



How to improve the use of medicines by consumers

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Abbreviations

AIDS	Acquired immune deficiency syndrome
ANM	Auxiliary nurse midwives
ARVs	Antiretrovirals
BCC	Behaviour change communication
CBIA	Cara Belajar Ibu Aktif (Mothers' Active Learning Method), Indonesia
CHS	Commune health station
DOT	Directly observed treatment
DOTS	Directly observed treatment short-course
DSPRUD	Delhi Society for the Promotion of the Rational Use of Drugs (India)
EE	Entertainment-education
EHCN	European Health Communication Network
FGD	Focus group discussion
HAI	Health Action International
HIV	Human immunodeficiency virus
IDD	Iodine deficiency disorder
IEC	Information, education and communication
IGD	Interactional group discussion
IMCI	Integrated management of childhood illness
ITN	Insecticide treated bednet
MOH	Ministry of Health
MSC	Most significant change
MSF	Médecins Sans Frontières
MTCT	Mother-to-child transmission
NGO	Nongovernmental organization
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
OTC	Over-the-counter
PATH	Program for Appropriate Technology in Health (USA)
PHT	Public health technician
PM&E	Participatory monitoring and evaluation
PRDUC	Promoting rational drug use in the community
PSAT	Cell phone prompted self administered therapy
STG	Standard treatment guidelines
SSRI	Selective serotonin re-uptake inhibitors
STIs	Sexually transmitted infections
TDR	Special Programme for Research and Training in Tropical Diseases
UNDP	United Nations Development Programme
VHW	Village health worker
WHO	World Health Organization
YVS	Youth variety show

Credits for graphics

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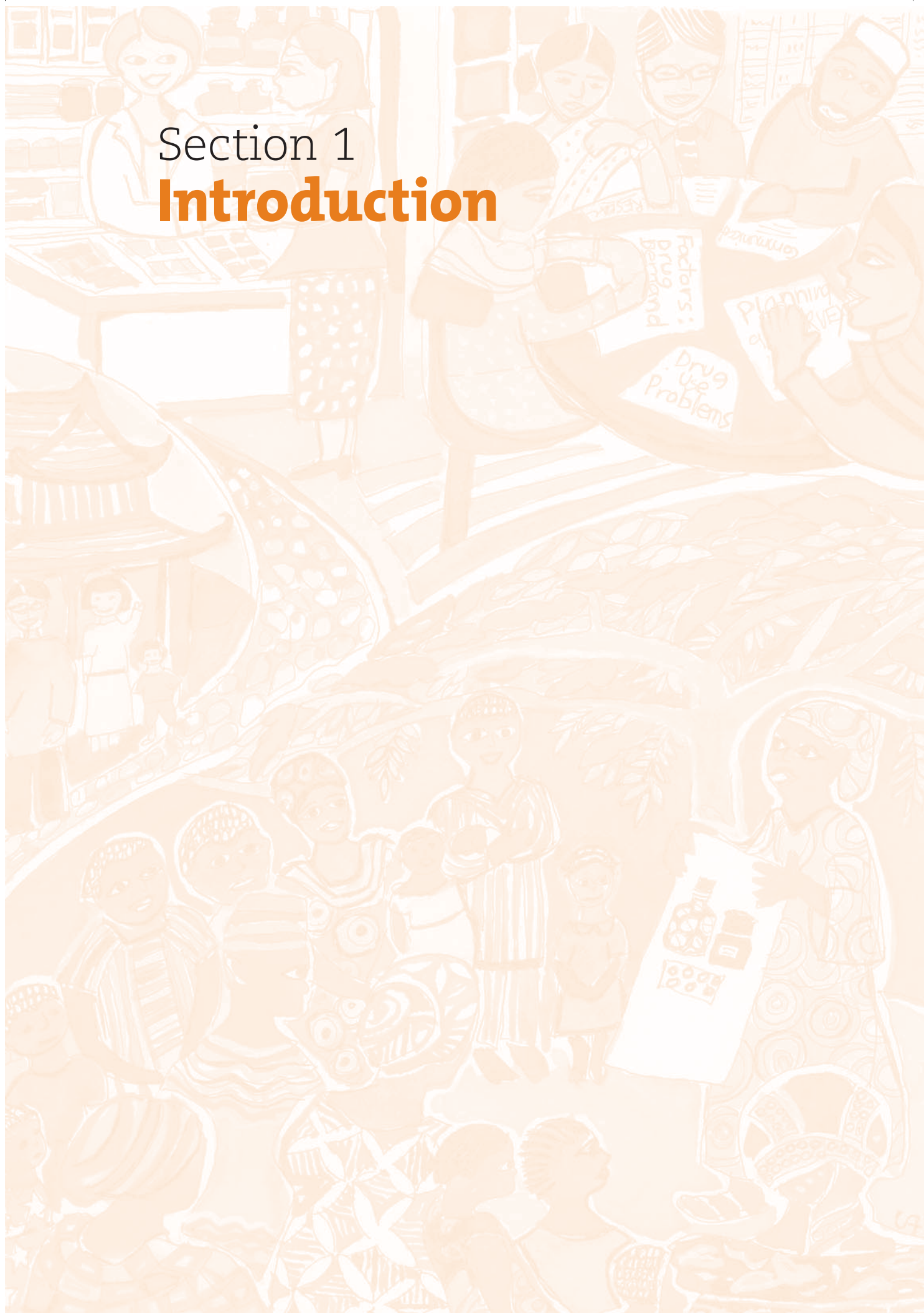
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Section 1

Introduction



Essential medicines are one of the vital tools needed to improve and maintain health. However, for too many people throughout the world medicines are still unaffordable, unavailable, unsafe and improperly used. An estimated one third of the world's population lack regular access to essential drugs, with this figure rising to over half in the poorest parts of Africa and Asia. When available, the medicines are often used incorrectly: around 50% of all medicines are prescribed, dispensed or sold inappropriately, while 50% of patients fail to take their medicines appropriately (WHO 2002a).

Since the beginning of the 1980s the essential drugs concept has become one of the cornerstones of international and national health policy – influencing decision-making in both developing and industrialized countries. The selection and rational use of medicines are accepted as key principles of health service quality and management in both the public and private sectors. WHO vigorously promotes the essential drugs concept and the rational use of drugs. National drug policies are promoted by WHO and others as a guide to action and a key framework within which to make the necessary commitment and coordinate the various policy components needed to guarantee access to and rational use of medicines.

For essential medicines to contribute to improved health, countries need to develop national medicines policies, ensure access to essential drugs, strengthen drug regulation, and improve rational use of drugs in both public and private sectors, and by both health professionals and consumers. Though much progress has been made in all of these areas, health policy-makers have generally focused more on the provision and regulation of medicines, and on efforts to improve health workers' prescribing, than on efforts to ensure rational use of medicines by consumers.



Health policy-makers have focused more on provision and regulation of medicines...



...than on efforts to ensure rational medicine use by consumers

What is rational use of medicines?

WHO's definition of rational use is that: "Patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community" (WHO 2001).

Rational drug use interventions that focus on health worker prescribing can only partly improve the use of drugs. This is because, as studies on medicine use by consumers have shown, *self-medication is the most common form of therapy choice* and people often rely on informal drug distribution channels as much as on the medicines prescribed and supplied by trained health professionals.

To address the problem of irrational use of medicines, health planners and administrators need specific information on:



- the types of irrational use that occur in their country or district, so that strategies can be targeted towards changing specific problems
- the amount of irrational use, so that the scale of the problem is known and the impact of the strategies can be monitored
- the reasons why medicines are used irrationally, so that appropriate, effective and feasible strategies can be chosen. People often have very rational reasons for using medicines “irrationally”.

Consumers’ perspective: a different rationality

Consumers have their own reasons for using drugs the way they do – reasons that are based on social and cultural rules, experience, health beliefs, financial means, and psychological aspects. Reasons can include:

- People in general treat symptoms, and not the disease. They are not given a chance to understand how the disease works, and how the drugs should be taken to treat the disease, because most health workers and prescribers are not taught how to give such explanations in a way that people can understand, based on their own belief system.
- People self-medicate for diseases such as malaria because it is a common disease that occurs often, and drugs are available at the local shops. Malaria is called “fever” in many African languages, and it is treated until the fever goes away – a logical response.
- Misuse of antibiotics often happens for the same reasons. People do not understand why they should take a full course (the reason given by the health worker does not make sense to them). A full course is expensive, and people treat until the symptoms are gone.



Common patterns of inappropriate medicine use

Research over the years has identified a number of common areas of inappropriate medicine use that have a negative impact on the health of consumers. These include:

- not taking medicine in the way intended by the prescriber
- self-medication with prescription drugs
- misuse of antibiotics
- overuse of injections
- overuse of relatively safe medicines
- unsafe use of herbal medicines
- use of non-essential combination drugs
- use of needlessly expensive medicines.

Not taking the medicine in the way intended by the prescriber

Health workers tend to stress the problem of consumers not complying with or adhering to instructions on how to take a medicine.¹ This has been the focus of many drug use studies (Homedes and Ugalde, 1993). People do not have full

¹ Compliance and adherence are words used to describe whether a consumer takes a medicine in the way intended by the health professional who prescribed it or according to the instructions on the packaging. Some people prefer not to use the word compliance because it implies a normative view that the consumer should obey/comply with instructions. The word concordance may also be encountered in this context. It refers to a consultation process between the health professional and the consumer, who reach agreement about the best course of treatment in a way which values the perceptions and opinion of both parties.

information about how to take medicines because health workers have too little time to explain, people tend to forget the details of the advice given because the explanation of use was not clear or was poorly understood, or fail to purchase all of the drugs that are prescribed, because they cannot afford them. Patients sometimes stop taking the prescribed drugs or take the wrong dosage. Of course, interventions to improve adherence only make sense if health workers' prescribing practices are appropriate and rational.

Self-medication with prescription drugs

Another problem is that in many countries people can purchase drugs over-the-counter that legally should be sold only on prescription. A study in the Philippines found that people keep copies of prescriptions to re-use (Hardon, 1991). Doctors' consultations are expensive and repeated use of prescriptions is a way to economize.

Self-medication with prescription drugs is especially a problem in developing countries where pharmacies freely supply medicines over-the-counter, as do informal drug shops and small groceries. Sometimes people even self-medicate with prescription drugs on the advice of traditional healers. People keep stocks of leftover medicines in their homes, and re-use them or give them to neighbours or relatives who request them.

These practices also occur in countries where dispensing of medicines is regulated more strictly. The possibility of buying medicines through the Internet means that those available only on prescription in one country can be obtained by post from a country where regulation is less strict. Immigration and people's increased mobility mean that more people buy medicines where it is easy to obtain them – or obtain them through family and friends.



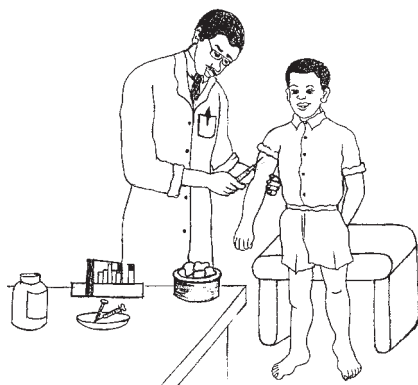
Misuse of antibiotics

Antibiotics are very important drugs, but they are over-prescribed and overused in self-medication for the treatment of minor disorders such as simple diarrhoea, coughs and colds. When antibiotics are used too often in sub-optimal dosages, bacteria become resistant to them. The result is treatment failure when patients suffering from serious infections take antibiotics. This is of great concern to public health policy-makers. People buy sub-optimal dosages because they cannot afford the full course prescribed, or because they are not aware of the need to complete antibiotic courses. Even in industrialized countries where antibiotic dispensing is better regulated, non-compliance with the prescribed regime is a common problem. People who have not understood the need to complete the course stop using antibiotics when the symptoms disappear, while others take an overdose as they think that this will lead to faster recovery.

Studies by Lansang et al. (1990, 1991) and others highlight some of the problems with antibiotic use in the Philippines. In urban settings, 66% of antibiotic purchases were made without prescriptions. Customers purchased 10 units (tablets or capsules) or fewer. In rural areas, 57% of antibiotics were purchased without a prescription, but only six tablets or capsules at a time were bought. These findings indicate widespread sub-optimal use of antibiotics in self-medication.

Overuse of injections

Health workers and patients in many countries believe that injections are more effective than tablets. This not only leads to unnecessary expense (in many cases tablets are a cheaper form of therapy), it also leads to unnecessary health risks when the injections are administered in unhygienic conditions or syringes and needles are re-used without being sterilized.



A WHO study on injection practices in developing countries found that in Uganda around 60% of patients bring along their own syringe and needle when they visit health facilities or pharmacies for treatment. The instruments generally have not been sterilized properly. People keep the equipment at home because they do not trust the injections provided in the health facilities (Van Staa and Hardon, 1996).

Overuse of relatively safe medicines

In many countries people believe that they need a “pill for every ill”. At the onset of all kinds of minor disorders they immediately take medicines. Vitamins and analgesics such as multivitamins, acetylsalicylic acid (aspirin) and paracetamol are the most commonly used drugs in many countries. Although relatively safe, they are not without risks. Aspirin can cause stomach bleeding and paracetamol, if taken in excess, can cause death. A study in Thailand found the overuse of analgesics in rural Thai communities for pain relief, related to hard agricultural labour (Sringernyuang, 2000). For the agricultural labourers, a painkiller a day seems essential. It allows them to continue work and have a regular income. Health workers recognize that the practice is unsafe, as it can lead to stomach bleeding, a commonly reported health problem in Thailand.

Unsafe use of herbal medicines

In developing countries people use herbal medicines routinely in self-care. Many countries test the safety and efficacy of these medicines, and some of them are selected for inclusion in national health programmes. The production of herbal medicines is commercialized in countries such as the People's Republic of China, India, Viet Nam and Thailand, and marketing is similar to that for modern pharmaceuticals. In industrialized countries the use of herbal medicines is also increasing. People believe that they are more natural than modern pharmaceuticals. Some herbal medicines are potent, and their safety is not always as evident as people think. Also they can be dangerous when taken in combination with modern pharmaceuticals. For example, the antidepressant herb St John's Wort cannot be used in combination with antidepressants such as selective serotonin re-uptake inhibitors (SSRIs).

Use of non-essential combination drugs

People tend to take all kinds of cough and cold remedies that contain more than one active ingredient. Sometimes these drugs even contain substances that counteract each other: one substance to **suppress** a cough and another to **encourage** it. Such



products do not contribute to a cure, are a waste of money and may increase adverse effects.

