 minutes. At any duration, many pieces of information that should have been exchanged were not exchanged. Offering a wide range of contraceptive options took up most of the consultation time and was highly correlated with session length. Discussion of the chosen method's side effects and screening for contraindications did not vary by session length. The study concluded that counseling sessions longer than 14 minutes confer little advantage in terms of effective counseling for women who choose the injectable. It is important that providers use the available time more efficiently, that they be more practical in assessing clients' needs, and that they avoid providing too much information about irrelevant methods. They should focus on the method chosen by the client and address that specific method in greater depth.

(León, Monge, Zumarán, García, & Ríos, 2001)

Types of Data Needed

In assessing communication programs, it is important to collect different types of data. Since communication affects individuals, groups, and communities, it is important to gather quantitative and qualitative information as well as information relevant to the appropriate unit of analysis.

Consider the following questions when planning for a survey:

1. What geographic areas will be surveyed? This is usually determined by policymakers, donors, and project managers.

2. What individuals, based on demographic or other characteristics, will be surveyed? This will be influenced by the audience and objectives selected in the strategic plan.

3. How many people will be included in the survey to assure the statistical significance of expected results? This usually requires a compromise between academic rigor in achieving the desired power and significance and the available financial, personnel, and time resources.

4. How will random selection of those to be surveyed within a population be achieved? Can existing census frames provide basic population data? What techniques will be used for random selection? This procedure of random selection is actually more important than the number surveyed and requires expert guidance. A useful reference for this purpose is: Sudman, S. (1976). *Applied Sampling*. NY: Academic Press.

5. What will be the content and length of the survey? This is clearly a major question and will also require compromise between the need for data and the practical constraints concerning interviewee time and resources.

6. What will be the number and timing of the surveys? Will surveys be conducted at the beginning and the end of a project or at specified midterm intervals? This question is also closely related to budget resources and to the length of the program.

7. How will the analysis of survey results be conducted? Here the skills of both local and international experts can be blended to achieve the most useful results.

- **Quantitative data**. These data can be derived from surveys, service statistics, or sales data and involve active measures to gather information from individuals, communities, sites, or facilities in sufficient quantity, quality, and relevance for further analysis. None of these are easy to collect or without problems.
  - **Surveys**—The most common form of quantitative data with respect to strategic communication and behavior change is derived from surveys among randomly selected individual respondents. Surveys are a complex, highly specialized form of operational research that require implementation by experts.

- **Service Statistics**—Collection of service statistics may appear as a relatively easy task to be undertaken by visiting various facilities. In practice, however, service statistics have usually proved less satisfactory than surveys conducted by experienced survey researchers. Problems in the use of service statistics include:

  1. Different degrees of accuracy and completeness in maintaining service statistics
  2. Different definitions of terms, such as initiation and continuation, as well as change in practices by different facilities
  3. Illegible or incomprehensible records
  4. Inaccessible records
  5. Gaps in key data

Improvement of service statistics through management information systems is a continuing goal which might simplify the evaluation of some strategic communication programs, but it remains an ideal rather than an actuality in most countries.

- **Sales Data—**Collection of sales data can be an important element, particularly in the evaluation of social marketing programs. Some questions to be answered include:

1. At what point (wholesaler, distributor, retailer) will data be collected?
2. How will price and packaging differences be recorded?
3. How will free promotional materials be distinguished from sales materials?
4. How can substitution effects be taken into account when a lower priced product displaces a higher priced one?

- **Qualitative Evaluation**

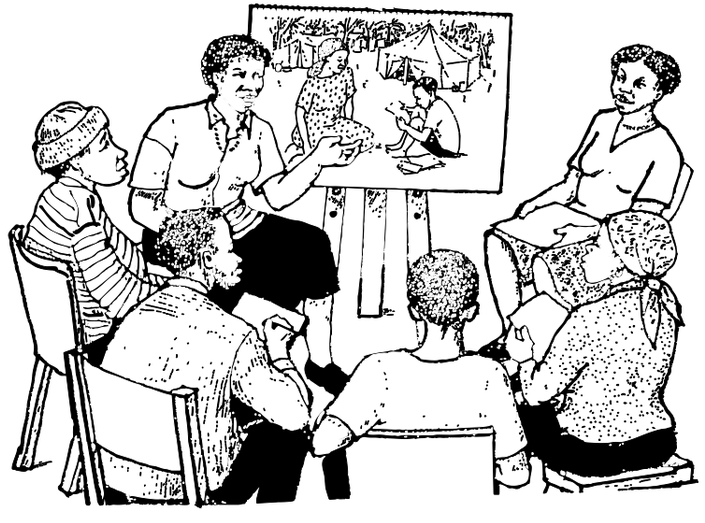
Essential at the start of any project in order to understand the problem, the audience, and the overall situation, qualitative research can also play an important role throughout the project both in monitoring and in evaluating impact. The major roles for qualitative research in program evaluations include:

- Helping to evaluate activities and products as they are disseminated
- Helping to explain how and why impact was achieved

Qualitative evaluation can be subtle, intuitive, and highly revealing when sensitively carried out, using ethnographic and unobtrusive measures.

Key qualitative methods that can be used for evaluation are:

1. **Focus group discussions**—Group discussions among homogeneous individuals led by a trained moderator can reveal community as well as individual values and prejudices, emotional intensity, points of controversy, and customary language used or "audience verbatims."
2. **Interviews**—Interviewers can tease out both information and emotional reactions by interviewing influentials, key informants, or typical audience members. Open-ended questions, followup to responses, and in-depth pursuit of significant issues as gathered through interviews can provide a wealth of valuable qualitative information.



3. **Observation**—Whether in person or through videotapes or even audiotapes, observation can provide an immediate insight into the reaction of an audience or client to specific types of communication or to recommended products and behaviors. Reproductive health programs offer less opportunity for direct observation than childcare and family health programs, but the observation of clinical practices or direct observation of those attending events or performances can provide valuable feedback.
4. **Diaries**—These can be useful in literate societies or among literate professionals to record immediate day-by-day actions and reactions, to monitor ongoing activities, to capture a full history of events, and to understand better a PBC as it actually takes place over time.

- **Combination ~~-~~Quantitative and Qualitative Evaluation**

Evaluations that are both convincing as to causal effects and useful for future programming combine quantitative and qualitative measures. Quantitative evaluations can determine how much change took place and even how much change can be specifically attributed to different communication interventions.

Qualitative evaluation is essential to frame the appropriate questions from which to derive quantitative data, to ensure the correct language so that the audience understands what is being asked, and to measure the intensity of emotions and certainty surrounding particular responses. Qualitative evaluation, above all, seeks to explore **why and how** change has taken place and to provide insights that can be useful in refining and improving future interventions. On the other hand, quantitative evaluation focuses on **how much** change has occurred.

Step 4
Tailoring the Evaluation to the Specific Situation

step 4 of 6
Evaluation Plan

On a theoretical level, the most useful evaluation will be tailored to the specific communication strategy and situation under consideration, which means it will reflect the conceptual behavior change model that was used to design the program initially; it will focus on the intended audience for the specific program; it will measure the extent of exposure to the various different media used in the program (whether radio, television, community meetings, IPC and counseling, or other channels of communication), and it will link findings closely to the objectives, positioning, and implementation of the program.

On a practical level, the design of the evaluation should be consistent with both the scope of the program and the availability of human, financial, and physical resources. A national multimedia program, which is the form taken by many strategic communication programs, calls for national surveys, selected service site statistics, and a combination of appropriate quantitative and qualitative measures from different areas. A small local intervention may benefit from an experimental/control design and may seek unobtrusive program measures rather than surveys to measure its impact. Basically, the scope of the evaluation must be consistent with the availability of budgetary resources. Evaluation costs can range from as little as 10 percent of a project size to, in rare cases, two or three times the size of the original project if research concerns are primary. Such evaluations can be misleading, however, if a weak, less costly intervention is evaluated through a strong research process. Results may often be negative. A general rule is that evaluation should amount to about 20 percent of project costs. Very small projects may justify no evaluation at all, since adequate resources are not available. Large projects justify a larger expenditure for evaluation, since the need for comprehensive feedback is greater.

step 5 of 6
Evaluation Plan

Step 5
Deciding Who Will Conduct the Evaluation

Perennial debates have occurred around the issue of whether evaluation should be performed in-house by researchers closely linked to the program designers or whether evaluation should be independent, carried out by external experts who have had little prior connection and no financial benefit from the program.

Whereas external evaluators lend an aura of authority and objectivity to an evaluation, the extensive knowledge and close connection between program objectives and evaluation designs suggests that evaluators should become intimately familiar not only with the program, but also with the environment and audience. Without working extremely closely with program staff, it is difficult for evaluators to ask the right questions, probe for the right interpretation, and make practical recommendations for project improvement.

Overall, therefore, a collaborative evaluation in which skilled evaluators work closely with program planners and managers but establish their own independent and rigorous scientific standards for measurement is the ideal situation. Moreover, in most countries because of language issues and because of the need to develop local expertise, data collection is carried out under contract by local market researchers or other survey firms. Such firms must recognize the value and integrity of the data, must respect rules for the protection of human subjects, and must carry out initial independent analyses. Their work, however, can be assisted and sometimes guided to a more sophisticated level with the assistance of researchers and evaluators who developed the original research design. Collaboration between implementers and researchers, with each party recognizing the separate and partially independent roles of the other, is the best combination to evaluate a strategic communication program.

Step 6
Planning To Document and Disseminate Evaluation Results

step 6 of 6
Evaluation Plan

The final stage for any evaluation should be a full documentation and report on the results. Evaluators who leave a few tables behind and do not write up or distribute results have not fulfilled their responsibilities. "Results" include insights and lessons learned in addition to data and tables. Since a program that is not evaluated and documented ceases to exist in the public mind after a very short time, this documentation is essential. A good evaluation should be clearly reported to at least three different audiences, each in appropriate ways:

1. **To participants and the public**—Basic data can be shared orally with community leaders, all others involved in the program itself, and the general public. Data can be explained in local media, and brief summaries can be provided to all who worked on the program and, to the extent possible, to those exposed to the intervention.

2. **To donors**—Whether government leaders, international agencies, or private foundations, donors are entitled to an honest and comprehensive report on the impact of projects that they have funded. Even where donors may appear busy and preoccupied, strategic communication programs have an obligation to present results. Presenting results can be done through meetings, to which national and local press are invited; through discussion groups, in which donors can participate; through reports that are released to the press; and through special media events particularly designed to call attention to evaluation results. Reports to donors should be accurate and clear and should give considerable attention to discussing not only the data, but also the implications of the data for future programming and other related activities.

3. **To the professional field**—For professionals in the communication field and in whatever substantive field may be involved, peer-reviewed articles, presentations at professional meetings, book chapters, and even textbooks are essential to document important findings. Results for the professional and/or academic field need to describe in detail both the nature of the strategic communication interventions carried out and the methodologies used to collect and analyze the evaluation data. Where communication strategies suggest new directions or alter previous concepts or understandings, such innovations should be clearly highlighted and well defended. Communication to peers in the field should provide sufficient information, so that others are encouraged and are able to replicate the program wherever circumstances warrant.

Strategic communication calls for strategic evaluation to be considered from the very beginning of the strategy design process. A strategic evaluation not only must include a full and adequate documentation of the process used, the objectives achieved, the impact, and where possible the cost-effectiveness of the program, but also guidelines and recommendations for improvement in future programs.

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Chapter 9
Summary

By the end of this summary, the reader will understand:

- **The importance of staying on strategy.**
- **How to take the 'Strategy Test"for future programs**
- **Why it is so important to ask, 'Why?"**

Staying on Strategy

Congratulations. You have completed the crucial steps for designing a communication strategy. You have:

- Learned how to analyze the health situation, the audience data, and the communication environment, with an eye toward identifying the most important problems for you to address through communication.
- Learned how to segment potential audiences so that you can efficiently and effectively design communication activities to help change behavior.
- Learned the importance of setting SMART objectives.
- Reviewed potential strategic approaches until you have settled on one best suited for achieving these objectives.
- Developed a message brief to help guide creative professionals in designing messages that will be most receptive to audiences while achieving the objectives.
- Identified the most appropriate channels and tools for communicating with the intended audience.
- Created a management plan that maximizes each partner's capability in a coordinated way.
- Planned for evaluation activities to monitor and measure outcomes and to fine-tune future communication efforts.

What you have accomplished so far, however, is not the end of the process. It is just the beginning. Designing the strategy is the second stage of the "P" Process. The subsequent stages involve producing materials, implementing the strategy, working with professional firms, and monitoring the implemented communication effort. Although the actual implementation may not exactly mirror the strategic design detail by detail, the essence of the strategy should always be apparent in all activities and materials. This is called staying on strategy.

Staying on strategy means that when an opportunity arises that seems like a really good idea but may not be geared for the intended audiences, or help achieve the strategic objectives, or contain key benefits for the audience, or add to the long-term identity of the communication plan, then maybe the idea is not as good as it seemed.

This dilemma is common to many communication managers. Many good ideas and opportunities arise, and seizing the moment may often work to the program's advantage. Also, you don't want the strategy to be so rigid that you are unreceptive to any new idea that is not exactly part of the original strategy design. But not all of the opportunities that come your way fit the strategy well. A good measure of whether a new idea is worth pursuing is to give it the Strategy Test.

The Strategy Test

New opportunities and ideas may come to your attention at times during the course of the effort. They can come from an outside source, such as the television producer in the example on this page. They can also come from your partners, other staff members, or yourself. The questions in table 9.1 on the following page constitute a simple test that you can use to measure the viability of a new idea or opportunity that comes to your attention once the strategy has been designed. The questions follow the "Communication Strategy Outline" that you first saw in the "Introduction" to this book. Answering the questions will help you ensure that everything developed and produced within the communication effort contributes to accomplishing the strategy.

Example

A television producer calls you and wants you to help produce a television serial drama for adolescent girls on better hygiene. It sounds like a great idea. It will reach young women and will be geared toward giving them sound advice in an area that may not be addressed anywhere else. The television program will cost $70,000 to produce and air and will require three technical experts for approximately 6 months. Should you do it? The question to ask is, "Is it on strategy?" Have adolescent girls been identified as an important audience segment in the strategy design? Has poor hygiene been identified as a key problem? Will spending the $70,000 to develop this television program and using the three technical experts take needed resources away from the ability to implement the strategic approach set forth in the communication effort? In other words, is it worth the trade-off between producing this new and innovative program and doing more of the work required to help accomplish the objectives set forth in the strategy?

Table 9.1: The Strategy Test

	Yes	No
Situation Analysis		
Does the proposed new idea help to solve the key problem?		
Audience		
Does the idea benefit the audiences identified in the strategy?		
Objectives		
Will the idea help to achieve the strategic objectives?		
Strategic Approach		
Is the idea in keeping with the strategic approach?		
Does the idea positively reinforce the long-term identity?		
Does the idea support the overall positioning?		
Key Message Points		
Will the idea enable the implementers to deliver the key message points?		
Channels and Tools		
Will the channels and tools for this idea effectively reach identified audiences?		
Program Management		
Is this idea realistic to implement?		
Are resources available to implement the idea?		
Can this idea be coordinated by organizations currently implementing other parts of the strategy?		
Evaluation		
Can you incorporate this idea into the communication effort evaluation?		
Does the idea match the indicators that you have already determined, or does it require a new set of indicators?		
Results		
Does the idea pass the Strategy Test?		

Ideally, there should be no "no" answers to the above questions. This criterion, however, may be unrealistic. If there is a "no" answer to one or more of the above questions, you may be able to change something about the new idea to get it on strategy.

Another part of the strategy is to test yourself as a reviewer.

Why Ask 'Why?"

A good strategy demonstrates not only what is being done, to whom, and how it will be done, but also why. All statements at every stage of a strategy should provide a clear rationale. Therefore, the most important question that a strategist can ask when developing or reviewing a communication strategy is, "Why?"

- Why is this the most important problem?
- Why are urban men ages 18–24 the primary audience?
- Why are you expecting to convince 25 percent of adolescents to visit health care clinics?
- Why are you designing a logo when all the partner organizations have their own logo?
- Why is it important to emphasize the friendliness of providers?
- Why use television when 70 percent of the households do not own television sets?
- Why produce newspaper ads when the intended audience does not read newspapers?
- Why do you need a poster?
- Why use community participatory activities when you are implementing a national program?
- Why evaluate all women when the intended audience is rural women ages 20–49?
- "WHY?"

You should ask "why?" at every step of the strategic communication development process and at every level of design. Asking "why?" ensures that everyone and everything stays on strategy.

Example

A donor has given your organization additional resources to reach a specially targeted audience segment that has not been identified in the communication effort. Through good formative research about this specified audience segment (understanding the audience problems and recognizing opportunities), you might be able to fold this segment into the strategic approach, use existing communication channels, and alter slightly existing message and materials. So, you can easily integrate this segment into the communication effort even if it is not part of the original strategic design and even if the effort is already in the implementation stage.

Strategy Summary Outline

The final step in designing a communication strategy is to prepare an instant picture of the strategy that you and your team have developed. You obtain this picture by filling in worksheet 9.1, the "Communication Strategy Summary Outline." Complete this outline by reviewing the summary worksheets that you prepared at the end of each chapter in this book. This exercise will provide you with a logical, well-thought-out, step-by-step approach to how your communication strategy will help solve the targeted health problem.

Example 9.1: Communication Strategy Summary Outline Worksheet

Example: Uganda:

I. Situation Analysis	
A. Purpose (Health situation that the program is trying to improve)	Reduce fertility rate in order to improve maternal and child health status
B. Key Health Issue (Behavior or change that needs to occur to improve the health situation.)	Unmet need for long-term or permanent methods (LTPM) of FP
C. Context (Strengths, Weaknesses, Opportunities, and Threats that affect the health situation)	Significant demands for services, radio widely available, trained providers. Limited knowledge about specific methods, limited availability of services
D. Gaps in information available to the program planners and to the audience that limit the program's ability to develop sound strategy. (These gaps will be addressed through research in preparation for executing the strategy.)	Needed more information about why usage rates for LTPMs were so low
E. Formative Research (New information that will address information gaps)	Identified client concerns, such as lack of awareness, fears and misconceptions about the methods, and service delivery issues, i.e., poor quality, unreliable, inaccessible services
II. Communication Strategy	
A. Audiences (Primary, secondary, and/or influencing audiences)	Primary—Men or women in DISH project areas who have decided to use an LTPM Secondary—Potential clients in same geographic area who want to delay pregnancy at least 3 years
B. Objectives	Between 12/2000 and 3/2002 to double the amount of CYPs provided via TL, vasectomy, and Norplant
C. Positioning and Long-Term Identity	One procedure protects you from pregnancy for up to 5 years (Norplant) or a lifetime. "These methods are safe and reliable ways for me to meet my reproductive goals."
D. Strategic Approach	Expand availability of LTPMs to new locations through new types of service delivery sites, by trained medical personnel and supported by mass media. Conduct community-based events and IPCs.
E. Key Message Points	(1) These LTPM methods are safe. (2) They are less expensive than others over the long run. (3) They are conveniently available near you. (4) Here is how they work. (Describe each method.)
F. Channels and Tools	Lead radio, then interpersonal, video, print, and supported by advertising, entertainment vehicles
III. Management Considerations	
A. Partner Roles and Responsibilities	DISH is the lead organization; partners are District Health Services, NGOs, and MOH. Partners are responsible for training CHWs, organizing doctor/nurse teams, and ensuring good quality of services.
B. Timeline for Strategy Implementation	Implementation occurs between 8/2001 and 9/2002
C. Budget	$100,000 U.S.
IV. Evaluation—Tracking Progress and Evaluating Impact	Service statistics, media monitoring, tracking survey

Worksheet 9.1: Communication Strategy Summary Outline

I. Situation Analysis	
A. Purpose (Health situation that the program is trying to improve)	
B. Key Health Issue (Behavior or change that needs to occur to improve the health situation)	
C. Context (SWOT that affect the health situation)	
D. Gaps in information available to the program planners and to the audience that limit the program's ability to develop sound strategy. (These gaps will be addressed through research in preparation for executing the strategy.)	
E. Formative Research (New information that will address information gaps)	
II. Communication Strategy	
A. Audiences (Primary, secondary, and/or influencing audiences)	
B. Objectives	
C. Positioning and Long-Term Identity	
D. Strategic Approach	
E. Key Message Points	
F. Channels and Tools	
III. Management Considerations	
A. Partner Roles and Responsibilities	
B. Timeline for Strategy Implementation	
C. Budget	
IV. Evaluation—Tracking Progress and Evaluating Impact	

Strategy Review

Table 9.2 is a checklist to help you ensure that the communication strategy is completely integrated into the health program. As mentioned at the beginning of the book, strategic communication is the steering wheel that guides the rest of the health program. This checklist helps to ensure that the steering wheel is working successfully.

Table 9.2: Checklist

Subject	Degree of Integration	Score: 1 (lowest)–10 (highest)
Objectives	Do the behavior change objectives fit with the program objectives?	
Program Integration	Do the communication activities fit well with other program functions, such as service delivery, logistics, policies, and staffing?	
Message Integration	Are the communication messages consistent with the availability, access, and cost (financial and psychological) of the service?	
Communication Mix Integration	Are the tools and channels being used to guide the audience through the PBC? Do they portray a consistent message?	
Message Design Integration	Is the message design consistent with the positioning of the product, service, or behavior?	
Management Integration	Are all internal and partner organizations working together in accordance with an agreed-upon plan and strategy with regular progress meetings?	
Financial Integration	Is the budget being used in the most efficient and effective way to ensure that economies of scale are achieved?	
Level of Integration: Total (Total Possible Score: 70)		

This checklist should help you determine how successful it will be to carry out the communication effort. The higher the score, the easier it will be to implement the strategy and the more effective the strategy should be in achieving objectives. If you achieve a middle range, it may mean that there are areas that require attention before the communication effort can be implemented, unless part of your strategy is to increase audience demand to help improve these weaker areas.

Using your scores as a basis, you and your team should decide what you need to improve before going forward with the implementation.

Conclusion

Strategy development is an ongoing process. Changes in the political environment or communication arena may have significant implications for the strategic approach. Think of your communication strategy as a "working document" that evolves based on audience, environment, and communication factors. Review your strategy at least once a year to ensure the viability and appropriateness of the factors that originally determined the strategy.

A great deal of thought and hard work goes into helping to fulfill a vision. The immediate benefit is working within a team, helping to orchestrate an effort that takes many partners, reaches many people, and, when done well, plays an integral role in changing behavior. In the long term, just like the work of our friend the architect, strategic planning is an important step in helping to fulfill the vision. In his case, it is seeing the completion of a building that encloses space for educating children that is safe, easily accessible, and pleasant. In your case, it is knowing that your strategic design is contributing to a health program that will help make society healthier and safer.

Appendices

Appendix 2

Case Studies

Uganda's DISH Project: A Case Study of an Integrated Communication Strategy

Table of Contents

I. Background Information

A. The DISH Project's Goal and Purpose

The DISH project, in partnership with the Uganda Ministry of Health (MOH) and the District Health Services of 12 participating districts, embarked on a multiphased initiative to improve the health and well-being of men, women, and children in Uganda. The goal of the DISH project was to reduce TFRs and the incidence of HIV infection by increasing the availability and utilization of integrated reproductive, maternal, and child health services by both public and private service providers. The project initially focused on FP and HIV/AIDS prevention—core issues with which project planners had the most experience and a strong research base. As the project unfolded, it highlighted additional, related family health topics.

The DISH project began its first 5-year phase in 1994 and its second 3-year phase in 1999. DISH II built on the successes achieved during the first 5 years of DISH I and continued to work with the Ministry of Health and District Health Services to promote improved quality, availability, and utilization of reproductive, maternal, and child health services and to improve public health attitudes, knowledge, and practices.

The DISH project featured a series of strategically designed, interrelated behavior change communication campaigns on various reproductive, maternal, and child health topics. The campaigns directed potential clients to health facilities for information and services and encouraged changes in individual health attitudes and behavior. These communication campaigns were designed to promote, complement, and reinforce simultaneous DISH project components to train nurses and midwives to provide integrated maternal, child, and reproductive health services (clients can get a full range of services during the same visit, often from the same health worker); train doctors and medical assistants in the syndromic management of STDs; expand HIV counseling and testing services; and provide training in logistics and management information systems.

This case study discusses the development of the overall communication strategy that guided the DISH communication campaigns. DISH was administered by Pathfinder International. Collaborating partners were the JHU/CCP, the University of North Carolina Program in International Training in Health (INTRAH), and E. Petrich and Associates. The project was funded by the U.S. Agency for International Development.

B. Defining the Health Problems

Almost half of the Ugandan population is under 15 years of age, with total fertility averaging about 7 children (Uganda Ministry of Finance and Economic Planning and Macro International, 1995: Uganda Demographic and Health Survey, 1996b). Fertility rates have stayed stable for the last 15 years. "A tradition of early childbearing has led both to a young population and to high fertility; 60 percent of Ugandan women have their first babies before they are 20 years old" (Uganda Ministry of Health and Institute for Resource Development (IRD)/Macro Systems, Inc., 1988/1989: Uganda Demographic and Health Survey, 1989). Modern contraceptive use is low, with a 2.5 percent prevalence, and birth intervals are short, with about half less than 2 years apart.