Use of needlessly expensive medicines

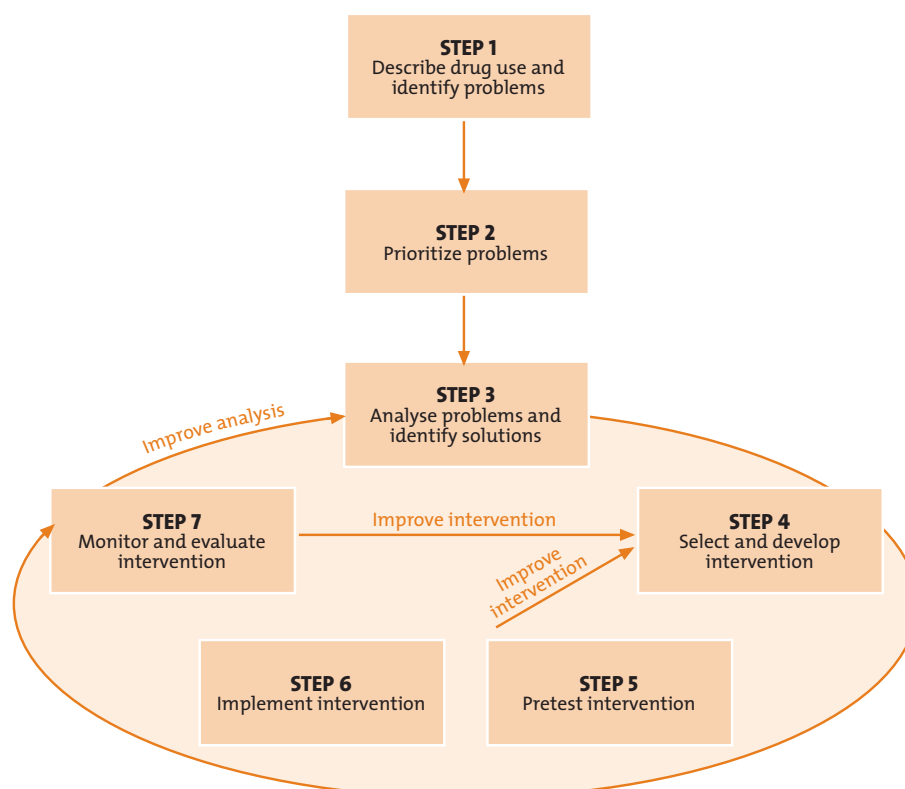
In many countries people rely on brand name drugs when choosing therapies. Pressure from advertising of branded products encourages this trend. Branded products are often more expensive than the same products under generic name. The price of medicines is an extremely important concern for consumers (WHO and HAI, 2003). Also people may not realize that two different brand name drugs may contain exactly the same substance.

Changing the way medicines are used

The starting point for any intervention to improve the use of medicines is solid participatory research that identifies problems related to drug use in communities and their possible solutions. A companion manual, *How to investigate the use of medicines by consumers*, (WHO, 2004) describes in detail how to prepare for and undertake such research together with community members. It covers the first three steps in a seven-step process of developing an effective intervention to improve the use of medicines at community level (see Figure 1).

This manual takes up the process from the point at which the research has reached its conclusions and recommendations and problems have been identified, prioritized and analysed. In the manual, we will look at how to move through steps four to seven: selecting, testing, implementing and evaluating interventions. In

Figure 1. Steps in an effective communication intervention



doing so, it is vital to remember that along the way it may be necessary to revise the intervention, in the light of monitoring information and feedback from the people in the communities in which the intervention is meant to be operating.

Interventions to encourage rational medicine use can be addressed in several ways. Two broad strategic areas are identified in this manual and they serve as the framework around which the main chapters are organized. These are:

- communication strategies
- strategies to create enabling environments, including managerial and regulatory strategies.

Chapter 1 explores leading communication theories and highlights the need to combine research, communication, managerial and regulatory strategies to achieve sustainable change at community level.

Communication strategies are looked at in more depth in Section 2, with detailed analysis of four possible communication methods or channels to use – face-to-face, drama and folk media, print, and mass media – covered in Chapters 2–5.

Section 3 looks at strategies to create enabling environments. Chapter 6 explores the role of the media while Chapter 7 looks at how advocacy and the mobilization of people, organizations and networks can help to move forward a particular concern. Chapter 8 highlights how managerial and regulatory strategies serve to stimulate enabling environments.

Finally, Section 4 brings the thinking together and looks at some very practical and important issues in Chapters 9–11: planning, pretesting, monitoring and evaluation. Chapter 12 draws together the main lessons of the collected experience covered in this manual and related literature.

Key reading

WHO (2004). *How to investigate the use of medicines by consumers*. Geneva, World Health Organization.

WHO (2001). *How to develop and implement a national drug policy*. 2nd ed. Geneva, World Health Organization.

WHO (1993). *How to investigate drug use in health care facilities*. Geneva, World Health Organization.



How communication works

Putting interventions into context

The way medicines are used does not take place in a vacuum but reflects profound cultural beliefs and economic, social and political realities. Identifying how to use communication and other strategies effectively to address problems around medicine use practices at the community level requires paying careful attention to those beliefs and realities.

Communication plays a large role in attempts to tackle inappropriate drug use in communities. Examples later in this manual will show how a combination of effective approaches can change awareness and behaviour in communities. These methods can improve understanding by health workers about the type of communication that works best with young people or other population groups, and can influence policy-makers.

However, far too many communication approaches have failed because they did not pay sufficient attention to the specific realities, and instead tried to impose a standard solution and deliver a standard set of messages.

The alternative is to develop solutions to problems together with the people who live with the problems, and use these as a basis for the communication campaign. Such solutions will usually be more practical, suited to the local culture, be owned by the people, and will be implemented and lead to improved health.

Some communication approaches have also failed because they did not take account of the other interventions – managerial and regulatory – that may be needed to create an enabling environment for change to take place.

This chapter will:

- show the link between participatory research and communication and other interventions to address community medicine use problems



- help to improve understanding of core communication principles.

Changing models and approaches – from messages to dialogue

Over time, communication processes can be characterized as having moved through the following stages:

- from a model of **information transmission** which aimed information from a sender to a largely passive receiver audience
- to a process of **behaviour change communication**, which encouraged more interaction and involvement of audiences in the development of the messages being communicated
- to an **emerging concept around social change communication** that echoes earlier participatory communication concepts around the need to look not only at change in an individual, but the change that needs to occur in society to enable individual change to occur.



Each of these progressions has involved a shift towards greater emphasis on the individual as no longer being a 'target', but a critical participant in identifying, analysing and adopting the information that is most suited to his or her own circumstances (Jacobsen, 1997).

A recent development that underlines much of the previous experience and learning are the lessons emerging from the communication challenges around HIV and AIDS. There is increasing evidence that much of the communication work around HIV and AIDS has, in the words of a strong research report from the Panos Institute (2004), been 'Missing the message'.

Knowledge alone does not change behaviour

Although improved knowledge is essential for behaviour change to occur, there is increasing evidence to show that knowledge by itself may not be sufficient (see Box 1). Many examples from everyday life demonstrate this: smokers do not stop because they know they can get lung cancer. In developing countries, many women do not use contraceptives even if they know about this option, and do not want more children.

For behaviour change to take place, several aspects are important:

BOX 1. HIGH KNOWLEDGE LEVEL, LOW BEHAVIOUR CHANGE

Research around efforts to improve home-based management of malaria in Ghana found that:

- 71% of mothers were able to accurately recall how to administer antimalarial drugs correctly **but** at home only 15% give the correct drug, at the correct dosage for the correct duration
- 63% of mothers knew that a child with fever should receive tepid sponging (ill) and antipyretics **but** only 3% cent actually practiced this treatment.

Ford N et al. (2003). *Communication strategy for implementing community IMCI*. Nairobi, UNICEF East and Southern Africa Regional Office.



- On the **individual** side, the person must understand WHY a change is needed, and the reasons must make sense from his/her point of view (not only from the health planner's or health worker's point of view). The reasons need to connect to their belief system, and be channelled through credible people. Furthermore, an emotional event is often the starting point for change.
- Sometimes, changes in the social construction of the household, community or broader society are needed to enable people to act on new knowledge. Effective communication helps to create the 'social space' or 'enabling environment' in which changes of practice become possible (Ford, 2003).

Many communication approaches fail because they take a top-down approach devised by health managers and professionals rather than responding to community needs, views, practices and realities. Respect for people's beliefs and actions starts to build a bridge to a new understanding that can lead to change.

Box 2 highlights some principles developed from working with rural women that apply equally to all community interventions. These principles were devel-

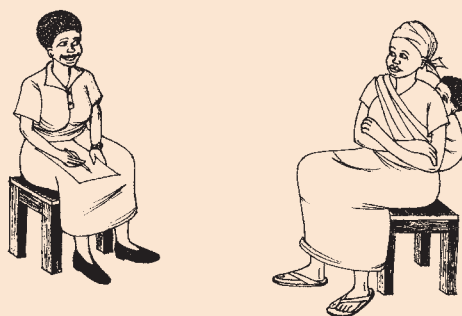
BOX 2. DIFFERENT APPROACHES TO COMMUNICATION WITH RURAL WOMEN

To reach rural women **a change in philosophy** is needed. Traditionally, strategies to communicate health messages have been driven by the goals of policy-makers and senior health professionals. A change in perspective is required, starting from where the community is in its thinking and experience. The possibilities open to them for change must also be taken into account. Those who seek to communicate meaningfully need to recognize that:

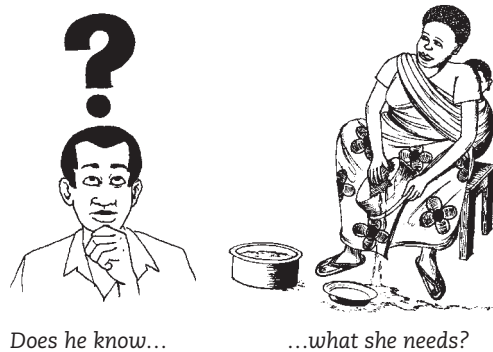
- Local perceptions of health and illness are valid, and should be accepted and incorporated into information design.
- Women already perform a health care-giving role that they and their families value. Information should enhance this role rather than undermine it.
- Women's actions are determined by the contexts in which they live. It is important to recognize how gender relations affect their health, and their ability to implement changes in their lives and those of their families.
- Rural women's understanding of health and disease is often dismissed as irrational and words like 'ignorant' and 'superstitious' are frequently used to describe their behaviour. Research, however, has shown that local understandings of health and illness can be complex and detailed. Given the opportunity, rural women are able to explain their interpretations and observations in ways that are inherently rational. Their reasoning is inductive – based on lived experiences and built up over time, just as modern medicine is.

Local perceptions of health and illness should be understood and appreciated. Their basis and the validity they have for local people must be recognized and taken into account in the design of new health information. In many cases people's behaviour corresponds closely to modern medical ideas. Only certain aspects that are inappropriate or harmful may need to be pointed out. Health information can be designed to incorporate traditional and modern biomedical practices so that it is meaningful within a community's lives and within its range of possible actions.

WHO (1998) *The healthy women counselling guide: a model for reaching women*. Geneva, UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases.



(Female) interviewers with good communication skills – like active listening, a non-judgemental attitude, and patience, can find out how rural women understand health issues.

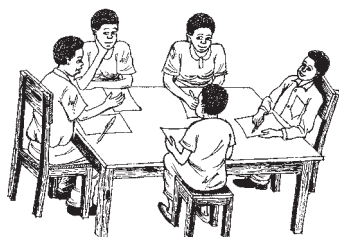


oped by the UNDP/ World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), based on extensive field experience.

Any health communication intervention must take context and practice into account, and be sensitive to the possible tension between the health planner's desired behavioural change and people's own needs and realities. Only if a balance between the two is achieved will the intervention be successful. This is particularly the case when dealing with community-level communication.

Health communication theories

There is a rich body of literature, of varying levels of complexity, dealing with communication. Within this, there is a field of practice called development communication – literally, the application of communication strategies and principles to the process of development and social change – which has evolved over the past 50 years. One of the leading influences on development communication has been health communication. While we cannot discuss in detail all the models and approaches that have been used in health communication, Table 1 summarizes



some key theories. What has become clear over the years is that there is no single model or approach that is the solution to all health communication challenges (National Cancer Institute, USA, 2003). Different techniques are appropriate in different contexts to deal with different priorities and problems.

Selection of the appropriate approach from a 'menu' or 'tool-kit' of possibilities based on an understanding of both the realities of the situation and the most appropriate change theory to apply is increasingly the way to develop effective communication interventions. This manual will help you to build the skills and experience to make that selection more effectively.

In an effort to bring together most of the major theories underpinning behaviour change, a simple framework was developed at a consensus conference held in Washington D.C., USA, in 1991 (see Box 3). Of the eight elements identified, the first three are considered essential for ensuring behaviour change. The remaining five enhance the intensity and direction of the intention to change behaviour.

For example, the treatment supporter assigned to a tuberculosis patient (to observe the patient taking her medicine every day) functions to a large extent to support this theory.

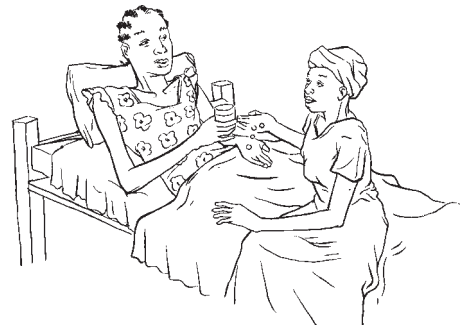
1. The patient has a strong interest in taking medicines for 6–8 months to get cured.
2. Environmental constraints: This is often where the problem is – because of stigma.



Table 1. Summary of key communication models and approaches

THEORY/MODEL	DATE	THEORISTS	KEY ELEMENTS
Information transmission	1950s, 1960s	Shannon-Weaver, Lerner, Schramm	Persuasion techniques, uni-directional (from sender to receiver), linear, (mass) media focused.
Diffusion of innovations	1960s, 1970s	Rogers	Early study of individual behaviour, identified five stages of adoption of new approaches: awareness, knowledge and interest, decision, trial, adoption/rejection that has formed the basis of much behaviour change work; recognition that interpersonal communication as well as mass media were necessary.
Social marketing	1970s, 1980s	Kotler, Zaltman, McKee, Lefebvre	Strong focus on influencing behaviour, promotion of practices/products of benefit to a defined target group, importance of market research and understanding consumer preferences, interaction with consumers and segmentation of target audiences.
Behaviour change communication	1980s, 1990s	Piottrow et al., Bandura, Terry et al., Becker	Strong focus on cognitive theories and models including drawing heavily on the health belief model, the theory of reasoned action and theories of social learning. Has tended to focus on individuals as the unit of intervention and analysis, although more recently, more attention is being paid to social influences.
Participatory communication	1970s onwards	Freire, Snowden	Primarily concerned with transforming social conditions and fostering community empowerment. A human-centred approach that values interpersonal and horizontal communication and community-based forms of communication that are easy to access for community members. Can include mass media and new technologies, but the issue here is who controls the use of these channels of communication.
Health promotion	1980s, 1990s	Ottawa Charter, Jakarta Charter, Nutbeam	Health promotion is defined in the Ottawa Charter as a 'process of enabling people to exert control over the determinants of health and thereby improve their health'. Thus, it is not something done to people, but with people. Participation and partnership are valued processes.
Social mobilization/social action	1980s	UNICEF, Rothman et al.	Aims to increase the problem-solving ability of the community and to achieve concrete changes to redress social injustice identified by a disadvantaged or oppressed group. Empowerment processes stimulate problem-solving and activate community members. Focuses on demands for action to meet health needs. People living with HIV and AIDS and women's health advocates are among those who have used social action. Media advocacy is often used.
UNAIDS communication framework	1999	Airhihenbuwa et al.	Identifies five contexts which need to be considered when developing communication initiatives around HIV and AIDS: government policy, socio-economic status, culture, gender relations and spirituality. Individual health behaviour is recognized as a component of this set of domains.
Communication for social change	2000	Rockefeller Foundation	A process of public and private dialogue through which people define who they are, what they want and how they can get it. It is informed by principles of tolerance, self-determination, equity, social justice, empowerment and active participation for all. It sees people and communities as the agents of their own change, supports dialogue and debate on key issues of concern, and focuses on social norms, policies, culture and a supportive environment. It aims to negotiate the best way forward in a partnership process that ensures that the people most affected by the issues of concern play a central role.

3. The supporter (who is often a former patient) has the skills, and teaches the patient.
4. The patient gets better (and perceives advantages) and gets care and support every day.
5. The supporter and the patient's family apply social pressure.
6. Taking medicine is OK for the patient's image.
7. The emotional reaction is positive, especially as the patient improves her health.
8. The patient increasingly believes she can be cured, with the practical, emotional and "moral" support of the treatment supporter.