In addition to its high fertility rate, Uganda has one of the highest rates of HIV in the world. When the DISH project was initiated, as many as 1.5 million people were HIV positive, perhaps 1 in 5, with substantially more young women infected than men. Surveillance at some urban clinics suggested infection rates ranging from 7.5 percent in small towns to around 30 percent in Kampala and highly endemic areas of the southwest.

Widely believed to be cofactors in the transmission of AIDS, STDs were and still remain ubiquitous in Uganda. A 1990 review revealed that 19 percent of more than 108,000 outpatient visits were STD-related. In 1991, 26 hospitals reported more than 254,000 cases of STDs, about 60 percent of which were thought to be syphilis and gonorrhea. Fifteen to 25 percent of women attending routine antenatal care in sentinel surveillance sites were infected with syphilis.

In 1995, the maternal mortality ratio in Uganda was one of the highest in the world at approximately 550 deaths per 100,000 live births. More than two-thirds of deliveries took place outside health facilities without assistance from a qualified health worker. In addition, in 1995 about one-third of Ugandan children were stunted by the age of 3 years. Although breastfeeding was ubiquitous, most mothers introduced fluids or other solids before the recommended 4–6 months.

C. Context: SWOT

Against this backdrop, the DISH project defined its goal as reducing the incidence of HIV and other STDs, increasing the prevalence of modern contraceptives, and improving care before, during, and after childbirth (Promoting reproductive health in Uganda: Evaluation of a National IEC program, 1996a). As with other integrated communication campaigns, preliminary planning began with an analysis of Strengths, Weaknesses, Opportunities, and Threats—also known as a SWOT analysis. Conducting a SWOT review can provide information about and insights into existing resources and information, potential weaknesses that could undermine the campaign if not addressed, threats or barriers to success that must be addressed in program development, and campaign opportunities. Through a SWOT analysis, for instance, project planners may identify ways to build on successes in similar, earlier campaigns, discover the types of critically needed services and information that clients most want, or identify current networks or partnerships that can contribute to the program's reach or effectiveness.

1. Strengths

While DISH required addressing multiple issues, it was able to build on the experience and knowledge gained from previous FP programs. Uganda initiated FP activities in 1957, with the establishment of the Family Planning Association of Uganda (FPAU), an affiliate of the International Planned Parenthood Federation.

In 1987, the Government of Uganda established a population secretariat as part of the Ministry of Planning and Economic Development. In addition, more than 30 multilateral and bilateral donors and international NGOs supported health and population activities of various sizes and scope in Uganda.

There was also a precedent of communication program success in the reproductive health arena. Prior to the DISH project, the MOH carried out a project to increase the use of modern FP methods among married couples in urban areas of eastern, central, and southwestern Uganda. The multimedia effort entailed the development and widespread dissemination of IEC materials.

Survey data gathered in a precampaign and postcampaign household survey showed that the campaign had reached the majority of respondents and had influenced the behavior of many audience members. More than half of the population could identify the Yellow Flower symbol, which represented FP nationally. HIV/AIDS communication efforts were also widespread, and most adults knew the modes of transmission and consequences of HIV/AIDS. The HIV prevalence rates had already begun to decline at the start of the DISH project.

2. Weaknesses

In the communication area, there was a general lack of quality IEC materials for staff to use to promote FP, to explain the various FP methods to clients, and to share with AIDS clients in counseling. HIV/AIDS messages predominantly instilled the fear of AIDS and offered only abstinence and faithfulness as solutions; neither of which were practical for adolescents.

FP services were limited mostly to urban areas, but more than 80 percent of the population resided in rural areas. Many providers were poorly informed, provided incorrect information about FP, and did not discuss HIV/AIDS prevention with their clients. The health infrastructure required to support a broad behavior change communication campaign was weak.

Uganda's health provider network was characterized in many areas, especially rural areas, by limited availability of health services, inadequately trained personnel in the areas of FP and maternal health (MH), and shortages of trained staff, drugs, laboratories, supplies, and related equipment for STD services. Moreover, MH, STD, and FP services were not generally provided in an integrated fashion, and limited planning and management capability thwarted efforts to anticipate client needs and deliver services accordingly.

3. Opportunities

Despite the low level of contraceptive use in Uganda, the UDHS indicated that the potential need for FP was great. While 39 percent of currently married women wanted another child within 2 years, 33 percent wanted to space their pregnancies for at least 2 years, and another 19 percent wanted no more children. "This [meant] that 52 percent of currently married women in the surveyed area may require FP services either to limit or space their births. Furthermore, 35 percent of the women who had a birth in the 12 months prior to the survey indicated that their last birth was either unwanted or mistimed" (Uganda Ministry of Health and IRD/Macro Systems, Inc., 1988/1989: Uganda Demographic and Health Survey, 1989).

Studies indicated a generally positive attitude towards FP among women who knew about FP. "Seventy-one percent of currently married women knowing about FP approve of FP use by couples. Only 26 percent of married women think that their husband approves of FP use by couples. One-third of women do not know their husbands attitudes" (Uganda Ministry of Health and IRD/ Macro Systems, Inc., 1988/1989: Uganda Demographic and Health Survey, 1989). In the Uganda baseline survey, "over 90 percent of respondents agreed that FP has positive impacts on mother's health, children's education, the family's standard of living, and society at large" (Kiragu, Nyonyintono, Sengendo, & Lettenmaier, 1993).

At the start of the DISH project, AIDS was almost universally known, there was already a large condom social marketing program in place, a STD reference laboratory had been established, and the MOH had developed protocols and guidelines for syndromic STD management. The Government was also very supportive of HIV/AIDS/STD prevention efforts.

4. Threats or Barriers

There were serious barriers to contraceptive use and safe sex practices in Uganda. As of 1994, the dominant television and radio stations, which were controlled by the Government, would not allow contraceptive product promotion. In addition, there was strong opposition to condom use by the religious community.

Contraceptive use in Uganda was low. DHS indicated, "Only 6 percent of all women and 5 percent of currently married women reported using a contraceptive method at the time of the interview . . . 21 percent of all women and 22 percent of currently married women have used a method at some point in their lives" (Uganda Ministry of Health and IRD/Macro Systems, Inc., 1988/1989: Uganda Demographic and Health Survey, 1989).

The most common reasons for nonuse of contraception cited by women who were exposed to the risk of pregnancy but did not want to get pregnant immediately are fear of side effects, prohibition by religion, lack of knowledge, and disapproval by partner. There was also a lack of knowledge about modern contraceptive methods, and many women did not know where to obtain contraceptives. Low rates of contraceptive use may also be related to the belief by many women that a large family is the ideal—"sixty percent of women report 6 or more children as the ideal number" (Uganda Ministry of Health and IRD/Macro Systems, Inc., 1988/1989: Uganda Demographic and Health Survey, 1989).

Polygyny is still a common practice in Uganda, with 33 percent of currently married women reporting that their husband has other wives. However, "the relationship between polygyny and fertility is not straightforward. There is a tendency for women in polygynous unions to compete with co-wives in number of children, so as to have the largest share of family property. In this respect, the desire to have as many sons as possible is likely, and polygyny may be one of the factors that sustains high fertility" (Uganda Ministry of Health and IRD/Macro Systems, Inc., 1988/1989: Uganda Demographic and Health Survey, 1989).

Barriers to adopting safe sex practices and to seeking diagnosis and treatment of STDs include inadequate knowledge about maternal-fetal HIV transmission, misperceptions of personal risk, negative attitudes towards condoms, and absence of perceived community support for condom use. In addition, youth had a fatalistic attitude toward HIV/AIDS, believing that there was little that they could do to protect themselves.

Chart A2.1:Focus Group and In-Depth Interview Findings and Campaign Message Recommendations-1995

Audience: Married men and women who do not use modern FP methods but do not want to become pregnant now

- Respondents relied most heavily on the safe period to prevent pregnancy. However, they had an incomplete understanding of when the safe period was.

Recommendation: Since birth spacing is already practiced through use of the safe period, promote FP as "an easier way to space your births."

- Most of the nonusers were aware of what modern methods are available but had little in-depth knowledge about any of the methods.

Recommendation: Find every opportunity to provide details about how the methods work, their reliability, and safety.

- Most of the nonusers had heard mostly negative things about modern methods.

Recommendation: Dispel rumors and misinformation about the modern methods through testimonials by satisfied users, statements by medical experts and other authorities, and presenting correct information about the various methods.

- Most nonusers felt that there was a complete lack of community support for using modern methods.

Recommendation: Build links between nonusers and those who support the use of modern contraceptives: satisfied users, educated youth, and health care workers.

- Most of the couples had talked about HIV/AIDS in impersonal terms. When they got to the issue of condom use and faithfulness in their own marriages, however, talking became difficult.

Recommendation: Model husband and wife communication in which the difficult issues of personal behavior change are confronted.

- Knowledge, attitudes, and practices concerning FP and HIV/AIDS differed greatly among married women, married men, and unmarried youth.

Recommendation: Design separate messages for unmarried youth, married women, and married men.

(continued)

D. Gaps

DISH project designers faced significant gaps in knowledge about how men and women make reproductive health decisions throughout Uganda as well as other African nations.

Research was needed into how reproductive decisions and their outcomes are negotiated within sexual unions. Little was known about how a woman's life circumstances may affect her achievement of reproductive and health goals or what types of roles men play in reproductive decisions (Blanc et al., 1996).

"Relatively little is known about the processes by which decisions about reproductive matters are made. While both partners in a sexual union may express the same fertility preferences . . . survey data do not indicate what factors may influence fertility preferences . . . which partner's preferences carried the greatest weight, and to what extent other people influenced the decision" (Blanc et al., 1996).

Additional research was needed into how the position of women influenced their ability to negotiate the outcomes that they desired. In settings where HIV/AIDS is prevalent, social norms "and their relationship to reproduction—and particularly to the use of condoms—are complex and evolving. Explicit consideration of gender inequality is thus an important component of the study of reproductive outcomes" (Blanc et al., 1996).

Little information about adolescent sexual practices, beliefs, and knowledge was available. There was also a lack of understanding about reasons for poor utilization of MH services and about the quality of reproductive health, MH, and FP services.

1. Formative Research

Formative research prior to the DISH project development involved the review of existing qualitative and quantitative research findings. In addition, each individual campaign developed for the DISH project included audience research to determine attitudes, knowledge, concerns, and beliefs related to a wide variety of reproductive health issues(Family Planning Association of Uganda (FPAU), 1992).

Available quantitative research used to develop the program included at least two surveys: UDHS 1988/1989 and Uganda Baseline Survey: Key Findings 1993. The former survey provided data on the background characteristics of survey respondents, marriage and exposure to the risk of pregnancy, current fertility levels and trends, contraceptive knowledge and use, fertility preferences, and mortality and health. The latter survey provided information on knowledge, attitudes, and beliefs about family size; knowledge of FP methods; use of FP; attitudes and approval of FP; sources of FP information; and exposure to mass media. The data from these two quantitative surveys, as well as data from the 1995 DHS, are used throughout this case study.

In 1995, formative research was conducted through focus groups and in-depth interviews in six districts in Uganda. This qualitative research examined current knowledge, beliefs, and practices concerning HIV/AIDS and FP among men and women ages 15–35. The results were used in formulating the DISH Integrated Communication Strategy.

The research objectives were to:

- Learn what motivated current FP users to adopt modern methods.
- Identify myths and misconceptions about FP and HIV/AIDS.
- Determine the barriers to discussion between partners regarding FP, HIV/AIDS, and condom use.
- Explore the reasons why people are not using modern FP methods despite their desire to delay or stop childbearing.

Key findings from this research are summarized in chart A2.1 (Glass, Gamurorwa, Loganathan, & Lettenmaier, 1995).

(continued)

Chart A2.1:Focus Group and In-Depth Interview Findings and Campaign Message Recommendations ~~1995~~

Audience: Married men and women who currently use modern FP methods

- Most of the men thought that they had controlled the entire process of FP decisionmaking.

Recommendation: Men's statements and photos need to be included in FP materials, even if they are designed for women.

- Most of the users were spokespeople for FP in their communities.

Recommendation: Use testimonials by satisfied users to convince others.

- Users were tenacious in their commitment to FP. They all had experienced some challenges (side effects or adverse community opinion) and had persevered.

Recommendation: Be honest in print materials and counseling about the potential temporary adverse effects of modern methods—it will not deter people from using these methods.

- For both male and female users, the reasons for their use had to do mostly with economic issues. Women also mentioned health reasons behind their decisions to use.

Recommendation: Use economic messages in promoting male motivation and both economic and health messages when reaching women.

(continued)

(continued)

Chart A2.1:Focus Group and In-Depth Interview Findings and Campaign Message Recommendations ~~1~~995

Audience: Unmarried Youth

- More than one sexual partner was the norm, and most felt that the different partners could serve different purposes.

Recommendation: Show adolescents that they are putting themselves at risk for HIV/AIDS by having more than one sexual partner at a time or by changing partners frequently.

- Most of the youth knew that they were at risk for AIDS, but they did not feel that they could do anything about it.

Recommendation: Design messages to convince youth that they can do something to protect themselves from HIV/AIDS, rather than convincing them that they are at risk.

- Peer pressure to have sex in this age group was overwhelming.

Recommendation: Communication should help adolescents to resist peer pressure and to decide for themselves.

- The only modern methods of FP that adolescent respondents had used were pills or condoms. They had very little knowledge about other methods.

Recommendation: Develop materials that explain the variety of FP methods available in Uganda.

II. The DISH Integrated Communication Strategy

A. Background

The original objective of the IEC component of the DISH I project was to increase the utilization of basic reproductive health services and to encourage personal behavior that improves personal health. The IEC component worked hand in hand with the training and service delivery components under which health services were offered. At the beginning of the project, FP services were already available in about 50 percent of health facilities in the project area.

In 1995, DISH project planners held a strategy design workshop with representatives from organizations active in reproductive health and with District Health Services personnel from the DISH I project districts. During that workshop, participants reviewed research in Uganda about reproductive heath topics, including MH, FP, HIV/AIDS, and other STDs.

Based on that meeting and the overall objectives of the IEC component of DISH (see chart A2.2), they developed a 5-year IEC message strategy. They decided that it would not be possible to produce materials and activities about all five topics simultaneously; instead, messages and topics would be added in stages.

B. Intended Audience

The DISH project launched a total of seven campaigns between 1995 and 1999. (See table A2.1 for an overview of the DISH project Integrated Communication Campaigns 1995–1999.)

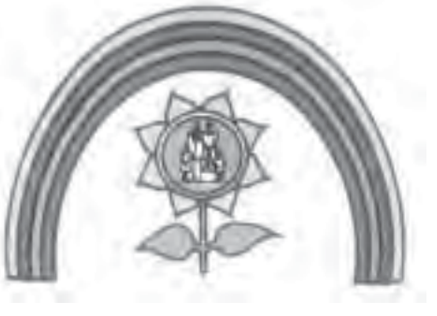
Persons 12–45 years old residing in the 10 DISH districts, both rural and urban, regardless of their level of education, were the intended audience for DISH messages. Each DISH campaign sought to communicate with a segment of the target audience most likely to need and be receptive to the campaign's messages. During the 5-year DISH project, communication campaigns targeted the following audience segments:

- **HIV/AIDS Prevention for Youth:** Males ages 15–19
- **FP:** Women ages 18–35 in rural areas who were nonusers of modern FP but did not want children right away
- **Family Health Logo:** All IEC segments
- **Maternal Health:** Sexually active women ages 16–35 in rural areas who did not plan to attend antenatal care clinics at least 3 times during pregnancy
- **Sexually Transmitted Diseases:** Men ages 18–35 in both rural and urban areas in stable sexual relationships who also had other partners but did not consistently use condoms
- **HIV Counseling and Testing:** Men living in rural areas who were in sexual relationships and had not had an HIV test
- **Breastfeeding and Infant Nutrition:** Rural mothers ages 18–35

The campaigns were designed to be implemented in three stages: first promoting existing FP services and addressing HIV/AIDS prevention among youth; next focusing on STDs and MH services, to coincide with training activities and to enhance the provision of these services; and then promoting HIV testing and counseling services as they became more widely available. At each stage, the team would design specific research-based strategies and media and materials plans. While each stage focused on a different service or issue, it simultaneously promoted the issues of the previous campaign. At any one time since 1997, as many as four separate communication campaigns were going on simultaneously. (See chart A2.4, Communication Impact, October 1999, Number 6.)

C. Overarching Campaign Themes and Concepts

The DISH project initially promoted FP services at the sign of the Yellow Flower logo, a well-established symbol for FP. In 1997, the project assisted the MOH in designing, distributing, and publicizing the rainbow-over-the-yellow-flower symbol to identify health facilities offering a full range of family health services, including FP, antenatal and postnatal care, immunizations, STD management, and HIV counseling. An important factor behind the design of the family health logo was the indication that a facility offered STD treatment, as well as other family services, so that clients seeking STD treatment did not feel stigmatized. All materials developed advised couples to visit health facilities with the Yellow Flower or rainbow over the Yellow Flower, for information and services (Katende, Bessinger, Gupta, Knight, & Lettenmaier, 2000).



Example

For instance, for the STD campaign, the audience would hear something like, *You can avoid HIV infection by properly treating STDs. It's as easy as 1–2–3—Stop, Treat, and Destroy.*

1. If you have an STD, STOP having sex, or use a condom while on treatment.
2. TREAT yourself as well as all your sexual partners at a health facility with the rainbow symbol.
3. DESTROY the disease completely by completing all your medication, even if symptoms have disappeared.

For more information, visit a health facility where you see the logo.

Example

For the MH campaign, the concept was "To Have a Healthy Baby, Have a Healthy Pregnancy." It's as easy as 1–2–3:

1. Visit a health facility for antenatal care as soon as you know that you are pregnant.
2. Go at least three times for antenatal care.
3. Return to the health facility if you have any problems.

For antenatal care, visit any health facility with the rainbow over the Yellow Flower.

Reinforcing the visual identity of the family health logo was the slogan "Family Health Made Easy," promoting the campaign's promise that those who go to a facility that displayed the family health logo would receive a variety of family health services from trained providers.

In addition to the logo, the project developed a creative concept to link the various campaigns together. The creative concept was, "It's easy. 1–2–3."

D. Strategic Approach and Timeline for Strategy Implementation

The overall objectives of the project are summarized in Chart A2.2.

Chart A2.2: Overall IEC Objectives

IEC campaigns implemented under the project will communicate
The benefits of FP and breastfeeding, including the noncontraceptive benefits of each (e.g., effects on maternal and child health and the economic advantages of smaller families)
Basic information on various FP methods, including the differences between temporary, longer acting, and permanent methods and the pros and cons of each method
Information to dispel rumors and misconceptions related to FP
The importance of spousal communication regarding FP
The importance of antenatal and postnatal care and of deliveries assisted by trained personnel
The possibility of transmitting HIV from mother to child perinatally (The nature of transmission among adults is widely known.)
Basic information on STDs and their symptoms, consequences (including the link between STDs and HIV), treatment, and prevention
The benefits of HIV testing and counseling
Where to go for services, including HIV testing/counseling, and the promotion of service providers trained under the project

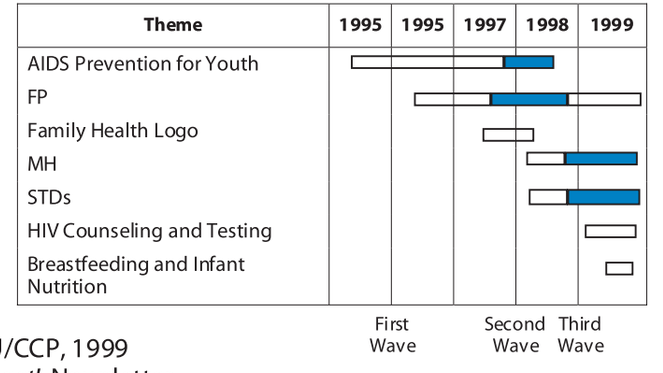
The timeline for implementing the strategy unfolded in 3 stages over a period of 5 years:

Stage I (Years 1 and 2). FP services were already available, and the Yellow Flower logo was already established. HIV was a serious problem, and prevention did not depend on improved services. Thus, the two topics of FP and HIV were introduced during the first stage while training, renovations, and equipment procurement were underway.

Stage 2 (Years 3 and 4). It was anticipated that training, equipping, and renovating facilities would have progressed enough to make STD and MH services more widely available by the third year. So it was decided to add messages directing people to these services during the second stage.

Stage 3 (Year 5). HIV testing and counseling were not available in all 10 districts until the final year of the project. It was thus decided to add messages directing people to facilities and services for HIV-related health issues during the third phase.

Chart A2.3: Integrated "Family Health Made Easy" Communication Campaigns



Source: JHU/CCP, 1999
Impact! Newsletter

Key: Intensive Campaign Maintenance Campaign

E. Key Promise/Benefit

If you are informed and educated about healthy reproductive and sexual behavior and utilize Integrated Health Services, you can have better health.

1. Support Points

You can have better health by:

STAGE 1: Practicing Safer Sex to Prevent AIDS

- Condoms
- Abstinence
- Delaying sex
- Remaining faithful to one partner
- Nonpenetrative sex

STAGE 1: Using modern FP methods to avoid unwanted pregnancies

- Safe
- Effective
- Reliable
- Widely available where you see the Yellow Flower

STAGE 2: Having STDs properly diagnosed and treated

- Location of services
- Dispelling misconceptions

STAGE 2: Adopting appropriate health care before, during, and after pregnancy

- Antenatal care
- Delivery assistance
- Postnatal care
- Location of services

STAGE 3: Learning your HIV serostatus and acting responsibly

Positioning: Convenience.

F. Campaign Channels and Tools

The campaigns included a mix of mass media, community-based, and interpersonal channels. Mass media used included television, radio (such as the weekly "Choices" radio program, which won the 1998 Global Media Award for Best Radio Program on Population Issues), and print. Community activities included drama performances, video shows, village meetings, soccer matches, special World Cup promotions during the event (June–July 1998), and bicycle rallies. Interpersonal channels included training; client counseling materials, such as flip charts and cue cards; and Group Africa experiential marketing road shows. All materials were produced in three or four different languages for the different audiences.

III. Management Considerations

A. Partner Roles and Responsibilities

DISH I was administered by Pathfinder International in close collaboration with the Ugandan Government's MOH. Collaborating partners were the JHU/CCP, INTRAH, and E. Petrich and Associates. Responsibilities of partners were as follows:

- Pathfinder International: Project management, monitoring, and evaluation; health management and information systems (HMIS); contraceptive logistics support; and community-based programs
- JHU/CCP: IEC
- INTRAH: Training and clinical services
- E. Petrich and Associates: Health financing

District-level IEC campaign plans were designed and implemented by the District Health Services, in collaboration with NGOs, community-based organizations, and other Government departments active in each district. The District Health Educators (DHEs) were the overall coordinators of the district campaign plans. DISH I provided grants to each District Health Service to implement the activities in its plans.

Implementation was carried out by a District Action Committee formed by the DHE and comprised of representatives from various organizations and departments active in health activities in the district. DISH project IEC coordinators provided technical assistance to the District Action Committees and DHEs to design and implement their action plans and provided the supportive print and audiovisual materials for use during their activities.

B. Budget Parameters

The DISH project was funded by the U.S. Agency for International Development. Innovative administrative mechanisms were developed to place responsibility for funds management and much decisionmaking at the district level. These funds helped defray the cost of local district community mobilization activities. This decentralization of project management through the empowerment of district-level personnel resulted in a strong sense of project ownership and active support by the local population. At the same time, financial resources were used centrally to develop nationally distributed media products for print, radio, and television.

IV. Evaluation and Continuity Issues

A. Monitoring Progress and Evaluating Impact

The project monitored and evaluated the impact of counseling and IEC on knowledge, attitudes, and practices and used this information to improve district-level IEC interventions. IEC monitoring built on the DISH project Management Information System. Midterm and final evaluations examined sources of clients referred for MH, FP, STD, and HIV services as well as examining time-series analyses of client visits to DISH centers before, during, and after campaign interventions.

DISH designed campaign monitoring and evaluation plans for each campaign, in addition to the periodic community- and facility-based surveys and DHS. Most of these evaluations involved client exit or entry interviews at a sample of health facilities. For the "Safe Sex or AIDS" campaign for youth, baseline and intervention surveys were conducted with youth to evaluate exposure and impact. For the FP, MH, STD, family health logo, and HIV campaigns, interviews were conducted with FP, antenatal, STD, and HIV clients at selected facilities during the campaign to determine their exposure to campaign interventions and their reactions to campaign messages and materials. Small-scale studies were also conducted to measure the impact of specific interventions, such as the "Choices" and "Straight Talk" radio programs and the video "Time To Care: The Dilemma."