BOX 3. CONDITIONS FOR BEHAVIOUR CHANGE

1. The person has formed a strong positive intention (or made a commitment) to perform the behaviour.
2. There are no environmental constraints that make it impossible for the behaviour to occur.
3. The person has the skills necessary to perform the behaviour.
4. The person believes the advantages (benefits, anticipated positive outcomes) of performing the behaviour outweigh the disadvantages (costs, anticipated negative outcomes).
5. The person perceives more social pressure to perform the behaviour than to not perform the behaviour.
6. The person perceives that the behaviour is consistent with their self-image and does not violate their personal standards.
7. The person's emotional reaction to performing behaviour is more positive than negative.
8. The person believes (has confidence) that they can execute the behaviour under a number of different circumstances (the person has the perceived self-efficacy to execute the behaviour).

Fishbein, M et al. *Factors influencing behaviour and behaviour change*. Final report prepared for the National Institute of Mental Health, USA, theorists workshop. Washington, D.C., 1991. Reproduced in: *Changing behaviours: a practical framework*. Toronto, The Health Communication Unit, 2004. Available at <http://www.thcu.ca/infoandresources/publications/Changing%20Behaviours4.2.june.15.04.pdf>

Levels of influence

Another way of looking at what influences behaviour emerged in the late 1980s when McLeroy and others identified five levels of influence for health-related behaviours. (McLeroy et al., 1988) These were:

- individual or intrapersonal factors – characteristics such as knowledge, attitudes, beliefs and personality traits that influence behaviour
- interpersonal factors – such as the interactions among family, friends and peers that provide social identity, support and role definition
- institutional or organizational factors – such as rules, regulations, policies and informal structures which may constrain or promote particular behaviours



- community factors – social networks and norms, both formal and informal, among individuals, groups and organizations
- public policy factors – local and national policies and laws that regulate or support healthy action.

The degree to which communication processes deal with each of these various factors is a probable indicator of the effectiveness of the intervention and its likely impact on behaviour.

These levels of influence for health-related behaviours are consistent with the main levels of influence that have been identified as affecting consumer medicine use (WHO, 2004):

- family/household level
- community level
- health service institution level
- national level
- international level.

Interventions to improve medicine use can take place at a number of levels. Table 2 illustrates some of the issues that might be tackled under each of these levels. For example, if there is a significant problem of unethical drug promotion this could be tackled:

- at the national level through the adoption of a code of pharmaceutical marketing practices with hefty penalties for infringements
- through education at the health institution level through medical schools and professional societies on critical evaluation of drug promotion and awareness-raising of drug marketing techniques and disguised marketing practices
- through education in the community (including schools) on the difference between drug information and drug promotion
- through local media involvement, using examples
- through “shame and blame” activities to publicize at national and international levels the most blatant infractions and their possible public health and societal consequences in the media.

But in the real world such multi-level interventions may be very difficult. We then need to decide whether it is worth tackling the problem at one or perhaps two levels or whether the chances of even a modest impact without a fully supporting infrastructure are too low to make this worthwhile. This weighing up of possibilities for a successful intervention is part of your initial prioritization of problems to tackle. Sometimes windows of opportunity occur when political, social or economic change creates an environment ripe for a given intervention. When making this evaluation it is important to look at possible alliances with other stakeholders (see Chapter 7, *Advocacy and networking*).

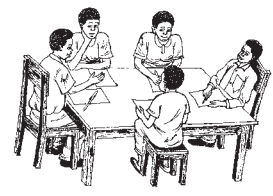
The role of emotions

Emotions play an important part in the process of behaviour change. The reasons people decide to change (or not to change) are almost always linked to their emotions. Information or knowledge about the advantage of the change (e.g. to stop smoking) is, although a necessary component, not sufficient to actually lead to the adoption of changed behaviour.



A friendly, caring health worker inspires trust, and is more likely to influence patients to adopt new behaviour.

Table 2. Main factors influencing drug use by consumers

LEVEL OF INFLUENCE	FACTORS
FAMILY/HOUSEHOLD	
	• Perceived need for medicines • Ideas about efficacy and safety • Uncertainty about the illness resulting in poly-pharmacy • Cost of medicines • Literacy levels • The perceived power of medicines • Basic health beliefs • Treating symptoms, not disease • Influence of traditional healers • Ideas and power of older generation
COMMUNITY	
	• Drug use culture • Medicine supply system • Information channels • Availability of drug shops
HEALTH SERVICE INSTITUTION	
	• Extent to which health workers are consulted • Quality of health worker training and information • Quality of health worker prescribing • Quality of the consultation • Quality of the dispensing process • Reliable supply • Cost of medicines
NATIONAL	
	• Implementation of essential drugs policy • Drug regulation • Drug legislation • Drug promotion • Financing and reimbursement • Consumer advocacy • The media • Public education
INTERNATIONAL	
	• Health consequences of global trade agreements • Donor support for essential medicines programmes • Global consumer advocacy • The Internet

Understanding how change happens for individuals and communities, and especially the role of the emotions, is critical to successful communication. As early as the 1920s social anthropologists provided important insights to this process. Everett Rogers describes this learning in his work on *Diffusion of innovations* – the title of a much cited book, now into its fifth edition since 1962 (Rogers, 1962, 1976, 1983, 1995, 2002). His model makes a clear distinction between the first two stages in the behaviour change process (Awareness and Interest), which are cognitive (i.e. involves thinking, without any commitment), and the next three stages (Trial, Evaluation and Adoption/Rejection), which are linked to the emotions (see Table 3).

Table 3

STAGES IN THE WAY AN INDIVIDUAL CHANGES BEHAVIOUR		INFLUENCED BY:
	Awareness Interest	Cognitive/ intellectual; “Head” Mass media, events, books, films, friends, family, etc.
	Trial Evaluation Adoption/ Rejection	Emotional (“Stomach”, feelings) Emotional/life event particularly if it involves people close to you, or People you respect and trust such as friends, family, professional colleagues

It is important to realize that the process of change is not a simple sequential series of steps, one following seamlessly after the other. The sequence moves forwards and backwards over time, and is dependent on a range of external factors. Someone might become aware of a need to change behaviour but do nothing about it for some time. Then some additional information, or another life event may lead to an interest in doing something about it, maybe even an attempt to make a change. The change might not be all that comfortable, so the individual could revert back to the previous behaviour, until the process is rekindled.

Box 4 emphasizes the need for an emotional input for change to take place. Messages that only affect our rational mind are less likely to motivate us to act or to change. It takes an emotional response to generate either individual or social change. And in the case of some social change, it will also take economic and political responses as well – making a difference through managerial and regulatory strategies – to arrive at real and sustainable change.

In this manual, we are emphasizing the importance of participatory approaches, of reaching people’s emotions. We stress the need to develop interventions that not only motivate people to take action, but also look at what needs to change in the surrounding community and at the policy level to create an enabling and sustainable environment for change. This includes the need for health planners and communicators who manage programmes that aim at behaviour change to understand their own emotions and processes of behaviour change so that they can facilitate learning on these aspects for the groups they work with (Haaland and Molyneux, 2005).

Combining approaches

Box 5 explores the way several organizations in Pakistan made use of a set of different strategies and methods to deal with the problems caused by iodine deficiency in communities with which they worked.

BOX 4. KEY LESSONS ABOUT HEALTH COMMUNICATION

1. **Health communication is more effective when it reaches people on an emotional as well as a rational level.** Emotional experience, self-esteem, security, inclusion, affection, control and social approval are among some of the most important factors that facilitate behaviour change, along with self-efficacy and perceptions of control. Communication that evokes empathy and other emotions typical of interpersonal dialogue enhance their impact.
2. **Health communication is more effective when it relates to people's social or 'life' contexts.** The process of making and maintaining a life change is made within the context of family, community and cultural factors. Incorporating health communication into a life context also may enable people to make changes across a range of health issues.
3. **A combination of the effectiveness of interpersonal communication and the reach of mass media communication is needed to change population behaviour.** Both types of communication are important and interrelated. Hornik's (2002) review of health communication and behaviour change outlines a communication model in which mass and interpersonal media operate at the individual, social and institutional levels needed to effect change.
4. **Tailored communication is more effective than general messages.** 'Tailoring' or 'customizing' information so that it more closely meets the needs of the recipients has resulted in significantly improved communication outcomes. The increasing health disparities among vulnerable groups in many countries points to an urgent need to improve our communication approaches with diverse audiences.
5. **Interactive communication is more effective than one-way information dissemination.** Passive dissemination of health information is the most common strategy and the least effective. Messages from experts about people's needs to improve themselves may be unintentionally disempowering.



Interaction and participation in both the process and content of communication are key factors. Research shows that when the beneficiaries are involved in the design and dissemination of health communication, the outcomes are more likely to be successful.

Taken together, these findings suggest that our current interventions do not effectively 'touch the emotions' of people in ways that relate to their daily lives and promote change. In other words, experts have messages to send, but people have lives to live. There is increasing evidence that health communication approaches that are set within multiple social contexts and that engage people interactively and personally are more effective (Emmons, 2000). It is clear that we need to do better.

Source: Neuhauser L, Kreps GL (2003). Rethinking communication in the E-health era. *Journal of Health Psychology*, 8(1):7–23.

BOX 5. FIGHTING IODINE DEFICIENCY IN DEPALPUR, PAKISTAN

Punjab Lok Sujag is a membership-based nongovernmental organization in Lahore, Pakistan, which works in the whole of rural and urban Punjab. Together with its sister organization, Punjab Lok RaHS – that specializes in alternative theatre – it is involved in organizing communities around a number of social development issues.

RaHS is the Punjabi word for a traditional form of theatre. Lok Sujag means “people’s awakening”. Sujag has worked on campaigns to improve women’s mobility in urban Lahore, advocacy on access to pharmaceutical products, research and campaigning on breastfeeding and iodine deficiency, agriculture and milk economy, cooperatives as an alternative organizational structure, and electronic resource development. It has close associations with a number of civil society organizations and is part of many networks and coalitions.

In the late 1990s, while exploring issues of concern to dairy farmers in villages of Tehsil Depalpur, Sujag was asked by the local people to attend to the problem of goitre in the area. Sujag undertook the issue on people’s demand and developed it into a strong campaign to raise awareness about iodine deficiency disorders and promote use of iodized salt.

Depalpur has a population of some 1.1 million people. Just over 35% of the population have goitre caused by iodine deficiency, much of it moderate to severe. Goitres, which manifest as a swelling of the neck, affect women more than men. The most severe consequence of goitre affects children: mothers with goitres are more likely to give birth to children who are physically and mentally stunted and often deaf and/or dumb.

Sujag began to develop a campaign against iodine deficiency disorders (IDDs) run in 22 villages under a Sujag-Unicef partnership. Unicef was contacted because of its work on promotion of iodized salt.

Sujag held formal meetings with the community, organized medical camps and awareness walks and used many innovative ways to disseminate the message chalking (ill).

Sujag’s sister concern, Lok RaHS, developed a piece of street theatre on the subject and performed it in villages. Sujag also made interventions to ensure continued supply of iodized salt, such as providing a local vendor with a donkey cart.

An important aspect of this campaign has been that Sujag was successful in involving a number of individuals and institutions. The Department of Nutrition, College of Home Economics, Lahore, helped Sujag collect baseline data, while Lahore General Hospital helped it in organizing medical camps in villages and where necessary providing surgical treatment to patients.



Two key communication principles that Sujag used were:

- all awareness-raising interventions need to be culturally relevant to the area and use people’s language and accent
- the awareness campaign cannot be a one-sided public relay of designed messages. Dialogue is important to generate and answer questions.

Sujag identified three groups of people who needed to know different things about IDD and for whom different communication strategies were needed.

1. Doctors needed to be reminded of the issue in all its scientific details and be convinced to promote iodized salt every day. Local opinion leaders needed similar information. A face-to-face communication strategy, reinforced with support materials was selected as the best approach. The support of local chapters of the Pakistan Medical Association helped to strengthen the impact.
2. Senior students at colleges and high schools who could be promoters of the use of iodized salt needed slightly less complex knowledge. Information was delivered through a school programme that included knowledge competitions, campaigning in neighbourhoods, report writing and walks and processions.

Continued

Box 5 Continued

3. The general population needed the most simple and easy to understand knowledge that was conveyed through leaflets, wall-chalking, mobile publicity vans and theatre.

But information was not enough on its own. Access to iodized salt was essential. Sujag was able to persuade three salt processors in the province to provide iodized salt. Sujag also researched which retail shops were available that could distribute iodized salt. They identified 2,500 shops in the entire rural area of Depalpur. Both the producers and the retail outlets were sensitized to the importance of iodized salt.

Sujag mobilized its sister concern, Punjab Lok Raahs, into developing a 40-minute street play 'Daroo' on the subject, which was performed in the villages along with other activities. Raahs has also performed the play in colleges of Depalpur town and held two theatre workshops for village school children. Raahs is developing a local theatre group in Depalpur that could more easily move around, especially to villages, and is working on a puppet play and an audio cassette with songs and short dramas to relay through mobile vans.

Overall, the campaign has resulted in a remarkable increase in use of iodized salt in these villages, which is expected to lead to a decrease in iodine deficiency diseases.

Daroo – the play

The basic objective of the play "Daroo" (Remedy) is to create awareness about goitre and other iodine deficiency disorders and promote use of iodized salt, so goitre and iodine have been personified as two characters. This animation makes the play interesting and eases communicating a lot of ideas that otherwise would have been boring if not impossible.



There is a doctor devoted to the cause of people's health. He takes a Dholi (drum beater) with him and goes to a village where many people are suffering from goitre.

As the Dholi beats the drum, and the doctor engages people in discussion on IDD, the 'Iodine' descends upon them. The

spellbound people, including the doctor, fail to recognize her and think she is some supernatural creature or a fairy. However a quack and a spiritual healer realize the "danger", the fairy poses to their business. The Malang, spiritual leader, is desperately looking for the Iodine wanting to capture her using his magical powers.

As the tussle continues, goitre takes its toll on the lives of the villagers. The children become dull and weak in their studies. Their memory is weakened. Nobody is ready to marry the girls with swollen necks. Ugly looking cretins are born to many women in the village.

The doctor finally recognizes the Iodine during one of her mysterious visits and requests her to free one of the villagers of the curse of goitre. She obliges, and the news of the miracle spreads far and wide. Villagers flock around the doctor and the Iodine and just then the Malang's relentless hunt for the fairy of Iodine also ends.

The Malang interrupts the hide-and-seek going on between the goitre and the Iodine. He kidnaps the Iodine but is resisted and blocked by the villagers when he tries to take her away. He recites mantras, which turn the Iodine into a sack of salt.

Dejected people encircle the Malang and just when they are about to beat the Malang to death, the doctor interrupts and tells them that all the powers of the fairy of Iodine are there in this salt and they need not to worry about her life. as such.

Here it is possible to see the interaction of a number of strategies. The communication approaches focused on both public and health worker audiences. The managerial strategies looked at issues of how to ensure dissemination of iodized salt. The regulatory strategies included ensuring that there was a requirement to iodize salt and therefore some reason for manufacturers to do so. Other enabling strategies included looking at ways to encourage dialogue and debate within the communities to ensure that demands for appropriate products were expressed. This included making use of available networks of contacts and mobilizing allies, including the Pakistan Medical Association and local village leaders.

Underpinning this example is the extensive research that was undertaken to identify the problem clearly, to look at what types of communication approaches could be used, and to identify the people and institutions with an interest (stakeholders) in the issue and who might be able to contribute to the solution of the problem. During this process, Sujag built up good relations with local people and gained credibility that enabled it to facilitate the change process with people's full cooperation.

Some clear lessons and basic principles can be drawn from this example which will be referred to and reinforced in other parts of the manual (see Box 6).

The type of analysis undertaken by the groups in Pakistan illustrates the importance of building a strategic approach to communication. Strategic thinking lies at the heart of effective communication. A strategic approach to communication moves communication programmes from being a



Building good relations often starts with contacting and respecting the traditional leaders in the community.