1. Results

The Uganda DISH Evaluation Surveys in 1999 collected information to assess the reproductive health situation in DISH districts and the effectiveness of DISH project activities. "The 1999 DISH Evaluation Survey gathered information from

1,766 women ages 15–49, 1,057 men ages 15–54, and 292 health facilities and 186 pharmacies and drug stores in 11 of the 12 districts in Uganda served by the DISH project, covering 30 percent of Uganda's population" (Katende et al., 2000).

The evaluation survey found that from 1995 to 1999, media exposure to FP IEC messages increased significantly for men and women. By 1999, the majority of men and women had heard radio advertisements about FP, antenatal care, exclusive breastfeeding, STD prevention, and HIV testing and counseling. In 1999, three-quarters of men and women reported exposure to the Yellow Flower FP logo and the rainbow-over-the-Yellow-Flower family health logo (Katende et al., 2000).

During the same time period, survey respondents reported a marked increase in the use of modern contraception. Survey data presented a strong and consistent association between women's and men's exposure to DISH-sponsored FP IEC messages and increased use of modern contraceptives. In addition, between 1995 and 1999, the proportion of men and women not already practicing FP who intended to use a modern contraceptive in the next 12 months increased significantly (Katende et al., 2000).

Survey data also found that exposure to other family health topics led to increased knowledge. During the first 4 years of the DISH project, there were significant increases for men and women in knowledge about use of condoms for STD and HIV prevention. Between 1997 and 1999, a significant increase in men's and women's knowledge of a place to obtain STD treatment occurred. In addition, a significant increase in the proportion of men and women ever tested for HIV occurred between 1997 and 1999. Among those not yet tested for HIV, nearly two-thirds of men and women expressed a desire to be tested in 1999 (Katende et al., 2000).

DISH IEC activities also appeared positively associated with increased knowledge of pregnancy complications among men and women in 1999. In addition, between 1997 and 1999, the proportion of mothers who could name at least three of four obstetric complications increased significantly. In 1999, the majority of men and women surveyed also reported hearing messages about child nutrition and

breastfeeding. Based on 1999 data, women's knowledge of 6 months as the ideal duration for exclusive breastfeeding appeared significantly associated with DISH IEC activities (Katende et al., 2000).

Some of the key findings and recommendations can be found in chart A2.1.

B. Five-Year Message Strategy

Since 1995, the DISH project has launched multimedia campaigns on various health topics. The project implemented two campaigns between 1995 and 1997—one promoting FP services at the sign of the Yellow Flower logo and a simultaneous "Safer Sex or AIDS" campaign which encouraged safer sex practices among youth to prevent HIV transmissions. In 1997, the project developed the rainbow-over-the-Yellow-Flower symbol to identify health facilities providing integrated family health services.

With the new symbol in place, the project launched two new campaigns in 1998 directing couples to the rainbow logo for antenatal care and STD treatment. The MH campaign promoted early and repeated antenatal care during pregnancy and recognition of four warning signs of serious obstetric problems. The STD campaign educated men to treat STDs properly. Both campaigns were launched in March 1998 and were at their highest level of intensity with both community-based and mass media messages until November 1998, when all but the radio spots were discontinued.

In March 1999, the DISH project introduced two new campaigns—one promoting newly established HIV counseling and testing services and the other renewing efforts to increase contraceptive use. Both campaigns employed a combination of community-level, print, and electronic media.

In June 1999, the project launched a final campaign promoting exclusive breastfeeding for the first 6 months of life and the appropriate introduction of complementary foods thereafter. Messages were disseminated through radio and print materials.

Table A2.1: Overview of DISH Project Integrated Communications Campaign, 1995–1999

Campaign	Objective	Audience	Key Campaign Promise	Messages and Support Points	District Channels and Activities	Campaign Materials
HIV/AIDS Prevention for Youth	Increase the number of people in the target audience who consistently practice safer sex, including delaying first sex, abstinence, reducing the number of sexual partners, nonpenetrative sex, and using condoms.	Primary audience: Males ages 15–19 Secondary audience: Females ages 12–19	You can avoid becoming HIV positive if you practice safer sex.	1. Abstain from sex. 2. Use condoms. 3. Be faithful to one partner. 4. Have nonpenetrative sex. 5. Delay sex. 6. Resist peer pressure.	Sensitization meetings Drama contests and tours Bicycle rallies Rap music contest Formation of school anti-AIDS clubs in one district Matter-of-fact quiz shows	Radio spots and jingle "Straight Talk" radio programs "Straight Talk" newsletters Posters "Hits for Hope" music contest Cassette music video: "More Time" video in vernacular
FP	Dispel myths and misconceptions about modern FP methods, and direct the intended audience to service delivery areas in the 10 DISH districts.	All women ages 18–35 years, who are nonusers of modern FP but do not want children now and live in rural areas of the DISH districts regardless of educational level	You will have increased peace of mind by using FP methods, which are all safe, effective, and widely available.	1. FP can reduce burdens, uncertainty, and anxiety in the home and can provide more time for better family relationships. 2. Modern FP methods are safe and are used by thousands of Ugandan women everyday. 3. Modern FP methods are approved and recommended by the Uganda MOH. 4. The many different modern FP methods available in Uganda are more than 96 percent effective. 5. Satisfied FP users readily provide testimonials and endorsements of modern FP methods. 6. With temporary FP methods, you can have normal healthy children again when you want them. 7. These FP services are widely available from trustworthy service providers who are being trained for a high quality of care. 8. FP services are available at more than 700 sites throughout Uganda where you see the Yellow Flower.	Kezia's choice drama tours Song competitions Video shows Family health fairs Campaign launches "Iraka rya Masindei" radio program Market fairs Kasese radio program Nakasongola radio program "Twomebeke Eiyanga"	Radio spots "Choices" radio programs "Top Health" radio talk show Six FP methods video "Time To Care: A Question of Children" video "Health Matters" newsletters FP logo signboards Billboards Posters Flip chart DISH/Top Radio Program

Table A2.1: Overview of DISH Project Integrated Communications Campaign, 1995–1999 (continued)

Campaign	Objective	Audience	Key Campaign Promise	Messages and Support Points	District Channels and Activities	Campaign Materials
Family Health Logo	Familiarize at least 50 percent of men and women with the reproductive health symbol, so that they recognize the logo and know its meaning.	All IEC-targeted subgroups		1. Facilities that display the reproductive health logo offer a number of important health services all under one roof. 2. Facilities that display the reproductive health logo offer improved health services.	Approximately 1,000 health facilities display the logo. Launching ceremonies Group Africa road shows	The logo symbol Radio and TV advertisements Posters, billboards, stickers, calendars, T-shirts, caps, umbrellas. Special badges for service providers who provide integrated health services.
Maternal Health	Increase the number of women in the intended audience who attend antenatal clinics at least three times during pregnancy, beginning in the first trimester.	Sexually active women, ages 16–35, living in the rural areas of the DISH districts and who live within 10 km of a health facility but do not plan to attend antenatal care at least three times during pregnancy	Women who attend antenatal care services at least three times during pregnancy, starting early, will be more likely to give birth to healthy babies.	1. High-risk pregnancies: Women who are at risk of complications during pregnancy and childbirth during their first pregnancies, when they are younger than 18 years old, when they have had four or more previous births, and when they have had problems during previous pregnancies or deliveries 2. Warning signs of problems during pregnancy: Return to see a doctor or midwife immediately if you have abdominal pain, fever, swollen hands or face, or vaginal bleeding during pregnancy. 3. When and how to go for antenatal care: Attend an antenatal clinic as soon as you miss two periods and go at least three times during pregnancy. The earlier you begin antenatal care, the longer the interval can be between visits. 4. Benefits of routine antenatal care: The Ministry of Health and the World Health Organization (WHO) encourage women to have at least three antenatal visits during each pregnancy. This helps prevent disability and death due to childbearing. 5. Properly trained antenatal care providers can detect and manage potential problems in mothers and unborn babies, as well as provide counseling and health information, such as advice on breastfeeding or caring for new babies.	Radio programs Village meetings Market Day fairs Song contests Video shows Drama tours Health quizzes Theater Religious outreach	Radio spots Radio programs TV program Posters Video "Time to Care: Three Visits" "Health Matters" newsletters MH flip chart

Table A2.1: Overview of DISH Project Integrated Communications Campaign, 1995–1999 (continued)

Campaign	Objective	Audience	Key Campaign Promise	Messages and Support Points	District Channels and Activities	Campaign Materials
Sexually Transmitted Diseases	Increase the number of people in the intended audience who attend a health facility with established STD services for treatment of STDs. Encourage the practice of safer sex.	Men, ages 18–35, in stable sexual relationships who also have other sexual partners These men reside in both urban and rural areas of the DISH districts and do not consistently use condoms. Secondary audience: Females, ages 15–30, who are the sexual partners of the primary audience	If you get proper treatment for STDs and practice safer sex, you will be less likely to contract HIV or have other health problems.	1. STDs facilitate HIV transmission and other health problems. Treatment and prevention of STDs reduces chances of HIV transmission. 2. STDs also cause infertility in both men and women. In pregnant women, STDs can cause miscarriage, stillbirths, and babies born blind or seriously ill. 3. The MOH and WHO endorse condom use, abstinence, and faithfulness as preventive measures against STDs. According to the MOH, condoms are reliable, safe, and readily available. They do not have holes and rarely break. 4. Proper STD management means getting diagnosed by a trained provider, notifying all sexual partners, using condoms or abstaining from sex until treatment is completed, completing all medicine prescribed, and returning to the trained provider when treatment is complete. 5. If you have STDs and continue having unprotected sex, you will spread STDs to your sexual partners. 6. If you have an STD and do not complete the medication (even when symptoms disappear) and do not treat your partners, you risk re-infection and other complications.	Group Africa road show in six districts Bicycle rallies Football matches Drama tours Market Day fairs Video shows Health clubs	Radio Spots "Choices" Radio programs TV program "Health Matters" Newsletters World CUP TV spot Poster Flip chart for service providers "Time To Care: The Dilemma" video

Table A2.1: Overview of DISH Project Integrated Communications Campaign, 1995–1999 (continued)

Campaign	Objective	Audience	Key Campaign Promise	Messages and Support Points	District Channels and Activities	Campaign Materials
HIV Counseling and Testing	Increase the number of men who go for HIV counseling and testing at rural HIV counseling and testing sites by 150 percent by the end of the campaign. Increase the proportion of clients tested at the sites who come as couples.	Primary audience: Men living rural lifestyles in the DISH districts who are in sexual relationships and who have not had an HIV test Secondary audience: Sexual partners of the primary audience and health workers in the DISH districts	If you go for HIV counseling and testing, you will be showing that you are a strong man who conquers fears and takes charge of his life and the lives of those he loves.	1. Knowledge of serostatus helps people to make decisions about marriage, bearing children, and their sexual behavior. It helps people decide how best to protect themselves and others from HIV infection. The test is not only for sick people. 2. The only way to be sure of your serostatus is to take the test. Testing is accurate, and your results will remain confidential. The test is affordable and safe. Only a small amount of blood is drawn. Sterile, disposable needles are used. Each of the new testing sites provides same-day test results. 3. Each site has trained counselors who can help you understand and accept your test results. 4. For information about where you can go for testing, visit a health facility with the rainbow over the Yellow Flower. 5. It has been proven that among sexual partners, one partner can be infected while the other is not yet infected. So both partners should be tested. 6. It is best for both partners to take the test together so that they can learn the results and make plans together. (Testimonials from couples who went for testing and counseling together and are still together.) 7. If you have recently had unprotected sex and your test result is negative, it is advisable to take a second test because the test may not detect infection during the first 3 months of infection. 8. The MOH recommends health workers to refer clients at risk of HIV infection for testing and counseling even if they have no symptoms. (Testimonials.)	Launching ceremonies for new HIV CT services and outreach voluntary counseling and testing (VCT) services	Radio spots "Choices" radio programs "Straight Talk" radio programs "Time To Care: Let's Face It" video "Health Matters" newsletters Poster Group Africa road shows "Top Health" radio talk show Signposts for health facilities offering HIV counseling and testing (CT) services

Table A2.1: Overview of DISH Project Integrated Communications Campaign, 1995–1999 (continued)

Campaign	Objective	Audience	Key Campaign Promise	Messages and Support Points	District Channels and Activities	Campaign Materials
Breastfeeding and Infant Nutrition	By the end of the campaign: The proportion of mothers in the DISH districts who exclusively breastfeed their babies until they are 6 months old will increase from 35% to 50%. The proportion of mothers in the DISH districts who begin giving solid foods according to the DISH feeding recommendations at 6 months will increase from 25% to 40%.	Primary audience: Women ages 18–35 in the DISH districts who have not exclusively breastfed their children for 6 months and women who have not begun giving solid foods at 6 months according to the DISH feeding recommendations Secondary audiences: Grandmothers, fathers, friends, relatives, health workers, and caretakers	If you exclusively breastfeed your babies until they are 6 months old and introduce solid foods according to the DISH feeding recommendations, you will be more likely to have a strong, active, and healthy baby.	The MOH recommends exclusive breastfeeding until babies are 6 months old and beginning to give solid foods at 6 months in order for babies to grow well and stay healthy. Women who do not exclusively breastfeed for 6 months and who do not introduce solid foods at 6 months are putting their babies at high risk of becoming stunted, underweight, or wasted. Benefits of exclusive breastfeeding: It is a natural FP method. As long as a woman is exclusively breastfeeding and is not menstruating, she is protected from pregnancy for up to 6 months. Babies who are exclusively breastfed for 6 months are less likely to suffer from diarrhea. Breast milk is nutritionally adequate. It is all that a baby needs for the first 6 months of life. More frequent suckling stimulates more milk production, so there is no need to worry about not having sufficient milk. Complementary feeding: After 6 months, a baby requires solid foods, such as posho or akalo, to provide extra energy and to meet body-building demands. Children who continue to breastfeed and who are given solid foods from 6 months of age rarely fall sick. Children who are breastfed until 6 months old and then begin solid foods cry less and sleep well. This allows their mothers more time to do their work. (Testimonials.)	Child health fairs Drama tours Training CHWs to do growth promotion Kitchen garden contest Song competitions Village meetings Women's group meetings	Health education cue cards Radio spots Calendars Posters "Health Matters" newsletters TV/video infomercials "Choices" radio programs

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Bolivia's National Reproductive Health Program: Las Manitos I

Table of Contents

I. Overview

Through the efforts of many public and private sector partners working collaboratively together, the National Reproductive Health Program (NRHP) in Bolivia was able to alter significantly the environment surrounding reproductive health in the country. The NRHP helped meet the needs of Bolivian couples and families by providing high-quality reproductive health information and services in a strategic way. This case study highlights the experience of Las Manitos I, which was the first large-scale campaign conducted under the auspices of the NRHP with technical assistance provided by the JHU/PCS. Follow-on campaigns are addressed briefly in this case study within the context of long-term strategy implementation.

II. Key Characteristics That Made Las Manitos a Success

Unfolded in Stages Over Time

The organizers of the NRHP understood the value of developing a continuous series of carefully calibrated campaigns that moved from cautious advocacy to countrywide action. The overall strategic approach developed by the NRHP was to develop a more positive environment surrounding reproductive health in Bolivia. A major emphasis was empowering women to take care of their own health and the health of their children. This effort was implemented by developing national level political support, training of key stakeholders in communication techniques, carefully segmenting audiences, and using innovative mass media activities.

The strategic approach unfolded in stages over time, expanding to additional audiences, geographic regions, health issues, and communication channels in a coordinated fashion. Each element of the strategic approach reinforced the work that had been done previously and added a new depth of understanding about the needs of the audience.

Multimedia Approach
Las Manitos I used mass media as the lead channel, which was supported by community and interpersonal channels of communication. The media campaign, which was the first of its kind in Latin America, was launched by the Bolivian President and Secretary of Health, who appeared in the first television spots.

Given the high penetration of television and radio and given the reasonable price of airtime in Bolivia, the Las Manitos I campaign primarily used mass media to disseminate key messages to the audience, which enabled the organizers to accomplish a quick and broad reach of the campaign messages. Specifically, 11 television and 44 radio spots were used to allow for maximum reach and frequency during the initial 7-month campaign.

Interpersonal channels focused on training service delivery providers and on providing them with a wide variety of materials to use with their clients. Materials included flip charts, reference manuals, method posters, reproductive health brochures, and individual method flyers.

Linkages to Reproductive Health Services
A training curriculum was also developed for use by institutions in training reproductive health providers in IPC skills. In preparing for the mass media campaign, a set of integrated print materials was produced, and training activities were implemented that assisted clinic staff in counseling, informed clients on methods, and promoted reproductive health services.

The campaign's logo and tag line, "Reproductive Health—It's in Your Hands" were used to identify where services were provided. The logo appeared, for example, on the doors of hospitals and clinics where reproductive health services were offered.

Interinstitutional Coordination Among Stakeholders
The Las Manitos I campaign was carried out under the auspices of the NRHP. The NRHP built linkages with various organizations through its National Coordinating Commission. Four subcommittees were established, with an initial membership of 28 institutions. These groups focused on the issues of services, research, training,

and IEC. The members of the different subcommittees represented various Government agencies and NGOs. Therefore, strong ownership of the NRHP was developed within various groups and sectors of society from the beginning of this effort.

Use of Research at Every Stage

The success of a campaign depends in great measure on the amount of research on which it is based. Planning for evaluation occurred from the very beginning of the strategy design process, thereby allowing researchers to work with the program staff throughout the process of campaign planning and development. Both quantitative and qualitative research methodologies were used to inform decisions and to track progress and outcomes.

Researchers tested the acceptability of words, phrases, and concepts surrounding reproductive health and FP issues that would help determine the future positioning of the campaign. After the first messages were drafted, additional research was conducted to pretest the comprehension, attraction, acceptability, and relevance to the audience of the different messages.

Research also played a role during the management and monitoring phase of the campaign to ensure that the materials were being properly distributed and broadcasted. This was accomplished by distribution reports completed by the NGOs, in the case of the print materials, and by reports from a media agency in the case of television and radio broadcasting. The monitoring led to some important adjustments in the broadcasting strategy and served as a reassurance to the NGO members that the distribution of the materials they had being working so hard to produce were, in fact, efficiently disseminated and helpful to the intended audience.

Finally, research was also conducted to evaluate the campaign impact and help to guide the strategic approach of the next campaign.

Reproductive Health Focus Instead of Family Planning

The positioning of FP within the greater context of reproductive health was very effective in attracting attention and encouraging acceptance of campaign messages. The reproductive health approach also received political support. Unlike FP per se, reproductive health was not a controversial topic in Bolivia. Rather it was a

major part of the Government's strategy to reduce maternal mortality and to improve child survival, and allowed for easy expansion of the approach to other geographic areas.

Unified Image of Reproductive Health Services
The success of the Bolivia campaign also relied on the creation of a unified image of reproductive health services. One of the main tools to help create this image was the design and positioning of a common logo that allow for identification of places where reproductive health services and information were available as well as an identification sign for all the materials and activities related to the Bolivian reproductive health program. In addition to providing a corporate image to the program, the shared logo helped to boost the feeling of teamwork among the NRHP stakeholders.

The logo, together with the lilac color, and the tag line "Reproductive Health Is in Your Hands" were used systematically in all materials and at the clinic level to build the program's identity and to establish the Las Manitos brand.

III. Analysis of the Situation

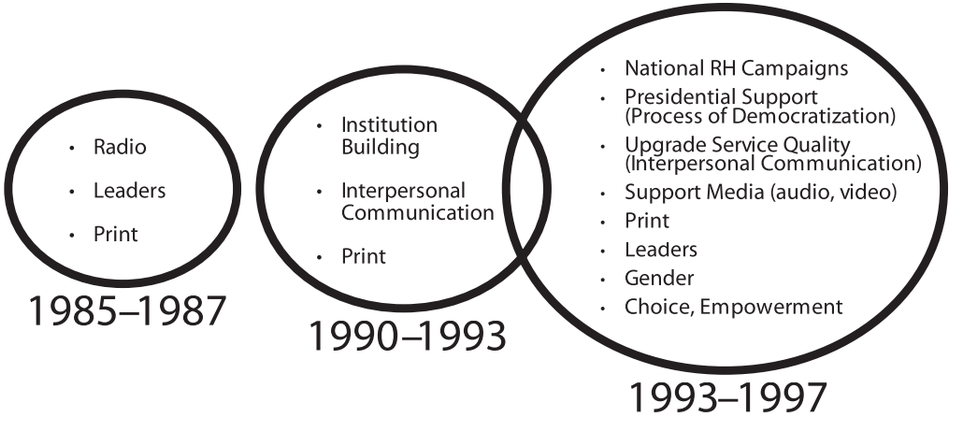
Context
Prior to the 1990s the climate for FP services was not favorable in Bolivia. In fact, in 1977 the Bolivian Government banned the provision of FP services by public institutions and closed the only NGO provider of these services. In 1982, a new Government explicitly banned the provision of FP services by NGOs. In this context, few FP efforts had been implemented prior to 1990, despite the high level of unmet need for FP services.

The turnaround began in 1986 with an advocacy and service promotion campaign to promote the private-sector organization Centro de Orientacion Familiar (COF), which was providing FP services in three Bolivian cities. About 700 policymakers and influential citizens attended 10 discussion meetings on the pros and cons of FP, especially the benefits for maternal and child health. Participants were very supportive of increasing services and advocacy. The positive experience of the 1986 campaign was instrumental in paving the way for the national strategy of the 1990s.

In 1990, the Bolivian Government and the U.S. Agency for International Development (USAID)/Bolivia signed the first bilateral agreement on reproductive health under the name National Reproductive Health Program. The NRHP was created to bring together stakeholder efforts directed toward the creation and promotion of healthy reproductive practices and increased acceptance of modern FP methods. At the inception of Bolivia's NRHP the country's population was 7.2 million, with almost half of the population concentrated in 7 urban areas. Bolivia also had the highest rate of maternal mortality in the Western Hemisphere, with 416 deaths per 100,000 live births during 1984–1989. Six out of 10 deaths of women in their reproductive years were related to pregnancy and delivery. Thirty-eight percent of these deaths were due to abortions.

The evolution of NRHP is depicted in Figure A2.1. As part of the third and largest phase of the program, the NRHP designed and implemented several campaigns between 1994 and 1997, three of them under the name "Las Manitos." This case study focuses on the strategic elements that made Las Manitos a success.

Figure A2.1. Evolution of Bolivia's NRHP



Program Goals
Based on the consensus obtained in the workshops of 1989 and having identified the lead institutions on the subject, USAID provided funds for the creation of a comprehensive national program on reproductive health. A large number of private and public sector stakeholders, in addition to a series of technical assistance agencies, participated in the design and implementation of the NRHP.

The NRHP's goal was to improve the health of Bolivian families through (1) promoting healthy reproductive practices, (2) improving the provision of services, and (3) increasing acceptance of modern FP methods.

Key Problem
The key problem influencing the development of the strategy was the combination of substantial unmet need for FP services and high rates of infant and maternal mortality. Low rates of knowledge about FP methods and lack of information about their use contributed to limited use of contraceptives.

According to the NRHP communication baseline survey conducted in 1994 at the start of Las Manitos, 30.9 percent of urban women were using modern contraceptive methods, with the condom the most popular method (11.6 percent), followed by the intrauterine device (IUD) (8.9 percent), and oral contraceptives (4.7 percent). Awareness of the most common modern methods was relatively high, with combined spontaneous and assisted recall of the pill, IUD, and condoms exceeding 75 percent.

The 1994 DHS showed that 17.7 percent of women in union (urban and rural) were using modern methods of contraception in Bolivia. This figure had increased from 12.2 percent according to the 1989 DHS, but in 1994 there were still many couples with unmet needs for FP. The 1994 DHS showed that 67.6 percent of women in union did not want to have any more children (excluding women who were sterilized). While fertility in 1994 was 4.8, the DHS revealed that most women ages 15–49 desired a total of 2.5 children.

As of 1994, 48 percent of Bolivian women who gave birth never received prenatal care, and 58 percent of births took place in homes, usually without the assistance of a health worker. Both fertility and infant mortality rates were higher in Bolivia than in most other Latin American countries. While the overall infant mortality rate was about 80 deaths per 1,000 births, the rate in some rural regions was almost twice that.

Information Gaps and Formative Research Findings

In addition to epidemiological information concerning fertility in different age groups (extracted from DHS), campaign strategists needed to learn more about current knowledge, attitudes, and practices regarding reproductive health as well as media habits of the intended audience. This information was gathered through quantitative and qualitative studies. In 1994, prior to the design of the strategy, a baseline household survey was conducted among 2,256 men and women in 7 urban areas. This survey measured the intended audience's knowledge, attitudes, and practices regarding reproductive health as well as their media habits.

To gain a qualitative perspective of the situation, a series of 16 focus groups was conducted in 1994 with members of the potential audience to clarify issues related to understanding of key terms and to gain insight concerning barriers to use of modern FP methods. The focus group discussions revealed that:

- Participants associated reproductive health with a broader range of services.
- FP had negative connotations.
- Misunderstandings and misinformation existed relative to knowledge about specific FP methods.