BOX 6. COMMUNICATION PRINCIPLES DRAWN FROM THE PAKISTAN CASE STUDY

- Research-based intervention
- Problem defined in and by the community
- Combination of strategies: communication and managerial (supply)
- Use of local resources leads to ownership
- Use of local artist – celebrates local culture; encourages dialogue and questions and may be cost-effective depending on materials used and on process to define methods
- Interactive process
- Process of developing communication materials influences the use and effect
- Balance between being specific and creating a process of talking about the issue
- Targeted approach to each audience
- Actors trusted by the community
- Practical support to stakeholders
- Pre-testing is important
- Be aware of non-intended outcomes
- Monitor!
- Evaluate!
- It's not what you do, but how you do it.

Analysis drawn from participants at a PRDUC training course in South Africa, 2004.

‘spare wheel’ to be used when all else fails, to being a ‘steering wheel’ that can provide direction for programme activities (Piotrow et al., 1997).

This can sound daunting, but it really consists of answering a basic set of key questions, such as these adapted from a Healthlink Worldwide methodology called Quest (Healthlink Worldwide, 2003):

- Who (which audiences) are you trying to reach? What do you know about their understanding, information needs and preferences?
- Why are you trying to reach them? What are you trying to achieve? What are your objectives? What is the problem that is being addressed? What do you know about the causes of that problem? What do you want the audiences to do? Do the audience experience the ‘problem’ as a problem? Is it a priority for them? Do they want to change? What do they believe is a cause of the problem? What do they want to do or what do they see as a solution? How do they want to achieve the change?
- What content needs to be conveyed to achieve the objectives, and to interest and motivate the audiences? What is the main area of dialogue that you want to encourage?
- How can you best do this with the resources and skills that you have? How can you make the best and most appropriate use of existing communication channels and methods?
- When is the best time to interact with these audiences? Are there opportunities and related events or activities that could be tapped into?
- Where are the audiences? In what settings will communication occur? What are the implications for using different approaches that may be suitable or appropriate?
- What feedback are you getting and from whom? Is the communication working? Is it achieving its aims? How do you know? How could communication be more effective?
- Who is involved in answering these questions? How involved are the people who are most affected by the problem that the communication intervention is seeking to address?



Do they see malaria as a problem?
Are bednets a viable solution? Can they afford them?



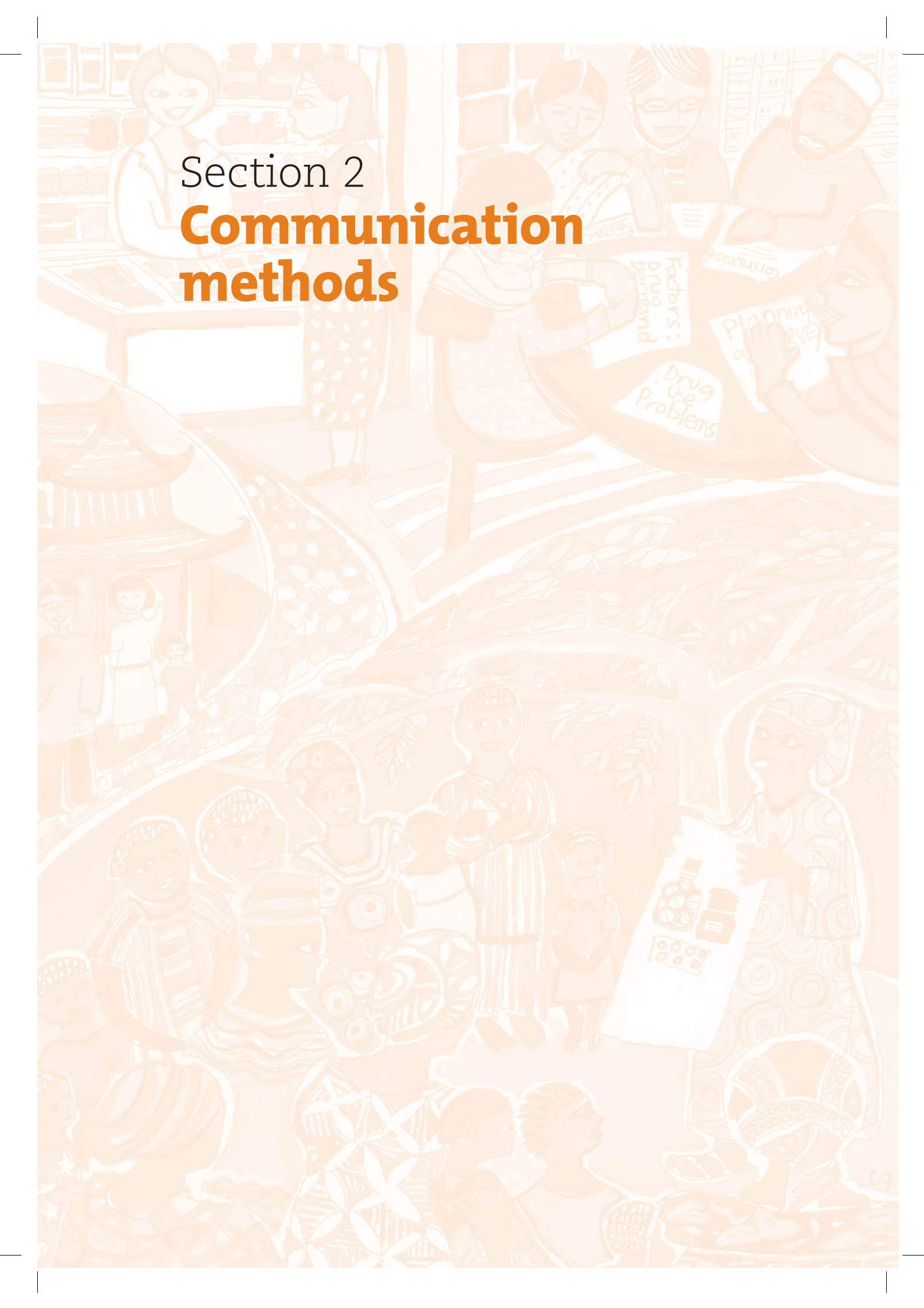
Applying questions like these systematically to communication work leads to more effective communication interventions.

Key readings

Haaland A, Molyneux C (2005). *Collecting quality information. Training manual on practical communication skills for field researches and project personnel*. Geneva, United Nations Development Programme/World Bank/World Health Organization Special Programme for Research and Training in Tropical Diseases.

Healthlink Worldwide (2003). *Quest manual: your guide to developing effective health communications*. London, Healthlink Worldwide, (more details available at: <http://www.healthlink.org.uk/resources/quest.html>).

WHO (1998). *The healthy women counselling guide: a model for reaching women*. Geneva, United Nations Development Programme/ World Bank/World Health Organization Special Programme for Research and Training in Tropical Diseases.



Section 2

Communication methods

This Section provides an overview of the different communication methods and ways in which they can be used to address particular community medicine use problems. It sets the scene for how to determine the most appropriate method and highlights some of the advantages and disadvantages of different approaches. The four main methods are examined in detail in Chapters 2–5.

Four main methods

Communication methods (sometimes called channels) usually fall into four broad areas:

- face-to-face activities, sometimes called interpersonal communication
- drama and other folk media, sometimes called performance, popular or traditional media
- mass media, including electronic media
- print materials and other support activities.

An effective strategy will usually involve a combination of two or more of these approaches, such as face-to-face and print, as shown in the illustration. Training might be needed to develop or improve knowledge and skills to use the different methods effectively. Participatory learning methods will usually give the best results, and will motivate the participants to use the skills well.

Below, we briefly explore the ways in which different communication methods can be used. Some of the advantages and disadvantages of different methods are provided in the summary table at the end of this Section.

Face-to-face communication

This is the most direct form of communication. Face-to-face communication is useful for engaging specific groups in the community, and is essential for encouraging behaviour change. It also provides opportunities for the community to participate actively in the dialogue and interaction with the communicator, and helps the communicator learn essential things about how community members view problems and solutions, and what experiences they have. Such dialogue and exchange are essential for community members to consider changing their behaviour. However, a face-to-face approach requires field staff with adequate time and strong communication skills. There are also training, transport and materials costs to be met.

Face-to-face communication methods are widely used everywhere: in workplaces, in health care facilities, in the community, among groups and in training programmes. Chapter 2 provides more detail on face-to-face communication.

Drama and other folk media

In communities, a wide range of drama and other folk media exist that can be mobilized in health communication activities. Their impact and popularity are widespread especially in communities with strong oral traditions. The example from Pakistan given in Chapter 1 shows the way in which a socially acceptable communication medium such as theatre can be used to tell a story about a



problem, portray issues and identify who needs to be involved in a solution, and help to open up a dialogue about how to move forward. Chapter 3 provides more details on drama and other folk media.

Mass media, including electronic media



Mass media can be useful for promoting awareness and raising interest in an issue, but do not usually lead to behaviour change. They are good for reaching large numbers of people quickly with general messages. Although the cost is high, the large audience makes them cheap in terms of cost per person reached. Mass media, including television, radio, newspapers and the Internet are discussed in more detail in Chapters 5 and 6.

Support activities, including print material

You can increase the impact of your communication programmes with well-designed and appropriate print and other support materials. These may be needed to explain difficult points, to help people remember key messages or to serve as a trigger to promote discussion. They are widely used in training and learning situations. Materials can appear in printed form, for example, leaflets, wall charts and discussion posters. Games or music/stories on audio cassettes or videos can also be used.

Helpful materials may have already been produced by others. However, things developed for other communities may not be understood or accepted by your own community. They will either have to be adapted or new material will have to be developed. Printed material is discussed in more detail in Chapter 4.

Choosing a communication method

The choice of communication method will depend on what you are trying to achieve, the characteristics of your audience, and the resources and constraints you have. Table 4 highlights some of the questions to consider in making a choice. But remember that it is likely to be a combination of methods that prove to be the most effective, as the example of a hygiene promotion programme in Burkina Faso shows (see Box 7).

BOX 7. LOCAL RESEARCH, LOCAL MEDIA LEAD TO CHANGE

Hygiene promotion programmes can change behaviour and are more likely to be effective if they are built on local research and use locally appropriate channels of communication repeatedly and for an extended period of time, says a study from Burkina Faso, reported in the June 2001 issue of the Bulletin of the World Health Organization. Changes resulting from the intervention included increased hand-washing with soap after cleaning a child's bottom (from 13% to 31%) or after using the latrine (from 1% to 17%). Focus group discussions and a small, population-based questionnaire were used to identify local channels of communication suitable for specific target groups. Among the channels used were: face-to-face home visits, discussion groups in health centres and in the community, street theatre, local radio spots and programmes, and hygiene curriculum in primary schools.

Source: Curtis V et al. (2001). Evidence for behaviour change following a hygiene promotion programme in West Africa. *Bulletin of the World Health Organization*, 79(6):518–527. [http://www.who.int/bulletin/archives/79\(6\)518.pdf](http://www.who.int/bulletin/archives/79(6)518.pdf)

Table 4. Questions to consider in choosing communication methods

AUDIENCES

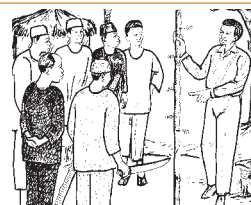
What are the characteristics of the audiences you want to work with?

- age
- gender
- language, including the words they use to describe health conditions or medicines
- life experience
- education and literacy level
- previous exposure to pictures
- ownership of radio/TV
- listening, watching, reading habits
- familiarity with different media, including local and traditional
- what do they know, believe and feel about the particular health issue or about particular medicines?
- what do they see as being the most important problems with the use of medicines? Is this a priority for them? What do they believe is the cause of the problem?
- how strongly held are their beliefs?
- how open are the audiences to new ideas?
- are there cultural norms around what type of health issues can be publicly discussed?
- where do they usually find information about health issues and the use of medicines?
- who influences them to take action or change practices or behaviour?
- where do they go to or meet regularly?

OBJECTIVES

Are you trying to:

- convey simple facts?
- share complex information?
- teach problem-solving skills?
- train in practical skills?
- encourage community dialogue?
- facilitate individual or social change?
- advocate for policy change?



RESOURCES/CONSTRAINTS

- how much will different methods cost, including staff and equipment costs, and what budget do you have for the communication intervention?
- how many staff and what level of skill are involved in using the method?
- will you need trained field workers or outreach workers to implement the method?
- how much time do you have? How urgent is your time-scale?
- are there underlying political or power issues that may emerge as a result of the communication intervention? Are your communicators/facilitators trained to deal with these?

Source: Adapted from Hubley J (2004). *Communicating health*. Oxford, Macmillan.

Three key questions that can help you to decide which communication approaches to use are:

- what audience(s) are you planning to work with?
- what objectives are you trying to achieve with those audiences?
- what resources can you mobilize and what constraints do you face?

Audiences



You will usually need to reach both primary and secondary audiences. Primary audiences are those who make decisions for themselves, for example a patient or mother (left).

Secondary audiences are those who have influence over other people's decisions, for example, the husband of a pregnant woman, a family elder, a community opinion leader (right) or a traditional healer.

While some communication may raise general points aimed



at the whole community, most of it is likely to be focused on specific audiences. Examples of specific audiences are mothers of children under five, husbands, mothers-in-law, family elders, people with specific illnesses, school children, traditional healers, health workers, journalists, policy-makers and community leaders. The clearer you can be in determining specific audiences, and the more you can learn about what they know and understand about the topic, the easier it becomes to decide how best to communicate with them.

A general communication campaign directed at everyone can fail because it does not meet the needs of specific sections of the community. One approach is to create awareness and interest by developing a general message that is relevant to everyone and promote it through mass media. Face-to-face communication can then be used with specific audiences to encourage people to change. You should keep your programme simple and aim to reach only two or three audiences at a time. On the basis of your formative research, start with those who you think are more likely to respond positively to new information, a new idea, new knowledge, or who appear ready to change an attitude, practice or behaviour.

Communication objectives

You cannot change someone else's behaviour. People have to take the decision themselves to change, and may do so if they are treated with respect, given appropriate information by a credible person, and the situation involves an emotional aspect (such as a sick child).

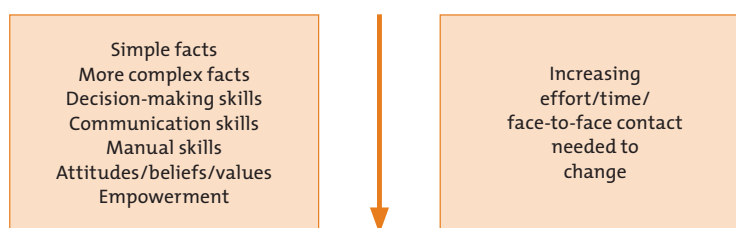
If you want to support the change of a particular behaviour, you will need to influence the factors that shape it. This may include knowledge, skills, attitudes, beliefs, values and empowerment.

Some methods are more appropriate for particular communication objectives (see Figure 2). For example, simple facts, the name of a medicine or a disease can be communicated using methods such as short advertisements on mass media or posters. However, more complex facts such as the cause of a disease or the life-cycle of a parasite take a longer time to explain – especially if the information you are trying to communicate is different from what the community already knows or believes about the problem. Usually this will require some form of face-to-face communication.

Your communication objective may well be to teach a skill. These fall into three broad headings:

- decision-making skills such as when you can treat an illness at home, when to go to the doctor and knowing when side-effects require prompt action
- communication skills such as explaining a health topic to one's children or partner
- manual skills such as preparing and giving medicines.