The participants thought that the phrase "reproductive health" was vague and that it alluded to women's health issues, not men's. However, when compared to "family planning," which was seen as narrow in its definition, "reproductive health" was associated with a wider variety of services. Another important insight gained from the focus groups was that a clear and positive definition could be attached to the term "reproductive health," whereas strong negative beliefs and barriers were already attached to the term "family planning."

The formative research also revealed concerns that women had regarding their ability to control their own reproductive health and to positively influence the health of their children. A number of religious, cultural, and educational barriers were identified as primary causes of this self-doubt. The religious concern was that the Catholic Church did not approve of modern FP methods. One cultural issue was that some men feared that if their partners used these methods they might develop other sexual relationships. Another cultural concern related to the discomfort that some men had regarding their partners being seen by a male physician. The major educational barrier was a lack of knowledge among both men and women concerning reproductive health issues.

IV. Communication Strategy

The Las Manitos I campaign was launched in 1994 in the four largest cities. It was the first audience-based communication effort developed under the NRHP.

Audience

The intended audience for the Las Manitos I campaign strategy consisted of individuals and couples between the ages of 18 and 35 living in urban and peri-urban areas. They represented the middle and lower socioeconomic groups, which comprised the urban majority and constituted a population of approximately 500,000 people. The campaign was implemented in the four urban areas of La Paz, El Alto, Santa Cruz, and Cochabamba.

Objectives

A number of behavior change objectives were developed for the Las Manitos I campaign, which ran from May through November of 1994. Desired changes were to:

- Introduce the NRHP logo to achieve recall by 64 percent of the intended audience.
- Explain the benefits of reproductive health, so that within a period of 3 months, 41 percent of the intended audience mentions at least one benefit.
- Inform at least 33 percent of the intended audience about the availability of reproductive health services and how to obtain them.

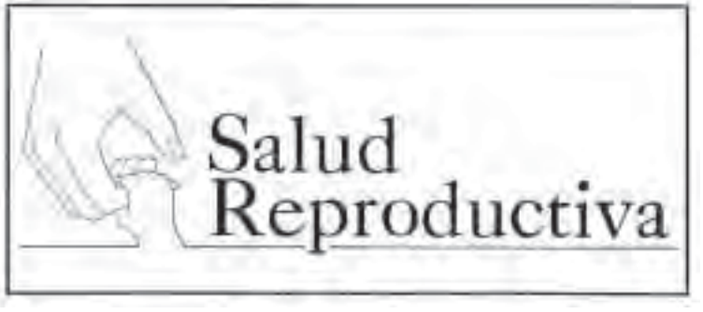
- Have at least 26 percent of the intended audience show a favorable attitude toward reproductive health services.
- Have at least 7 percent of the intended audience seek information and/or services by visiting health centers.

Indicators were used to verify that the campaign strategy was having the intended effect. Examples of these indicators were to:

- Have at least 17 percent of the intended audience talk about reproductive health themes with their spouses.
- Have at least 13 percent of the intended audience show intent to seek, in the near future, information and services provided by health centers.

Strategic Approach

The strategic approach of the Las Manitos I campaign was to empower women and men to take action to meet their reproductive health needs through the innovative use of advocacy and mass media channels.



To emphasize Government support of the Las Manitos I campaign, the President of Bolivia, Gonzalo Sanches de Lozada, delivered a keynote address to launch the effort. The President proclaimed reproductive health as the cornerstone of his 3-year "Plan for the Accelerated Reduction of Maternal and Perinatal Mortality." The inauguration of Las Manitos I represented the first time that the Government of Bolivia had ever prioritized FP and reproductive health on the national agenda in the history of the country.

Over time, a long-term identity was forged, in which women and men understood Las Manitos to represent a way to improve the health of children and mothers through birth spacing, FP, prenatal and postnatal care, breastfeeding and prevention of abortions.

The positioning statement for Las Manitos I can be described as:

> ***When you see the Las Manitos symbol, you will know that you can get the facts about reproductive health, and you can get a variety of reproductive health services to improve the health of your family.***

The NRHP ensured that the positioning of Las Manitos I reinforced the goals of the Government of Bolivia in the areas of maternal and child health. By offering information and services on a wide array of health issues, Las Manitos was able to support the President's initiatives to offer a range of services to improve the health of Bolivian families.

Key Message Points

In developing appropriate and effective messages, the Las Manitos I campaign had to overcome both cultural misperceptions about FP and opposition from conservative sectors to respond to the audience's perceived health needs.

Three sets of messages were designed and disseminated over the course of the campaign. The first set of messages explained the overall concept of reproductive health, which was not well understood initially by the audience. The Las Manitos logo was also introduced and featured prominently in all spots, and information was provided informing the audience where to go to obtain services.

In the second set of messages, specific information about particular FP methods was disseminated. Additional reproductive health concepts were also explained, including breastfeeding, prenatal and postnatal care, and the dangers of abortion. Factual information was shared in an attempt to educate the audience and to correct misperceptions. The messages also highlighted the benefits to the user of adopting these behaviors.

In the third round, the messages included testimonials from satisfied users to reinforce the benefits to women and men of taking charge of their reproductive health; in particular, the testimonials reinforced the positive effects of practicing FP.

Las Manitos I also aired a spot on the dangers of abortions and the importance of using FP methods to prevent unwanted pregnancy. Since one of the leading causes of maternal death in Bolivia was abortion, the Minister of Health requested that a spot emphasizing the potential risks of abortion be integrated into the mass media campaign. This was the first television spot aired in Latin America to mention this important health issue.

Throughout the campaign, pretesting and audience research were conducted to ensure that the messages were meaningful, appropriate, understood, and motivational. Special attention was given to language considerations as well.

Channels and Tools

Las Manitos I used mass media as the lead channel, which was supported by community and interpersonal channels of communication. Due to the low cost of radio production and broadcasting in Bolivia, the campaign was able to produce the number of spots required by the country's diverse population. Specifically, 11 television and 44 radio spots were used to allow for maximum reach and frequency during the initial 7-month campaign. To reach as much of the intended audience as possible, the radio spots were adapted to the indigenous languages of Aymara and Quechua. In addition, the Spanish versions were recorded in two linguistic norms—Coya and Camba.

At the community level, a series of four audiocassettes was developed for use on 1,000 city and interstate buses. Each cassette was 1 hour in length and included reproductive health messages complemented by popular music, a jingle, and jokes.

Interpersonal channels focused on training service delivery providers and providing them with a wide variety of materials to use with their clients. Materials included flip charts, reference manuals, method posters, reproductive health brochures, and individual method flyers. Print materials were used by all of the NRHP service delivery partner organizations and were adapted to the specific needs of their clinics. Clinic staff were trained in the use of the materials prior to initiation of the mass media campaign. A series of clinic videos for clients was also developed that covered the topics of breastfeeding, FP methods, and spousal communication.

V. Management Considerations

Partner Roles and Responsibilities

The NRHP had four technical subcommittees specialized by function: services, research and population policies, training, and IEC. Each of these committees was comprised of technical representatives of the participating public and private institutions. They met regularly each month and also met on an as-needed basis.

Members of these committees also met in minicommittees or working groups to execute a specific activity (e.g., printed materials, videos, campaign strategy). Despite the voluntary nature of this effort, the subcommittees worked very intensively and were instrumental in the success of the campaign. They participated in all phases of campaign development, shared the responsibility for the distribution of print materials, and acted as intermediaries with the Ministry of Health, other Government agencies, the church, and other key influentials. These partners also publicly advocated for the benefits of the campaign in different meetings and events.

The NRHP IEC Subcommittee was responsible for the campaign strategy design, implementation, and evaluation. This group primarily provided strategy oversight, direction, advocacy, and endorsement. The Ministry of Health was an active member of the IEC Subcommittee and also publicly endorsed the final campaign. The members of the subcommittee elected their own President and Secretary. The President served as the lead advocate in support of the campaign. A list of the IEC Subcommittee members is found in attachment 1.

Timeline

To lay the proper foundation for the Las Manitos I mass media campaign, prior to the campaign launch a number of training workshops were held with members of the IEC Subcommittee. Through these workshops, subcommittee members gained skills in developing health communication campaigns. The training covered audience research, message design, campaign development and implementation, pretesting and posttesting, and evaluation techniques.

Earlier, successful communication outreach efforts also played a role in laying the foundation for Las Manitos. A series of four 1-hour long audiocassettes had been developed beginning in 1986 and used extensively by intracity buses. The tapes covered many areas of reproductive health and FP methods. The response was so great for these audiocassettes that intercity bus drivers demanded that they also receive the audiocassette series.

The success of the Las Manitos I campaign, which aired from May–November 1994, provided the momentum for follow-on campaigns over the next several years.

Monitoring

The 7-month Las Manitos I mass media campaign was monitored primarily through media plan tracking. The advertising agency provided monthly television rating reports, and the distribution of the materials was verified through the IEC NGOs. This gave the campaign organizers the ability to monitor the reach and penetration of the campaign messages among the intended audiences.

VI. Evaluation

The success of the Las Manitos I campaign was measured after the campaign ended with a second cross-sectional national probability sample survey of households in urban areas conducted in November 1994. Modifications of the baseline questionnaire were made to include specific questions measuring impact based on message exposure and message recall.

Results indicated that the campaign reached more than 85 percent of the intended audience and met all of the stated behavior change objectives. Recognition of the Las Manitos logo was high; 94 percent of respondents were able to identify the logo. There was a significant increase in the proportion of the audience that knew about specific preventive health care measures. Among respondents in the four main cities, knowledge increased from 19 to 28 percent.

While awareness and IPC were found to be fairly high in the baseline survey and while attitudes were quite favorable, an increase in these measures was still achieved according to the followup survey. In the four main cities, method awareness increased from 84 percent in the baseline to 88 percent among those exposed to campaign messages. As for actual method use, new FP adopters in the four main cities increased from 5.4 percent of respondents in the baseline to 8.6 percent in the followup survey.

Indicators had been developed to track progress in reaching the objectives. One indicator looked at increased partner communication about reproductive health issues. The followup survey showed slight increases in partner communication among respondents, but these changes were not statistically significant. This finding implied that more refined measures of partner communication were needed for future evaluation efforts.

The other indicator examined respondents' intent to seek reproductive health information and services in the future. The change in the percentage of respondents who sought information on reproductive health was not statistically significant. Some of the intended audience may have "skipped" the information-seeking step and moved directly to the intention to use or actual adoption of a FP method. However, intention to use or continuation of method use increased significantly between the baseline and followup surveys for respondents in the four main cities. The percentage of men who responded "definitely yes" when asked if they would begin or continue using a method in the next 6 months increased from 25 to 53 percent.

The evaluation design allowed project managers to assess the impact of the campaign, measure changes, and determine their significance.

VII. Staying on Strategy

The Las Manitos I campaign was extended to seven medium-sized cities from October 1995 to January 1996. In 1996, a second campaign was developed to build on the experience of Las Manitos I. The focus of this campaign, which was implemented in all urban areas, supported the Government's goal of reducing maternal mortality. In addition, since this campaign was linked to a contraceptive social marketing campaign, the slogan "Reproductive Health Is Closer to You" was developed to reinforce the fact that contraceptives were now available at traditional and nontraditional outlets, and the health centers were not the only providers of reproductive health services or commodities.

Specific objectives of Las Manitos II were to:

- Expand the audience to reach more young adults and more couples living in urban areas.
- Emphasize the importance of preventing the spread of STDs and AIDS by using condoms.
- Reinforce the benefits of using specific contraceptive methods to prevent reproductive health problems, such as unwanted pregnancy and abortion.

Compared to the February 1994 baseline survey, the August 1996 survey analyzing the Las Manitos II campaign showed the following percentage changes among members of the intended audience:

Behavior Change Steps	1994 Baseline	1996 Followup
FP Method Awareness	49%	61%
Reproductive Health Detailed Knowledge	50%	53%
Reproductive Health Attitude	87%	88%
FP Intention	67%	67%
IPC	67%	79%
Current Modern Method Use	19%	23%

In 1997, recognizing the significant unmet need in rural areas for reproductive health information and services (modern method prevalence in rural areas was 6.9%), the NRHP developed a strategy called the Lilac Tent (Carpa Lila) to empower rural communities to learn more about reproductive health issues. A combination of mass media, community-based channels, and IPC is used to attract the intended audience, which is predominantly young adults, and to provide information in an educational and entertaining manner.