Figure 2. Choice of methods according to communication objective

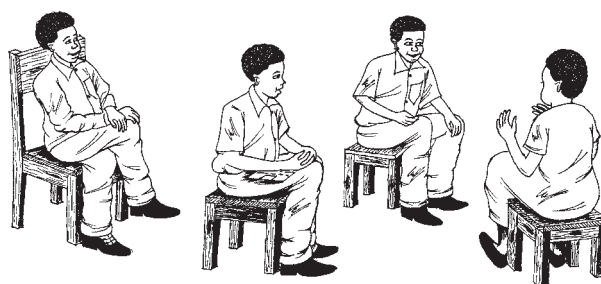


The best way to teach a skill is to first demonstrate it. You can perform a role-play to show good communication, show a manual skill, such as making up oral rehydration solution (ORS) or give examples of decision-making.

Afterwards let people practise the skill themselves through role-plays or exercises and give them feedback. If the new skill is very similar to skills the community already knows, you may be able to explain the skill using mass media or large-scale demonstrations at meetings. However, if the skill is a new one, some form of face-to-face contact is needed, with opportunities for those learning to give feedback.

Beliefs, attitudes and values can include beliefs about the causes of disease, the value of traditional medicine, the importance attached to being respected in the community, the value of following the advice of an elder and the value of being a good mother. These ideas operate at a deeper level than knowledge and are much more difficult to change. Effective change programmes respect and build on existing perceptions and beliefs, attitudes and values and start building bridges to different ideas using participatory processes. Such approaches often result in the people themselves deciding to change, by taking on their new understanding and being empowered in the process.

Changing attitudes, beliefs, practices and values must be built on a process of dialogue with the community. Such a communication approach takes time, a very careful plan and people with credibility in and respect for the community culture.

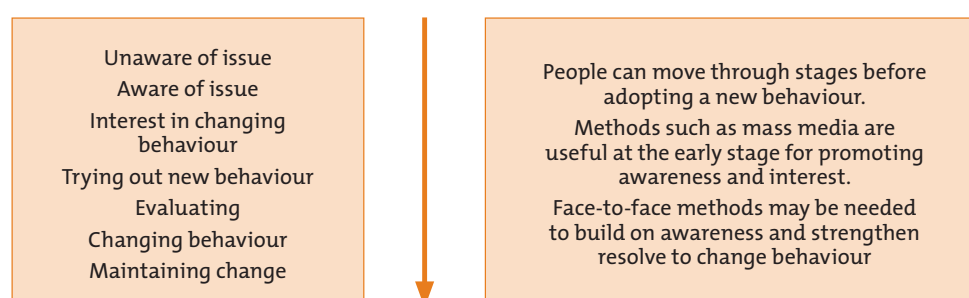


Different objectives at different stages

The communication objectives – and therefore the methods – can change at different stages of a communication programme. When changing behaviour, the individual, community or institution goes through a series of steps – sometimes moving forward, sometimes moving backward and sometimes skipping steps. Figure 3 shows the different stages and the need to use different methods for communication.

Even when individuals, communities, or institutions adopt new behaviours, they may at times revert to old behaviours, at least under certain circumstances. Understanding where the majority of a group is in the change process is crucial

Figure 3. Communication objectives at different stages of a programme



when designing a communication strategy. Different channels have been shown to be more effective at different stages of the continuum and for achieving different goals. Communication through mass media can ensure that correct information reaches a specific population and can model positive attitudes. To motivate an individual or community to attempt new behaviours, face-to-face communication is usually needed. In addition, policies and the larger social environment become more important. When audiences become ready to change, the activities, services or products being promoted must be available to them.

Resources/constraints

Among the questions you should ask are: can you afford it? Do you have access to field staff? Can you involve other agencies? Do you have the equipment? Are the right conditions available to use the method in your community?

You may find yourself in a situation where you are not able to use a method because it costs too much or you do not have access to it. If that is the case, persevere. The following ideas might help:

- Try simpler and cheaper methods first. Monitor and evaluate their impact. If those do not work, you can then try more expensive methods.
- If you do not have access to field staff with technical skills, are there other organizations or groups you could involve in your programmes that do have suitable field staff?
- Can you work to mobilize existing skills and resources in the community to do their own work with only limited input from the outside?
- If you do not have money to purchase advertising time, look for ways of working with members of the media to encourage them to cover your topic at no cost (see Chapter 6 on working with journalists).
- Don't give up! Are there sympathetic donors who might be prepared to provide additional funds if you can justify that they are necessary?

Field staff

To carry out face-to-face communication methods you need to have field staff available who have sufficient skills. These field staff might be people in your own organization, field staff from other services, NGOs or volunteers. Start by deciding who should carry out the interpersonal communication activities and define their role by preparing a job description. You should then make sure the activities you want them to do are realistic. You will have to train them to carry out any unfamiliar tasks. Even if they already have good communication skills, you will need to provide some orientation to your programme, including any specific knowledge required. If you develop any new materials you will need to train your field staff to use them. Training will usually require some kind of workshop where the trainees have an opportunity to practise the required communication skills. Chapter 2 on face-to-face communication gives examples of methods for training health workers in communication skills.

Importance of monitoring and evaluation

Keep in mind that there are no guarantees of success. That is why pre-testing communication materials is important (see Chapter 10). What has worked in one country or community may not work in another – but looking at what works in

Table 5. Advantages and disadvantages of different communication methods

METHOD	EXAMPLE	ADVANTAGES	DISADVANTAGES
Mass media	Television	• Broad reach • Can use entertainment to convey key ideas • Cost per person reached can be low • Can reach low-literate audiences • Combines visual images with spoken word • Can influence behaviours that are not deeply entrenched	• Television ownership may be restricted to higher-income, urban population • High initial production cost • Difficult to meet needs of specific groups • Lack of immediate feedback • Needs electricity access
	Radio	• Very broad reach • Regional radio provides opportunity to broadcast in local languages • Easy to include content from interviews/music recorded in local communities	• Similar problems as TV: difficulty making content specific to different local communities and to obtain feedback • Lacks a visual dimension • Radio sets often controlled by men
Mass media/ Print	Newspapers, posters, leaflets, manuals	• Reach can be broad • Can be distributed to highly targeted group and influential people • Can include pictures • Can provide background or detailed information	• Written material unsuitable for non-literate communities • Reach of newspapers may be limited • Some print materials may have limited distribution
Folk media/ (face-to-face)	Using folk media, theatre, songs, dance in community settings, for example bars, roadsides, markets and public places	• Takes activities to the community and is therefore good for difficult-to-reach groups • Allows for a focus on the audience's special needs • Can stimulate interaction and discussion • Can be very effective in influencing beliefs, attitudes and behaviours, providing specific skills and generating empowerment	• Field staff may not be available or appropriately trained • Takes longer to reach the audience • Performances may be interpreted differently in different settings
Face-to-face	Individual or small group for example patient education, schools, workplace, training	• Can be tailored to the audience's specific needs • Can be very effective in influencing beliefs, attitudes and behaviours, providing specific skills and generating empowerment • Can be delivered efficiently • Stimulates dialogue • Encourages teacher to learn	• Only reaches those people who use services (but through them can reach family members and neighbours) • Formal setting can inhibit the use of participatory methods • Time may be limited because of work pressure
	Large groups Public meetings, folk media	• Capable of generating a large amount of interest • Can lead to community participation	• Without advance preparation and follow-up may not lead to lasting change • Depends on skilful facilitation

other places is a good starting point. You will need to build up your own experience based on evaluation of what has worked in your communities, using other programmes as an inspiration. The best approach to take is a flexible one. Prepare a strategy that fits in with what you know about the problem and the community, then implement it and monitor and assess the impact. On the basis of your monitoring and evaluation you should respond quickly, and adapt and improve your methods and how you are communicating.

Monitoring and evaluation are discussed in more detail in Chapter 11. At this point, remember that you should look for both short-term and long-term changes. Short-term monitoring and evaluation is particularly important because you can use the results to improve your programme. However, you have to be realistic about what can be achieved in the short-term and what may require more time. In the short-term you can find out how many people were reached by your intervention, and if it had an impact on people's knowledge and skills. In the longer-term, you can find out if the early knowledge gains were sustained and led to changes in behaviour, empowerment and health.

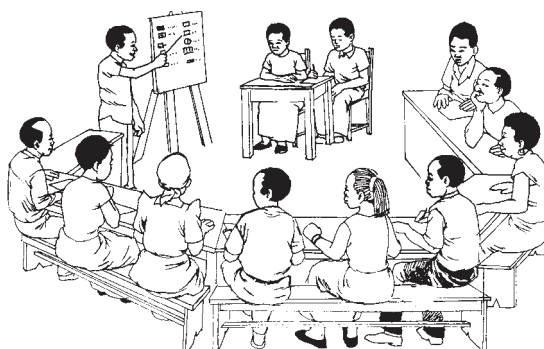
In some cases, for example, around issues such as access to antiretroviral drugs (ARVs) for use with people who are HIV-positive, an indicator of impact may be the degree to which dialogue about this issue increases in society. Unless people are talking about the problem, finding possible solutions becomes more difficult.

Another use for monitoring and evaluation is to identify when a communication intervention on its own is not working. This often means that something else needs to happen – a policy change may be needed or other changes may be necessary to improve the management and supply of medicines, or regulate advertising and promotion practices that compete with the intervention.

Summary

The choice of an intervention will depend on the type of medicine use problem and the reasons why it exists. Not all interventions are equally effective (Holloway and Green, 2003). Over the years, experience and studies have shown that:

- a combination of strategies – for example, communication with managerial staff or those who create an enabling environment – always produces better results
- a one-off communication intervention is usually not very effective and its impact is not sustainable
- focused small group and face-to-face interactive workshops have been shown to be effective, if effective trainers or facilitators are used
- the use of print materials alone is not effective
- monitoring and feedback and peer review are very effective managerial strategies, but require the agreed use of standards against which to judge prescribing and medicine use
- regulatory interventions may have unintended impacts that may be worse than the intended change (substitution of a less appropriate drug or a more expensive one for a banned drug, for example).



Further reading

Fresle DA, Wolfheim C (1997). *Public education in rational drug use: a global survey*. Geneva, World Health Organization.

Haaland A, Molyneux S (2006). *Quality information in field research. Training manual on practical communication skills for field researchers and project personnel*. Geneva, UNICEF-UNDP-World Bank-WHO Special Programme for Research and Training in Tropical Diseases.

Hubley J (2004). *Communicating health: an action guide to health education and health promotion*. 2nd ed. Oxford, Macmillan.

Piotrow P et al. (2003). *Advancing health communication: The PCS experience in the field*. Baltimore, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs.

Piotrow P et al. (1997) *Health communication: lessons from family planning and reproductive health*. Westport, CT, Praeger Publishers.

US Department of Health and Human Services (2002). *Making health communication programs work: a planner's guide*. 2nd ed. NIH publication no. 89-1493. Bethesda, National Cancer Institute. (Available at: <http://publications.nci.nih.gov> then perform a search on Publications).

WHO (2004). *How to investigate the use of medicines by consumers*. Geneva, World Health Organization.

Women's Health Project and WHO/TDR (1999). *Impact studies of Health Workers for Change*. Johannesburg/Geneva, Witwatersrand University/World Health Organization Special Programme for Research and Training in Tropical Diseases.

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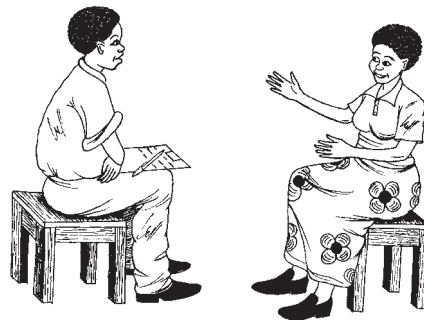
Face-to-face communication

Using medicine is very personal. It touches deep beliefs about our health, and ultimately about life or death. To change the way we use medicines, we need to talk with a person we trust. This person needs to know about and respect our ideas, and to have good communication and education skills. If we are to take action on new instructions on which medicines to use, and how to use them correctly, or when they are not needed at all, the person should be easy to contact. We may have questions about the drugs, and we may have forgotten exactly how to use them after some time.

Face-to-face communication is used in various situations, from direct dialogue within communities, to advocacy around policy, and in pretesting. This chapter focuses on face-to-face communication.

This chapter examines:

- What face-to-face communication is
- Why it is important and what you can achieve with it
- How and when to use face-to-face communication
- Advantages and disadvantages
- How to use face-to-face skills as part of a communication strategy to address medicine use in communities.



What is face-to-face communication?

Face-to-face communication involves two or more people in a direct exchange of views, experiences, information and knowledge. It may be one-to-one, or it may involve groups of people in dialogue. For rational medicine use, the facilitator of the dialogue could be, for example, a trainer, a drug dispenser, a health worker (formal or informal), or a community leader. **For good face-to-face communication, the attitude of the dialogue facilitator is as important as his or her knowledge.**

BOX 8. WHAT CHARACTERIZES GOOD FACE-TO-FACE COMMUNICATION?

- **Relevant to personal and cultural needs:** The content is established through formative or participatory research.
- **Respect and bridge-building:** For people to consider change, the facilitator needs to understand and respect their present practices, and be able to make a bridge from these to the new practices. Understanding reasons for practices is necessary for effective bridge-building.
- **Skills and credibility:** The facilitator is skilled in participatory education and communication techniques, and has credibility in the community.
- **Key information:** The facilitator focuses on key information relating to behavioural change, using simple local language.
- **Discuss and negotiate:** The facilitator listens carefully to the people receiving the information, watches their body language and discusses suggestions for new practices.
- **Check for understanding:** The person repeats key information, for example, about dosage of drugs, to make sure he/she has understood what to do.

Box 8 identifies some key characteristics of good face-to-face communication.

The method can be used directly to discuss the use of medicines with a customer or a patient. It can also be used in other situations like supportive supervision, training courses, or convincing managers of the need for a programme or activity. Face-to-face is a powerful communication method to improve people's understanding of why and how to use drugs correctly. Lack of communication and understanding will often lead to problems of low adherence to treatment and other misuse of drugs.

Studies show the impact of face-to-face

A review of 37 studies on patients' compliance with medical treatment in developing countries, all of which studied compliance from the biomedical perspective (Homedes and Ugalde, 1993), states that:

- several studies found that “teaching patients in the administration of therapies increased compliance” (using face-to-face communication).
- poor communication between practitioner and patients was the most frequent problem leading to non-compliance (Mull et al., 1989).
- lack of continuity in patient-physician interaction contributed to non-adherence.
- most cases of non-compliance were due to patients not understanding the problem and miscommunication between family and health providers (Martinez et al., 1982).
- when non-compliers receive education, they comply (Martinez et al., 1982).

Face-to-face essentials: active involvement of and respect for people

In an address to the 1986 World Health Assembly, Halfdan Mahler, former Director-General of WHO, said: “primary health care starts with people and since they have a major role to play in solving these problems they have to be actively involved in doing just that rather than being passive recipients of care from above ... for people to be intelligently involved in caring for their own health they have to understand what leads to health and what endangers it ... the very first element of primary health care is educating people and communities on health matters”.



Face-to-face communication will only be effective long-term if developed through interaction with the community. The interaction must build on an understanding of and respect for present practices, and use this as a bridge to explaining new practices (understanding what is important to people, and why).

To be able to help a client or customer solve a problem or change a practice (which is usually the aim of face-to-face communication), you need to

be able to understand what is important to the person, and see the problem from his or her perspective – to understand WHAT he or she does, and WHY, and HOW the person thinks and acts, and what the reasons behind beliefs and actions are. A sensitive and skilled communicator can link this understanding to the new practice a person is encouraged to use, and help him or her see and recognize connections.

If we as communicators only attempt to get people to change one (bad, from our point of view) practice with another (good, from our point of view), without addressing the underlying reasons for the practice, then the change will be superficial, and will not last. It is very likely that there will be no change at all.

Advantages and disadvantage

The most important advantage of face-to-face communication is that in principle, it is easy to see whether the communication is working. Feedback is usually immediate and it is an easy method to adjust and modify quickly, and make relevant to the people with whom you are communicating. The main disadvantage is that it takes time and is resource-intensive, both in terms of people needed and the costs of reaching people. However, that disadvantage is true of all good communication: it takes time and skilled people, and involves costs if it is going to be effective. Box 9 summarizes the main advantages and disadvantages.

Where and how can face-to-face communication be used?

Face-to-face can be used:

Where?

- In one-to-one and small groups: the most effective way of using face-to-face is probably in a one-to-one situation, but face-to-face can also be used in small groups. In a larger group, there is less time and opportunity for interaction, and thus less likelihood that all participants have the chance to express their concerns and have them addressed.
- In many venues: such as health clinics, pharmacies, local shops, community groups and in households.

How?

- To change practices: face-to-face is an effective method to encourage people to change practices, such as how they use drugs. When used well, it can result in important changes
- With other methods: to increase awareness about the need for change, and to give opportunities to discuss the topics.

BOX 9. ADVANTAGES AND DISADVANTAGES OF FACE-TO-FACE COMMUNICATION

Advantages:

- **Improves adherence to treatment:** Learning about correct drug use in a dialogue with an effective communicator enhances understanding and helps people use drugs better.
- **Empowers people:** Learning why you need to use the drugs in a certain way gives people new knowledge, which they will use to make their own (informed) decisions now and in the future.
- **Motivates learning:** An effective dialogue between the health worker/provider and client/customer can motivate further learning about health.
- **Encourages changes in behaviour:** When people see that the new ways of using drugs actually work, many will leave their previous practices behind and continue to use drugs (biomedically) correctly.
- **Closer to home:** Training face-to-face communicators in the community (informal providers, community health workers) gives people access to quality service closer to home, from people they trust, and who respect them as fellow community members. This reduces the economic burden of having to travel to the clinic when it is not necessary.

Disadvantages:

- **Expensive:** Since the interaction is mostly one-to-one or in small groups, the number of people each communicator reaches is small.
- **Requires skills and motivation:** Finding and training good face-to-face communicators is time-consuming, demanding and expensive.

- With educational materials: face-to-face should be supported by educational materials, such as drug instructions or leaflets, to help the client or customer remember why and how to take the medicines.

The choice of setting will depend on the specific problem and the audience. Interaction between health workers and patients, usually in formal health facilities is one of the most frequent uses of face-to-face communication. This will be explored in some detail in this chapter, but it is worth remembering that other settings offer considerable opportunities for community dialogues around rational medicine use.

Communication at health facilities

Health facilities provide many communication opportunities. Activities can focus on patients who are coming for treatment or their caretakers and healthy people who are making use of preventive services such as child health, antenatal care and family planning.

The success of face-to-face communication in a health centre depends on the quality of the interaction between health care providers and patients. This quality may be low because communication skills are frequently not taught during professional training, and patients may not know how to elicit the information they need in an unfamiliar and sometimes intimidating environment.

Improving the quality of communication is an important priority. This means making sure the patient understands everything the health care provider says, remembers the key points and is empowered in turn to provide key information and to ask questions.



BOX 10. RURAL SHOPKEEPERS GAVE CORRECT ADVICE: THE KILIFI STUDY

Research from Kilifi, Kenya, demonstrates the potential of face-to-face communication. In a pilot study, shopkeepers from 23 shops were trained to treat all childhood fevers with a full course of chloroquine, and given reasons why they should do so. Participatory methods were used to improve both knowledge of malaria and its treatment and to strengthen communication skills, so that shopkeepers could engage in effective face-to-face communication with customers.

While only 4% had given correct advice on chloroquine dosage before the training, 98% did so after the training (in their shops, under observation). Before training, 32% of the customers bought an adequate amount of chloroquine for the child; after training 83% did so. The biggest and most important change came in the amount of chloroquine that was actually given to the child with fever. Less than 4% of the mothers gave an adequate amount to the child over three days before, and 65% did so after the shopkeeper training. This means the mothers were willing to listen to the shopkeepers, and followed their advice - even when it meant spending more money on drugs.



The pilot study showed that a very large percentage (83%) of the customers followed the advice of the shopkeepers. This result is to a large extent due to good training and frequent monitoring, which gave the project a relatively high profile and positively influenced both shopkeepers and customers.

In a follow-up study in Kilifi, local government health workers and community health workers (rather than specialist trainers, as in the pilot study) were training the shopkeepers. Mid-term results showed that 95% of the shopkeepers were giving correct advice about the use of chloroquine. Before the training of the shopkeepers, 5% of the mothers used an appropriate dose of chloroquine over three days for their children with fever. After training, 37% of the mothers gave their children a sufficient dose over three days. By 2001 (the end of the programme), and with the introduction of sulfadoxine-pyrimethamine group drugs in accordance with national policy, this proportion rose to 64%. Overall, the proportion of shop-treated childhood fevers receiving an adequate dose of a recommended antimalarial drug within 24 hours rose from 1% to 28% by 2001.

In the qualitative assessment, several community leaders, health workers and traditional healers said there was less malaria among the children in their community since the programme started, and fewer children died from malaria. This finding is not confirmed statistically, but the comments from the leaders and from other community members were consistent on this point and positive overall.

Since the project went to scale, training and monitoring of shopkeepers have been conducted by Public Health Technicians (PHTs) and Village Health Workers (VHWs). The PHTs conduct this training as one of their many duties, and the VHWs are volunteers with no formal background in health or training methods. Both groups receive very basic remuneration for the training they conduct. Considering these limitations, the mid-term impact of 37% of mothers giving their children a sufficient dose of chloroquine still appears high, particularly since this figure also includes mothers advised by shopkeepers who have not been trained (assistants in shops included in the study). When including in analysis only shopkeepers who were trained, the result is 49% giving a sufficient dose. The training is being monitored to see how it could be improved. The final result of 64% of mothers giving the correct dose of sulfadoxine-pyrimethamine to children with fevers strongly supports the inclusion of private drug retailers in control strategies aiming to improve effective treatment of malaria.

Marsh VM et al. (2004). Improving malaria home treatment by training drug retailers in rural Kenya. *Trop. Med. Int. Health* 9(4):451-460.

Marsh VM et al. (1999). Changing home treatment of childhood fevers by training shopkeepers in rural Kenya. *Trop. Med. Int. Health* 4(5):383-389.

Health workers can be very busy and complain that they do not have time to communicate with patients on specific topics. In such cases, it is possible to train non-clinical staff to lead on communication around rational drug use.

Health workers' attitudes are often a problem. Many health workers treat patients in an unfriendly way, blaming them for their actions. This prevents patients from learning and from being able to take action to use medicines correctly.

Communication through informal health providers

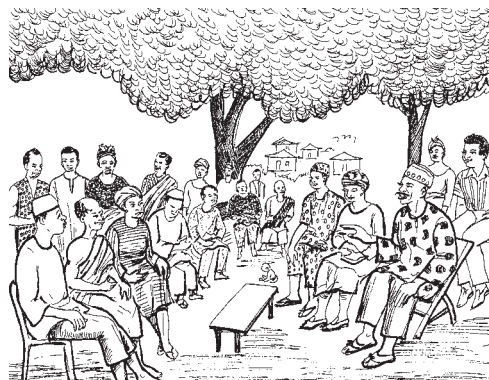
Many people visit traditional healers or buy medicines from community pharmacies or shops. In a number of countries, 60–80% of the medicines for malaria are bought in local shops. The example above (Box 10) shows the potential of using this channel to improve rational medicine use for antimalarials.

In some countries, for example Ghana and Nigeria, people may travel from community to community selling medicines. Could these informal health providers become involved in your educational efforts? You would have to train them about rational use of medicines and the importance of educating clients about their use. However, you may face serious difficulties. Because selling prescription medicines is usually illegal, it may be difficult to set up official programmes to train shopkeepers or travelling medicine salespeople. In many countries training of shopkeepers has however become accepted, as research results have demonstrated the positive effect on learning about how to use drugs correctly.

Shopkeepers in the Kilifi study (above) had a high credibility in the community. They were motivated to participate in the training because they learnt to treat their own family members more effectively, the training improved their status in the community, and they earned more money (through people buying and taking full courses of the malaria drugs).

Outreach approaches

Outreach approaches involve conducting face-to-face communication programmes in community settings. This can include home visits to carry out follow-up interviews with patients or to discuss medicine use with individuals and their families. Community meetings and public events provide good opportunities for dialogue using methods such as drama and folk media. It is also possible to reach influential persons such as community and religious leaders. In addition to engaging with community members directly, you may also be able to work with other community organizations such as youth groups, women's groups, farmers' associations and religious groups to identify how to improve rational medicine use. Box 11 describes the way in which communication outreach activities in Indonesia improved the quality of self-medication.



Working with schools

Schools provide a good opportunity to reach children and parents. Schools can influence health in three main ways: through the provision of health-promoting school surroundings, through school health education and through school health

BOX 11. IMPROVING THE QUALITY OF SELF-MEDICATION THROUGH MOTHERS' ACTIVE LEARNING IN INDONESIA

There are at least five pieces of information required for appropriate self-medication: information about the active compound; indication; dosage and administration; side-effects; and contraindications. However, a survey carried out in Yogyakarta, Indonesia, in 1993 showed that the level of knowledge mothers had about medicine was considered inadequate to support safe and effective self-medication.

The most common lack of information concerns the active compound. Mothers only know the brand-name drugs marketed for a certain symptom. The direct effect of this lack of knowledge can be seen in household drug consumption patterns, where several brand-name drugs with the same active compound are used concurrently. This not only wastes money, but could also lead to overdose of powerful drugs, particularly painkillers.

An innovative communication strategy

Many types of public education have been tried to improve knowledge about self-medication, such as campaigns through the mass media, seminars and articles in magazines, but their impact has been limited. In a large country like Indonesia, with over 200 million people, it is impossible to rely on the limited drug information services available. A better approach would be to use an innovative communication strategy that promotes active learning; facilitates self-learning; empowers the community with skills and a critical attitude in seeking information; and creates information-seeking behaviour. The learning process should also be transferable. Much of the necessary information is already available on drug packaging in Indonesia. If it is used optimally people would have the facts they need for appropriate self-medication.

CBIA: taking up the challenge

CBIA is an abbreviation for Cara Belajar Ibu Aktif (Mothers' Active Learning Method). It is an educational module developed by the Department of Clinical Pharmacology, Gadjah Mada University, Yogyakarta, in 1993, aimed at improving mothers' knowledge and skills to select non-prescribed or over-the-counter medicines. CBIA uses a problem-based approach and self-learning process. Information printed on the pharmaceutical package is used as training material. The training is intended to empower mothers to seek and critically assess information on the drugs that they commonly use, and to increase drug procurement efficiency in households.

Conducting CBIA sessions

The CBIA module uses small-group (6–8 people), interactive discussions. The process can be incorporated in regular meetings of women's grassroots organizations, as well as in other arranged gatherings. Not only mothers but fathers, the elderly, teenagers and primary school pupils can all participate. Community gathering points, such as houses, mosques and village offices, are excellent for conducting CBIA. Students or others familiar with the contents of drug packages can be recruited as tutors, and it is also possible to invite tutors from the target groups. Before carrying out the activity, tutors familiarize themselves with the problems relating to each drug package being used in the session. A pharmacist or physician can be invited as a resource person.

Each participant is requested to bring all the medicines they have at home, and in addition reusable sets of medicines can be provided. Each group works with one set of around 30–40 preparations in original packages, with price labels, consisting of several classes of medicine, such as antipyretics/analgesics, vitamins/minerals and cough remedies.

The activity usually takes 2–3 hours. A tutor begins with an introduction on the advantages/disadvantages of self-medication, and then participants are requested to form small groups. Using the medicines, they observe where they can find information on active ingredients, group together over-the-counter drugs based on their main ingredients (not the indications), and then discuss the findings.

Topics to cover

Discussion usually covers the following points, (although experience shows that participants can identify others, and sometimes come up with surprising findings):

- Active ingredients are always stated on the package, and this information is hardly ever found in drug advertisements. Incomplete and unclear information in drug advertisements can be clarified by consulting the drug package.
- Brand names may be sold in many different forms such as syrup or tablet, with exactly the same active compound. Participants should learn the difference between brand names with Forte or Plus included, and their conventional forms.
- Though the brand names for adults and children are often similar, the active ingredients are sometimes different. Participants should be aware of those differences.
- Prices vary between the drug forms, for example, syrups may be 10 times more expensive than tablets.
- Drug purchasing can be more efficient if people think about the prices in relation to the dose. Brand names with Forte in may be several times more expensive than the conventional one, although there is only a slight difference in the amount of the active ingredients.
- For commercial purposes, the names of active ingredients are often hidden in other names, which are not commonly known by the public. For example, 1,3,7 trimethylxanthine is used for caffeine and paracetamidophenol for paracetamol.

After completing the discussion, participants are requested to collect the information needed for appropriate self-medication: the active ingredient, indication, dosage and administration, side-effects and contraindications. At the same time, participants examine the clarity and completeness of information found on each package. The expected impact of this exercise is to encourage participants to read all information critically.

Is CBIA effective?

CBIA has been field-tested and evaluated in a controlled study, in comparison with a large seminar, which is a more common form of education. One hundred and twelve mothers of low to moderate levels of education were recruited for the study, and randomly assigned to three groups. Group A received CBIA, Group B attended a large seminar to train them in the same skills, and Group C served as the control.

The results showed that the scores of the five main components of knowledge increased significantly in both Group A and Group B, in comparison to controls, where there was no change. In addition, the increase in knowledge in the CBIA group was significantly greater than among mothers attending the large seminar. Furthermore, the number of brand name drugs used in households in a one-month period reduced drastically in Group A (from 5.3 to 1.5), while in the other groups the number of medications did not change.

Not only was the CBIA approach effective in increasing knowledge and reducing the number of products used, but all of the mothers who underwent CBIA intervention found this type of problem-based learning enjoyable.

After dissemination of the field-test results, CBIA was replicated by interested colleagues in various settings. Feedback on use of the intervention shows that CBIA works well with groups of mothers, fathers, the elderly, teenagers and primary school students. The best results were achieved with mixed groups. Experience shows that a forum consisting of mothers, fathers and family members living in an immediate neighbourhood resulted in a more sustained impact. A practical guide to conducting CBIA has been developed by the University of Gadjah Mada.

Source: Suryawati S (2003). Improving the quality of self-medication through mothers' active learning in Indonesia. WHO Essential Drugs Monitor No. 32. Available at: mednet2.who.int/edmonitor/32/32_12.pdf



services. Of special importance are the opportunities provided for health education of school children and reaching out to parents through school-based activities in the community. Programmes such as Child-to-Child have prepared activity sheets which suggest ways in which teachers can carry out education about use of medicines. Half the population in developing countries is under the age of 15. The potential for teaching children about the risks and benefits of medicines is enormous in both developing and developed countries. Children are already very active users of medicines and they are also often sent to buy drugs in the shops (Geissler and Meinert, 2001).

There is increasing interest in training teachers in first aid, referral of sick children and in the use of simple medicines dispersed through a school medicine chest.

Schools are also being used for mass treatment programmes such as de-worming, ivermectin distribution (for onchocerciasis or river blindness) and vitamin A and other micronutrient supplementation.

BOX 12. USING CARTOONS AND TALKS TO INFORM SCHOOL CHILDREN ABOUT ANTIBIOTIC USE IN SWEDEN

A mix of face-to-face and print communication in Sweden for primary school children – making use of a photo novel with cartoons and teachers' guidelines – was found to increase children's knowledge about the rational use of antibiotics. Teachers found the material easy to use and both teachers and children liked the intervention, particularly as it captured children's interest. Educational entertainment materials were developed together with children, medical doctors, pharmacists, health communicator, photographer, and designer. The intervention consisted of a one-hour lecture covering infections, treatment, hygiene and pathogens, followed by reading of the cartoons. It was evaluated by knowledge-assessing questionnaires, interviews, and focus group discussions (FGDs).