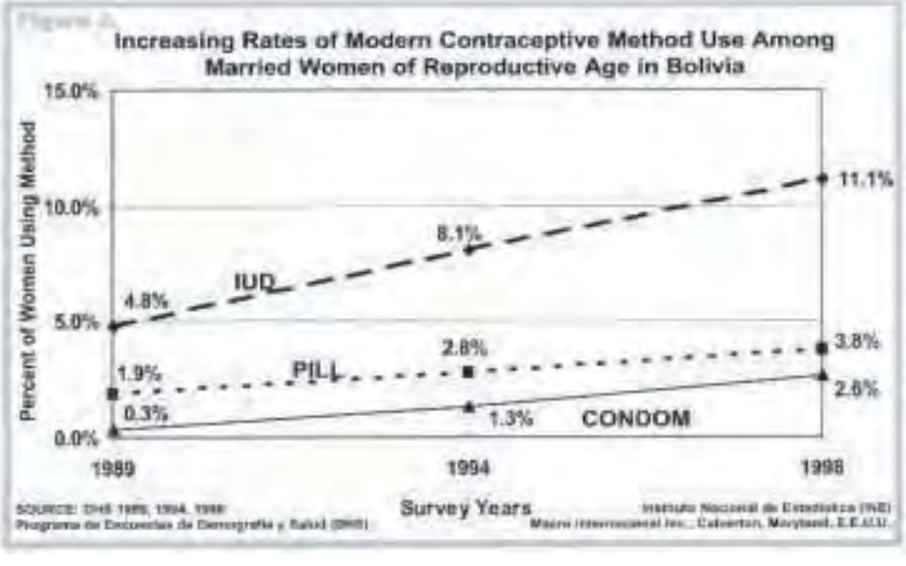
The Lilac Tent uses a community participation process to identify who should be trained as facilitators. Radio station producers are trained and given educational programming materials, and other community stakeholders, such as teachers and health workers, are also given training and materials. In the first year of the Lilac Tent, a total of 495,362 people were reached. Of these, 196,105 participated in community-based events, and 299,257 were reached through local radio and print.

VIII. Conclusion

The experience, lessons learned, and research results generated by Las Manitos I were used to refine the NRHP strategic approach over time. The IEC Subcommittee membership continued to grow to 45 organizations (as of 1998), and the group remained active in shaping messages to meet the needs of audiences in wider geographic areas, including rural communities. Additional audiences, such as young adults, were also identified as having significant needs for reproductive health information and services. Subsequently, there were two television series aimed at youth as well as a life skills curriculum for use in the classroom.

Due to the collaboration of many stakeholders and an unyielding focus on the needs of the couples with unmet needs, the rate of modern contraceptive method use has steadily increased in Bolivia from 7 percent in 1989 to 17.5 percent in 1998. This success is due in large measure to the vision and commitment of the NRHP and to the role that Las Manitos played.

Figure 2.



Lessons Learned

Las Manitos I broke new ground in Bolivia by highlighting a sensitive issue in a public, educational, and motivational way. In addition, for the first time in Bolivia high-level Government officials appeared in some of the Las Manitos television spots to reinforce the Government's support of reproductive health.

Between 1991 and 2000, significant changes occurred in community norms. The use of modern FP methods became more openly discussed, accepted, and prevalent. Las Manitos started a movement that showed, with a series of well planned campaigns over time, that substantial changes in community norms can occur. For example, in 1993–1994, traditional methods were more prevalent than modern methods. By 1999, this ratio had been reversed.

Las Manitos played the role of a catalyst and provided momentum for other health initiatives in Bolivia. Las Manitos also established an enabling environment that empowered other groups to speak out in support of reproductive health efforts.

Attachment 1
List of IEC Subcommittee Members

The 10 founding members of the subcommittee were:
Ministerio de Salud (MINSA)
Fundación San Gabriel (FSG)
Caja Nacional de Salud (CNS)
Unidad de Políticas de Población del Ministerio de Planificación (UPP)
Centro de Orientación Familiar (COF)
Protección a la Salud (PROSALUD)
Centro de Investigación, Educación y Servicios (CIES)
USAID
JHU/CCP
FAMES

Additional subcommittee members at various points in time included:
IPAS
Educación en Población/UNFPA
AVSC
Family Care International (FCI)
FHI
Freedom from Hunger
Fuerzas Armada de Bolivia (FFAB)
Programa de Salud Reproductiva (GTZ)
JHPIEGO/SMN
Mothercare
OPS/OMS
Focus/Pathfinder
Population Council
Proyecto Comunitario de Salud Integral (PROCOSI)
Proyecto contra el SIDA
PSI
Save the Children
Sociedad Boliviana de Ginecología (SBG)

Winay
UNFPA
UNICEF
Viceministerio de Genero
AYUFAM
Ilustre Alcaldia Municipal de La Paz
Viceministerio de Educación Alternativa
SERVIR
CROF
Centro de Investigación Social, Tecnología Apropiada y Capacitación
CISTAC
Cruz Roja Boliviana

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Appendix 1

Behavior Change Theories

Theories of Communication Impacts on Behavior

Over the last 50 years, social scientists have advanced various theories of how communication can influence human behavior. These theories and models provide communicators with indicators and examples of what influences behavior, and offer foundations for planning, executing, and evaluating communication projects (Piotrow, Kincaid, Rimon, & Rinehart, 1997). Theories particularly relevant to health communication include the following:

Ideation Theory (Kincaid, Figueroa, Storey, & Underwood, 2001). This theory (Cleland, 1985; Cleland et al., 1994; Cleland and Wilson, 1987; Freedman, 1987; Tsui, 1985) refers to new ways of thinking and the diffusion of those ways of thinking by means of social interaction (Bongaarts and Watkins, 1996) in local, culturally homogeneous communities. Recent sociodemographic literature has identified ideation and social interaction as important determinants of fertility decline. This perspective amounts to a shift from macrolevel structural explanations to microlevel decisionmaking explanations of demographic change.

Stage/Step Theories. Diffusion of innovations theory (Ryan and Gross, 1943) traces the process by which a new idea or practice is communicated through certain channels over time among members of a social system. The model describes the factors that influence people's thoughts and actions and the process of adopting a new technology or idea (Rogers, 1962, 1983; Ryan and Gross, 1943, 1950; Valente, 1995). The input/output persuasion model (McGuire, 1969)

emphasizes the hierarchy of communication effects and considers how various aspects of communication, such as message design, source, and channel, as well as audience characteristics, influence the behavioral outcome of communication (McGuire, 1969, 1989). Stages of change theory, by psychologists J.O. Prochaska, C.C. DiClemente, and J.C. Norcross (1992), identifies psychological processes that people undergo and stages that they reach as they adopt new behavior. Changes in behavior result when the psyche moves through several iterations of a spiral process—from precontemplation through contemplation, preparation, and action to maintenance of the new behavior (Prochaska et al., 1992).

Cognitive Theories. Theory of reasoned action, by M. Fishbein and I. Ajzen, specifies that adoption of a behavior is a function of intent, which is determined by a person's attitude (beliefs and expected values) toward performing the behavior and by perceived social norms (importance and perception that others assign the behavior) (Fishbein and Ajzen, 1975). Social cognitive (learning) theory, by A. Bandura, specifies that audience members identify with attractive characters in the mass media who demonstrate behavior, engage emotions, and facilitate mental rehearsal and modeling of new behavior. The behavior of models in the mass media also offers vicarious reinforcement to motivate audience members' adoption of the behavior (Bandura, 1977, 1986).

Social Process Theories. Social influence, social comparison, and convergence theories specify that one's perception and behavior are influenced by the perceptions and behavior of members of groups to which one belongs and by members of one's personal networks. People rely on the opinions of others, especially when a situation is highly uncertain or ambiguous and when no objective evidence is readily available. Social influence can have vicarious effects on audiences by depicting in television and radio programs the process of change and eventual conversion of behavior (Festinger, 1954; Kincaid, 1987, 1988; Latane, 1981; Moscovici, 1976; Rogers and Kincaid, 1981; Suls, 1977).

Emotional Response Theories. Theories of emotional response propose that emotional response precedes and conditions cognitive and attitudinal effects. This implies that highly emotional messages in entertainment (see chapter 4) would be more likely to influence behavior than messages low in emotional content (Clark, 1992; Zajonc, 1984; Zajonc, Murphy, and Inglehart, 1989).

Mass Media Theories. Cultivation theory of mass media, proposed by George Gerbner, specifies that repeated, intense exposure to deviant definitions of "reality" in the mass media leads to perception of that "reality" as normal. The result is a social legitimization of the "reality" depicted in the mass media, which can influence behavior (Gerbner, 1973, 1977; Gerbner et al., 1980).

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Appendix 3

Glossary

Activity
A specific event or action.

Campaign
Goal-oriented attempt to inform, persuade, or motivate behavior change in a well-defined audience. A campaign provides benefits to the individual and/or society, typically within a given time period, by means of organized communication activities.

Channels
Three categories of communication channels are interpersonal, community, and mass media. Interpersonal channels include one-to-one communication. Community channels reach a group of people within a distinct geographic area or reach a group that shares common interests or characteristics. Community-based media, community-based activities, and community mobilization are all forms of community channels. Mass media channels, which can reach large audiences quickly, include television, radio, newspapers, magazines, outdoor/transit advertising, and direct mail.

Community Mobilization

A process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups, and organizations on a participatory and sustained basis to improve health. In addition to improving health, the community mobilization process also aims to strengthen the community's capacity to address its health and other needs in the future. A participatory process of communities identifying and taking action on shared concerns.

Formative Research

Research studies conducted during the initial stages of program and message development. Includes reviews of existing research studies, pretesting concepts and messages, or trying out a program on a small scale before full implementation.

Gender Equality

The same status, rights, and responsibilities for women and men.

Gender Equity

The quality of being fair and right. Addresses imbalances. A stage in the process of achieving gender equality.

Indicator

An interim measure used to track progress toward achieving objectives.

Intervention

A health communication implementation that takes place within a given time.

Key Influencers

Influential people in the primary audience's social network, such as friends, relatives, religious leaders, and traditional healers.

Long-Term Identity

A unique set of associations that represent what the product, service, or behavior stands for in the minds of the audience.

Media Advocacy

The strategic use of mass media to advance a social or political policy initiative. Attempts to reframe community-based public dialogue and to increase support from the public in general and community policy and decision-makers in specific for public health policies.

Outcome Evaluation

A type of evaluation that determines whether a particular intervention had the desired impact on the intended audience's behavior, that is, whether the intervention made a difference in knowledge, skills, attitudes, beliefs, behaviors, and health outcomes. Also called impact or summative evaluation.

Positioning

In the context of strategic design, positioning means presenting an issue, service, or product in such a way that it stands out from other comparable or competing issues, services, or products and is appealing and persuasive. Positioning creates a distinctive and attractive image, a perpetual foothold in the minds of the intended audience.

Program

A plan or system under which action may be taken toward a goal. In the context of this book, "program" refers to a broad health-related effort with long-term goals, perhaps national in scope, usually generated or at least endorsed by the government. A health program may include various projects and strategies focusing on issues, such as health care service delivery, service provider training, commodity supply, clinic infrastructure, communication, and research. Examples are FP, HIV/AIDS, integrated health services, and child immunization.

Project

A specific plan or design scheme. In the context of this book, "project" refers to a subset of a health program in which a portion of the program is implemented, such as a specific child immunization project under a broader maternal and child health program. Other projects under this program might focus on breastfeeding, nutrition, and prenatal and postnatal care, for example.

Public Policy Advocacy

The effort to influence public policy through various forms of persuasive communication. Public policy includes statements, policies, or prevailing practices imposed by those in authority to guide or control institutional, community, and sometimes individual behavior.

Segmentation

This process involves dividing the audience into smaller groups of people who have similar communication-related needs, preferences, and characteristics. Each audience segment requires tailored messages that will be meaningful to the audience members.

Segmentation entails subdividing an overall population into similar subgroups in order to better describe and understand each subgroup, predict behavior, and formulate the appropriate messages and programs to meet specific needs.

Social Capital

The resources embedded in social relations among persons and organizations that facilitate cooperation and collaboration in communities.

Strategic Approach

Describes the overarching direction that guides the choice of messages, channels, tools, management components, and indicators to achieve desired goals.

Strategic Communication

A process based on a combination of data, ideas, and theories integrated by a visionary design to achieve verifiable objectives by affecting the most likely sources and barriers to behavior change, with the active participation of stakeholders and beneficiaries.

Strategic Communication Tools

The various tactics used to conduct messages through the channels. They include advocacy; advertising; promotion; IPC enhancement, event creation and sponsorship, community mobilization; publicity; and entertainment vehicles, such as television or radio programs, folk dramas, songs, or games that provide entertainment and educational messages simultaneously.

Strategy

A careful plan or method; the art of devising or employing plans toward a goal.

In the context of this book, a "strategy" is the health communication strategy that includes subsections describing the situation, the audience, behavior change objectives, the strategic approach, key message points, channels, management and evaluation plans.

Appendix 4

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