Kristiansson C, Cars O, Torell E, Hartvig P (2004). *Children as health information carriers: an "Edutainment" intervention concerning rational use of antibiotics*. Presentation at the International Conference on Improving Use of Medicines (ICIUM) 2004, Chiang Mai, Thailand. Available at: <http://mednet3.who.int/icium/icium2004/resources/ppt/CH022.doc>

Community participation

Community participation approaches depend upon the active involvement of community members. This approach calls on them to take part in the process of planning, implementing and evaluating the communication activities.

The starting point for community participation approaches is dialogue with the community to determine their felt needs and concerns. This is followed by participatory learning activities which encourage discussion, the sharing of experiences and allowing individuals, groups and communities to discover their own solutions to problems.

Recently the United Nations Development Programme (UNDP) and others have been developing successful 'community conversation' or 'community dialogue' interventions in Africa and Asia to explore sensitive community issues. Box 13 describes some of the impact this approach is having in Ethiopia.

While the concept of community participation is widely promoted and can lead to effective and sustainable change, it takes time, effort and care to involve

BOX 13. ENGAGING THE COMMUNITY IN CONVERSATION

The Community Conversation approach is being used in Ethiopia to stimulate changes in social norms, values, and customs, and to increase community acceptance of people living with HIV and AIDS. It is based on the recognition that communities have their own capacity to care, change and sustain hope, and that local responses to the epidemic need to take into account the community's existing social dynamics, relationships and concerns. Trust and respect are critical, so that genuine interaction can stimulate sustainable changes from within the community, related to prevention, care, eventually treatment and reducing the impact of the epidemic.

The approach uses participatory methodologies that stimulate a 'Community Conversation' and reflection on deep issues and concerns related to people's lives, values, attitudes, behaviours and choices in the context of HIV and AIDS. The aim is to increase understanding of how *change* happens.

The methodologies include storytelling, strategic questioning, active listening, reflection, participatory evaluation and documentation, and they are related to 'social capital' and socio-cultural dynamics. Social capital refers to the social and cultural coherence of society, the norms and values that govern interactions among people and the institutions in which they are embedded. The kind and the extent of linkages and relationships within a community are critical determinants of the spread and impact of the HIV and AIDS epidemic.

A Community Conversation starts from where people are – from their perspectives of the situation and their interest in change. Participants are grouped and undertake a conversation, facilitated by a well-trained facilitator from among themselves, to reflect, discuss and present.

Their discussion might address questions such as: 'How would you describe the nature of the AIDS epidemic in your community/country?' It is explained that the methodology is like a staircase, taking steps together, learning together and moving towards the community's goal. Then the following steps in the facilitated community change process are explained, and skills and tools identified:

1. **Relationship-building:** necessary for gaining mutual trust, understanding and respect, and so that the community will talk about their real problems.
2. **Identification of community concerns:** these are general issues that worry or disturb the communities; from these they extract their needs, which are more specific.
3. **Exploration of community concerns:** looking for a deeper understanding of the underlying factors causing the identified problem.
4. **Decision-making:** based on the community's identified concerns and findings from their exploration of these; known also as the planning phase.
5. **Action (implementation):** this must involve as many community members as possible so that they can take ownership, and ensure sustainability.
6. **Reflection and review:** participatory processes should be used, with the communities identifying their own changes and indicators of change.



The process has achieved remarkable breakthroughs in Ethiopia, providing people with the means of identifying their own problems and solutions. People are now openly talking to each other about 'taboo' subjects, understanding which of their cultural norms and values are fuelling the epidemic, and identifying the social capital within the community to overcome them. Changes have included:

- shifting perspectives, attitudes and cultural practices on gender issues
- taking action to know one's own HIV status

Continued

Box 13 continued

- learning how to prevent infection and make health services safer
- assuming accountability for actions and lifestyles
- distinguishing between cultural practices prescribed by religion, and those that have been attributed to religious requirements in error.

The methods have been used in two selected areas: Alaba district in the south, and the Borena area in Oromya region. The Community Conversations have led to the abandonment of a number of age-old customs and practices that have been fuelling the spread of HIV. For example, in the Borena area, participants in Community Conversations have decided to abandon wife sharing (*Warsa*), rape (*Jala*), multiple sexual partnership (*Jalafi Jalto*) and other customs that were increasing their exposure.

Participants have also become interested in knowing their sero-status. In Alaba discussions about HIV and AIDS are now much more open, and practices such as female genital mutilation, wife sharing, and abduction and sharing of the bride (*Jalla*), are now being challenged through discussion.

Source: Bogale H (2004). Engaging in community conversations. SIPAA News, No. 1. Support to the International Partnership against AIDS in Africa (SIPAA).

communities successfully. Communities can be divided and not have a common purpose. They can be suspicious of outsiders. If you want to use a community participation approach, you must take the time to understand the community and use field workers who are good listeners and sensitive to the needs of communities. This process of listening and dialogue takes time. However, the time spent should result in a programme that meets local needs and involves the community in defining problems, the reasons for them and identifying possible solutions. Programmes using a community participation approach therefore have been shown to have a more long-lasting and sustainable impact.

One of the key outcomes of a more participatory approach to communication activities should be a greater sense of empowerment among the community members involved in a programme. Box 14 explains what is meant by empowerment in the context of health.

BOX 14. EMPOWERMENT

An empowered person or community has the necessary understanding of health issues and has acquired any needed skills. However, most importantly, she or he has the confidence to put those two things into practice. The key to an effective empowerment approach is to use face-to-face methods to encourage community participation that leads to understanding problems and perceived reasons for these, finding solutions and taking action.

The community empowerment approach to health promotion is quite different from traditional persuasion-oriented health education. The empowerment approach:

- uses a small group face-to-face approach
- avoids a top-down model with solutions imposed from above
- respects and builds upon the community's knowledge, perceptions, practices and strengths
- encourages discussion and dialogue
- helps the community to discover solutions to problems.

Empowerment is increasingly seen as one of the most important but difficult objectives for health communication.

Source: Adapted from: Lavarack G (2004). *Health promotion practice: power and empowerment*. London, Sage Publications.

Self-help and advocacy groups

Self-help groups consist of people with a shared interest who come together to support each other. Self-help groups have been formed for many health issues, for example alcohol abuse, weight problems, parents of children with diabetes, and people living with HIV. Sometimes groups are formed by people themselves because of a shared need. In other situations, health workers have encouraged patients with similar problems and their families to meet and support each other. Such groups can be important sources of information and support. However, it should not be assumed that all of these groups operate solely to promote the interests of patients. Sometimes they are heavily sponsored and/or sometimes may be used as “fronts” for pharmaceutical companies interested in advocating the uptake of their products by consumers, social insurance groups and drug regulatory agencies.

Advocacy groups aim to influence the policies of governments and companies and provide information to the public. This is covered in more detail in Chapter 7 on advocacy and networking.

Learning through dialogue

A study in Kenya and Indonesia (Ross-Degnan et al., 1996) assessed the effect of one-to-one training of pharmacists and group training of pharmacy counter attendants. The results show a significant increase in knowledge, and a 30% increase in ORS sales in Kenya and 21% in Indonesia. There was also a trend towards increased communication in both countries, and in Kenya a significant increase in discussion about dehydration during pharmacy visits. The researchers did not measure the long-term effect of their intervention.

Another approach, and one which illustrates a different role for health workers, is outlined in the case study from Nepal in Box 16. This highlights the way a dialogue process in the community can bring about a change in practice.

Selecting communicators

The people who we allow to influence us to change are usually important people to us – someone we trust, someone we have known for a long time, or someone we respect for a number of different reasons. The person needs to be someone we can identify with, someone who is close enough to us in status, function, culture, or way of thinking.

BOX 15. DIALOGUE TO REDUCE THE USE OF INJECTIONS IN INDONESIA

A series of interactional group discussions (IGDs) involving physicians, paramedics and patients has led to a significant reduction in the use of injections in public health facilities in Indonesia. Each IGD of 12 people had 6 prescribers and 6 patients. The session lasted 90–120 minutes and was held in a relaxed informal setting of a restaurant with a free meal provided. The session included an exploration of the feelings of members about being included in the group, discussions of the discrepancies between the prescribers’ and patients’ beliefs and motivations for injection use, the presentation of scientific materials and a conclusion. An evaluation found that compared to patients not taking part in the IGDs, the programme reduced use of injections from 70% to 42%. Injections of analgesics and vitamins were almost halved. There was also a significant decrease in the average number of drugs per prescription.

Hadiyono JE et al. (1996). Interactional group discussion: results of a controlled trial using a behavioural intervention to reduce the use of injections in public health facilities. *Social Science & Medicine*, 42(8):1177–1183.

BOX 16. LESSONS FROM ORS COMMUNICATION IN NEPAL

A 1982 survey in Nepal showed that 40% of people were aware of ORS, but less than 5% used it when their children had diarrhoea. Diarrhoea was then still one of the major child killers in Nepal.

A Redd Barna (Norwegian Save the Children)/Ministry of Health project, asked the following questions:

- What will make the 40% change from awareness to action?
- Who will encourage them to make this change?
- Who are the 5% who are using ORS, and how can we engage them in sharing their knowledge with the others?
- In what setting should such a process take place?

Auxiliary Nurse Midwives (ANMs) working in the health clinics had a limited role. They were interested in the ORS problem and took part in a two-week course in face-to-face communication methods and skills - including how to run a community meeting. The MOH selected some villages for a trial project. Village leaders gave their permission for meetings with the women. Discussions took place with the traditional healers, who have a lot of power in the villages, and could obstruct – or encourage – the adoption of new practices. They agreed that diarrhoea is a big problem, and that their medicines did not always help. They were interested in ORS, and discussed the ideas thoroughly with the ANMs. They were invited to the meeting that had been called (by the community leaders) to discuss the issues with the women.

In these meetings, the ANMs asked women to describe what experiences they had with diarrhoea in the community. Many women stood up and described how their children had died. Most of them had stopped giving the children liquids when they had diarrhoea, because then the diarrhoea also stopped after a while. One or two women stood up and said they had given their children ORS when they had diarrhoea, and the children had survived (these were the “5%” the researchers had been looking for). They were challenged by the others – how could they give more water? Did this not make the diarrhoea worse? Did the mothers-in-law not protest? All the counter-arguments were given, and the ANMs directed the discussion by making sure everybody was listened to, and only one person spoke at a time. The ANMs gave a short input – on why it is important for a child with diarrhoea to get more fluids, and how ORS works to “balance” the child’s stomach and help him/her fight the diarrhoea. There were questions, and more discussion.



The women who had used ORS had a powerful argument with them – a healthy child. The other women saw this, and in an environment, (the group meeting, “blessed” by the community leaders) where it was acceptable to discuss these practices a great deal of learning took place. One of the women who had used ORS was then invited up to demonstrate how to make ORS. The other women watched with interest. There was further discussion. The ANM demonstrated once more, and repeated the “recipe”. Simple handouts with a pictorial description of how to make ORS were given out. Two traditional healers were present in the first meeting; they stayed at the back and did not contribute.

At least two meetings were held in each community. In the second meeting, several more women had tried ORS, and reported that their children were well. One said it was not worth the extra work with having to clean up the diarrhoea, but she was challenged by the others - how could she say that, when the medicine helped the child to survive? In some meetings, the traditional healers also contributed their experiences, and said they had used ORS with their own children

– with good results. This was important for accepting the practice in the area. The ANMs also had special meetings with some of the healers to discuss what they could do to help spread the use of ORS in their communities.

Continued

Box 16 continued

In the three project areas, the use of ORS went up from 5% to 60–70% within six months.

Lessons learnt from the Nepal case study

Opinion leaders in the community need to be addressed first, to gain their support for the project or idea. The community leaders were contacted to get permission to meet with the women. The traditional healers were contacted to discuss the problem, invite their opinions, and request their participation.

Opinion leaders can make a real difference to getting a new practice accepted and used. Frequent meetings to discuss project strategy and progress with the leaders is important.

Providing a forum for exchange of experiences – a village meeting of women is a good setting for spreading new knowledge.

The positive experience of neighbours using a new practice is a powerful inspiration to change, especially when confronted with the result of the experience – a healthy child.

Health worker as facilitator: the role of the health worker was changed, from the “lecturer who knows it all” to a facilitator who encourages women to share experiences and help build each other’s confidence. The ANMs were from the same area, spoke the local language, and were willing to travel to the different villages (on foot).

Source: Unpublished report, Redd Barna, Nepal, 1983.

BOX 17. PLANNING FACE-TO-FACE COMMUNICATION: INTERNAL AND EXTERNAL FACTORS

The factors the communicator has to understand to be able to influence someone’s behaviour or practice can be grouped under “Internal factors” and “External factors”.

Internal factors (which are “inside a person’s head”) are for example: knowledge related to the action, perceived risks, what consequences the action will lead to, attitudes and social norms related to performing the action, experiences with different forms of treatment, and intent or motivation to change. These factors can be explored during formative research, or participatory research.

External factors (outside the individual, those which can influence a practice positively or negatively) are for example: availability of services, demographic factors, epidemiology, policies, cultural norms, and skills and their consequences.

Ideally, it should be a person we can consult during the process of change (when trying out and evaluating the new practice, we will have questions – and we will have a strong pull from our “old habit” to go back and do what we did before). Sometimes family members will oppose a change, and then it is especially important to have someone you feel safe with to consult about how you are doing, and to keep giving you good arguments to stay with the new practice.

A good face-to-face communicator needs a combination of the right personality and the right knowledge, skills and attitudes. However, very often there is not much choice – your communicators may be the formal and informal health workers, the informal providers/drug store vendors or pharmacists. Be aware of what makes a good face-to-face communicator, and aim to move the trainees as far as possible in this direction. Box 18 identifies some of the key characteristics of an ideal face-to-face communicator.

The credibility of the communicator is essential to the success of the interaction with clients or customers. It is influenced by the communicator’s ability to:

- understand the person’s background (perceptions, practices, reasons)

BOX 18. THE IDEAL FACE-TO-FACE COMMUNICATOR

- Approachable
- Makes everybody feel welcome and at ease
- Respectful of others' knowledge and skills
- Curious, willing to learn from others
- Good communicator and good listener
- Inspires dialogue and views
- Able to identify problems and solve them constructively
- Knowledgeable about the subject
- Not afraid to admit to not knowing the answer. Will find out.
- Can accept and reflect on criticism, and does not become defensive
- Non judgemental

Source: Promoting Rational Drug Use in the Community Course (PRDUC) workshop participants, South Africa, 2004.

- respect this background, and also the reasons why it might feel impossible for the person to follow advice to change
- use this background/ideas as a starting point for the education (build a bridge from the informal knowledge to the biomedical knowledge)
- be sensitive to the person's emotional state (someone whose child is very sick will feel very scared, and needs to be treated in a friendly and considerate way)
- be available for follow-up advice.

Training in core communication skills

The communicator should have been trained in the necessary factual knowledge and skills to treat the common diseases in the community. The community members should know that the communicator has these formal qualifications. However, knowledge without communication skills will not convince community members to change their practices.

Setting up training programmes for health workers in communication skills is a necessary – though often neglected – managerial strategy for strengthening rational drug use programmes.

Understanding the problem

Understanding the problem of the client or customer requires three main communication skills:

- (1) observation
- (2) asking open questions
- (3) listening carefully.

These are very important skills in face-to-face communication and should be mastered by anyone working with this method. The skills need to be accompanied by a friendly and



respectful attitude to the client or customer. An uninterested, unfriendly communicator will not gain the confidence of the customer or client, and will therefore not be able to understand the problem, and influence him or her to change practice.

The communicator who understands a mother's difficulties and her dilemma, and is respectful, sympathetic and understanding, has a chance to get through to her and encourage her to try a new practice. Blaming her for sticking with the old ideas will only make her angry or unsure, and will only make her more likely to stay with what feels safe – doing what she has done before.

Communication, with feedback

Communication is a two-way process consisting of giving information to a person, and getting feedback. It is only by getting feedback that you know if the person has understood what you meant to say. See Box 19 for an example of how to build real understanding between two participants in a training workshop.

BOX 19. BUILDING REAL UNDERSTANDING

Peter: So I understand you came to this training because your boss told you to?

Daniel: Yes, he did, but I also very much wanted to come, I want to learn how to implement a community drug education programme in our village, there is so much misuse of medicines. My aunt died after getting the wrong dosage of antibiotics, and many other family members have been very sick. We have to do something!

Peter: Yes, drug misuse is a big problem, also in my area. What do you plan to do?

Daniel: Well, I'll tell you... and then I want to hear about your plans!

Peter had the idea that Daniel was there because he got an order to go (he assumed). If he had not checked this out (asked Daniel, and received feedback that he also had a strong personal interest), Peter might have treated Daniel as a bureaucrat whose heart was in his career, not in community education (where Peter's was). Now that they have exchanged ideas, and found out that they share a personal motivation to solve an important problem, their continued communication will be on a much deeper level.

To communicate means to exchange, or share. Good communication should lead to a shared understanding – which does not always mean that people agree! By asking about and listening to what the other person thinks and feels (getting feedback), you can find out if you have a common goal.

If a message is given from one person to another with no feedback, it is called information. This is a one-way “product”. When a health worker (or informal provider) gives a mother instructions about how to use medicines, he gives her information. If he does not discuss the instructions with her, he cannot be sure she has understood – and accepted – what he has said. This is usually the problem with information.

Information can change to communication when the person it is given to gets involved and gives feedback. The health worker asks the mother to repeat the instructions on how to take the drugs, and asks her opinion about the new way of using them.

Information is ONE-WAY

Communication is TWO-WAY

Responding to the problem

When the problem (and how the customer or client may change his/her practice) has been understood by the health worker or shopkeeper, he/she should respond by using three main skills:

- giving accurate and clear advice, and explaining why
- discussing the choice of medicines and the treatment with the customer/client
- checking that the customer/client has understood the instructions.

Maintaining a friendly and respectful attitude is as important here as when the communicator is trying to understand the problem.

Support face-to-face with other methods

Face-to-face is an effective method to influence people's behaviour and encourage them to reassess their (medicine use) practices. However, it does not reach many people at a time, and is therefore seen as an expensive method. A programme planner will be faced with the challenge of being "cost-effective" and reaching as many people as possible for the amount of money available.

Some additional ideas on how to supplement face-to-face communication on rational medicine use include:

- **Encourage community groups** – to discuss/continue learning on the selected topics. Simple educational materials would be a good support, as would having health workers or informal providers participate in the group meetings as resource people. A short training programme for the community group leaders on how to use the materials to facilitate and encourage group discussion and learning would improve the quality of the subsequent group learning sessions.
- **Encourage learning in schools** – possibly by using the same (or similar) materials for discussion. Teachers could participate in the short training programme, and/or they could invite health workers or informal providers as resource people.
- **Other channels** – the following channels could be used to spread information about the topics, and make people aware of the need to learn. It is important to note that most people would not change their practice after only being exposed to the information through these channels, but – having heard about the topic(s) through these channels – they are likely to be receptive to ideas about how to change practice that is communicated in a face-to-face dialogue. Examples of such channels are:
 - Discussing the topics in meetings at schools
 - Discussing at a community meeting
 - Making a community drama, with subsequent discussion
 - Making a radio programme (or a series).

Research shows that for any face-to-face method, the support of printed materials will usually improve the impact of an intervention. Box 20 shows how face-to-face counselling combined with print materials improved adherence to tuberculosis (TB) drugs in South Africa.

BOX 20. ENHANCING ADHERENCE TO TB DRUGS IN SOUTH AFRICA

Nurses were trained in patient-centred communication to be able to counsel TB patients. The aim was to enable the patients to understand the treatment process and the importance of adhering to the full course of medicines. A booklet, including a story, provided additional reinforcement and support, and patients were given a calendar so that they could monitor their own progress during treatment and feel that they had some control over their own treatment. A role model was created by the heroine of the story whose experience showed the obstacles to adherence, such as stigma of the disease, depression and side-effects. She overcame the obstacles and was cured. The patients exposed to the communication intervention achieved a mean adherence rate to treatment of 95% with only one patient defaulting. A similar clinic that did not have the intervention had a lower mean adherence rate of 83% with 13 patients dropping out.

Dick J, Lombard C (1997). Shared vision – a health education project designed to enhance adherence to anti-tuberculosis treatment. *Int.J.Tuberc.Lung Dis.* 1(2):181–186.

Communication barriers

There are a number of possible reasons why face-to-face communication might not work well. The three main ones are:

The environment

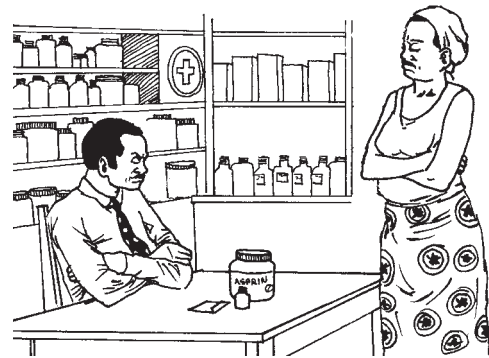
- The place where the communication is taking place is too noisy, cold, warm, full of distractions, not private, or does not feel safe.

The communicator

- Has an unfriendly attitude
- Judges the clients/customers negatively: considers they are ignorant, has no respect for their perceptions and concerns
- Does not find the real reason(s) for the problem, or understand the needs and concerns of the clients/customers
- Uses complicated technical language to show superiority
- Does not listen well
- Interrupts, argues and is impatient
- Jumps to conclusions before the client/customer has finished explaining
- Lacks knowledge – does not know the answers
- Does not follow-up to see if the advice is put into practice.

The client or customer

- Does not trust the health worker or medicine provider, feels uncomfortable
- Is nervous and worried, and is not met with sympathy
- Does not have enough money
- Has several children waiting at home, without supervision and is in a hurry
- Does not feel free to say she does not understand, because she feels the health worker or drug provider is not really interested in her perspective
- Does not feel free to ask questions
- Feels he or she is being judged negatively (for not coming for medicine earlier, for having used traditional herbs, for having used medicine at home).



- Gets too much information at a time, and no printed information to help him or her remember
- Does not understand the complicated language used by the health worker to explain the cause of the disease, which is different from commonly held community beliefs, and simply says the health worker is wrong.

It is easy to see how these barriers could – and very often do – stop the client or customer from learning how to use drugs in a rational way. When planning a training programme, make sure that these aspects are considered and fully included, and due attention is paid to them. Teach the communicator to be aware and make sure he/she clears away as many barriers as possible before starting the training.

The work of the communicator is strengthened by others in the community, such as influential neighbours, women's groups and community leaders, reinforcing their suggestions for new practices. For example, a communicator might be well advised to consult with the community leaders and other health workers before starting work with the community. If these influential people support the new practices, chances are high that these will be adopted much more effectively.

Additional reading

Aubel J, Rabei H, Mukhtar M (1991). Health workers' attitudes can create communication barriers. *World Health Forum*, 12(4):466–471.

Homedes N, Ugalde A (1993). Patient's compliance with medical treatments in the Third World. What do we know? *Health Policy and Planning*, 8(4):291–314.

Hubley J (2004). *Communicating health: an action guide to health education and health promotion*. 2nd ed. Oxford, Macmillan.

Laverack G (2004). *Health promotion practice: power and empowerment*. London, Sage Publications.

Pretty J, Gujit I, Thompson J, Scoones I (1995). *Participatory learning and action. a trainer's guide*. Chapter 1, pp.1–12. Participatory Methodology Series. London, International Institute for Environment and Development.

ZEDAP (1997). *Next is not enough. A training manual to strengthen the interpersonal skills of health workers*. Harare, Ministry of Health, World Health Organization and the United Nations Children's Fund.

3

Drama and other folk media

Introduction

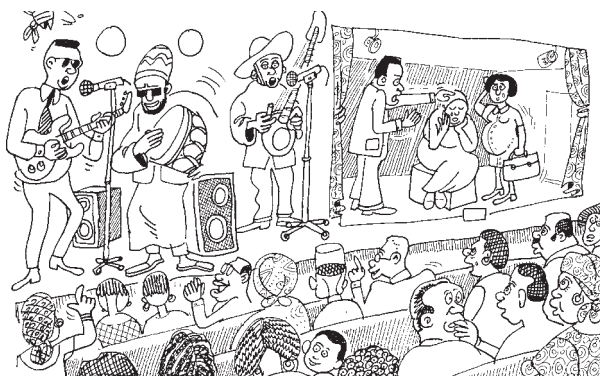
This chapter will explore a range of types of folk media, seeing how they can be used in combination with other communication approaches and how they can fit into an overall strategy. It will help you to:

1. Examine a range of folk and performance media
2. Consider the role of these media as part of a communication strategy to address medicine use problems in communities and the potential effect of programmes on knowledge, attitudes and practice
3. Explore what must be taken into account when mobilizing folk media for the promotion of rational drug use.

Drama and other folk media – also called popular media – are a vital part of most communities' culture. They can be both traditional and modern.

These media can be community-based or conveyed through mass media. Their impact and popularity is widespread especially in communities with strong oral traditions. While they have played a role in public communication on other health issues, they have not been widely

used to promote rational drug use. The idea of combining information about social concerns into popular education is increasingly becoming known as entertainment-education (EE) or edutainment. This comes in many forms, including serial dramas broadcast on mass media, cartoons developed in print, interactive radio talk shows and folk media. Framing messages in a popular, entertaining format helps create an environment where people of all ages can carry on conversations about topics raised in the performance. This increases the likelihood of the ideas



presented leading to action or change. This concept will be discussed in more detail in Chapter 6 on mass media.

Advantages and disadvantages

The overall advantages and disadvantages of using performance and folk media are highlighted in Table 6. Deciding which to use depends on which:

- has the most appeal among your intended audience
- is the most appropriate method to communicate the ideas
- is most likely to enable interactive dialogue.

Table 6. Advantages and disadvantages of performance and folk media

ADVANTAGES	DISADVANTAGES
• Combines entertainment with education • Attracts interest • Reaches large numbers • Culturally acceptable • Easier to explore sensitive issues • Performance skills likely to be locally available • Increases community involvement and participation • Can be interactive and stimulate discussion • If well done, the audience is more likely to remember the content • Makes attitudes visible • Includes emotional part and allows (integrated) messages	• May simply be seen as entertainment and not be taken seriously • Health messages may be lost • Needs multiple performances to reach large numbers of people • Can be expensive • Needs preparation and knowledge about the media



When the content of the folk media is well-chosen and followed up with appropriate discussion after a performance, it can help to bring about change in critical awareness of the audience, around how people understand problems, the reasons for them, and can stimulate trying out new approaches as part of the solution to the problems.

Types of folk media

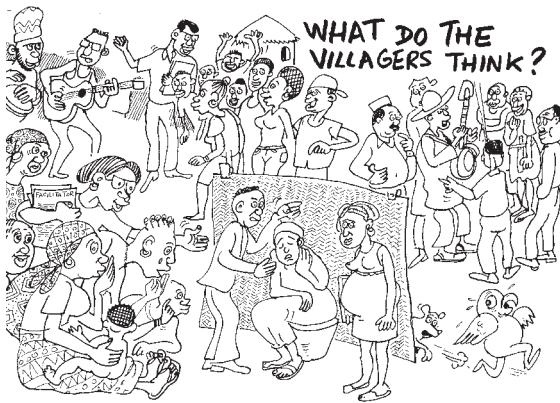
A wide range of performance and folk media exists in communities that can be mobilized in health communication activities. Such media include:

- theatre and mime
- puppets
- storytelling
- songs and dance
- magic shows, clowns, comedians.

Theatre and mime

Theatre and mime are examples of performance media that have been widely used in health communication. You can use them in many ways.

Theatre uses the spoken word, facial expressions, and the interaction of characters, including with the audience. It is a flexible medium that can be used in many different locations including theatres, community halls, schools and the open air.

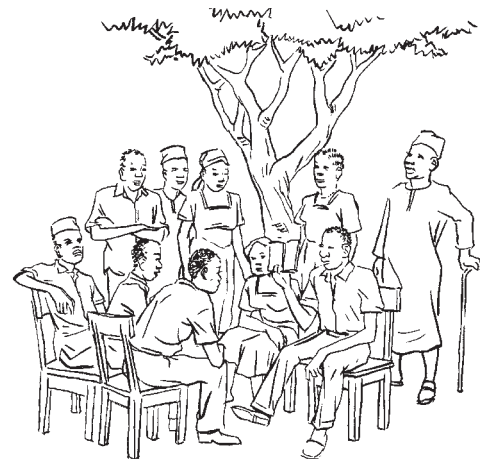


Theatre can involve professional actors, health workers, community members or school children or any combination of them.

While the actors might work from a script, that script can be developed by a single author or improvised by the actors – either on their own or in partnership with members of the community. Acting, music and dance can be combined to provide both entertainment and education. The power of theatre for health

communication comes from its ability to involve an audience, create characters with whom the audience can identify and to bring important, but often complex, issues alive. When using interactive theatre, the actors can stop to ask questions to the audience, discuss what comes up, and improvise to further illustrate some of the audience concerns. The example of the play about goitre from Pakistan, mentioned in Chapter 1, demonstrates how this can happen.

Box 21 discusses the way theatre was used to improve awareness about HIV and AIDS in India. Particularly important was the impact that this approach had on improving understanding about what it was like to be HIV-positive. Increasing dialogue in a community about a problem such as HIV (ill) is one of the first requirements to facilitate treatment of people living with HIV. However, this type of intervention needs to be followed up to see whether the intention to do something differently has actually led to change.



Mime relies on gestures and facial expressions to convey information. Mime can be useful when audience members do not understand the same language. This form has been used with success by the Jagran Theatre Group in slums and villages in various Indian states. The performance is an informal affair. People learn about an upcoming show by word of mouth and within a few minutes crowds assemble around the troupe. One of Jagran's plays is called *The Monster of Malnutrition*. In the story, a father and son are scared by a huge monster. They discover that this is due to their eating habits. As a result, they change their diet to a healthy,

BOX 21. THEATRE INCREASES HIV AND AIDS AWARENESS IN INDIA

The Nalamdana Theatre Group produced three plays to communicate HIV and AIDS information to men, women and children in inner city slums in Madras, India. A total of 121,000 people attended the one to two hours dramas (average audience was 1000 people for each performance). Questionnaires given to the audiences before and after each performance showed a significant increase in HIV- and AIDS-related knowledge in the group after watching the drama, and an increased intention to treat HIV-positive individuals more kindly.

Valente TW, Bharath U (1999). An evaluation of the use of drama to communicate HIV/AIDS information. *AIDS Education and Prevention*, 11:203–211.

BOX 22. 'MS. RUMOURS' IN PERU

A street-theatre play, Ms Rumours, was designed to dispel rumours about modern contraceptive methods among people living in urban areas in Peru. The misconceptions targeted included: the pill promotes cancer, the pill affects the foetus and the IUD promotes abortions. Each performance lasted about 20 minutes and was followed by a group question-and-answer counselling session.



The play was performed in parks and squares and also outside hospitals and clinics in front of people waiting for services. It involved four characters: Ms Rumours, a couple in love and a pharmacist. The street theatre showed how Ms Rumours promotes misconceptions and negative attitudes, and shows the pharmacist dispelling those rumours.

In a two-year period, the play was performed about 200 times to an estimated total audience of about 61,000 with an estimated 4,500 attending follow-up face-to-face counselling sessions.

Approximately four people per performance were interviewed before and after each of 17 performances (a total of 102 respondents). The interviewer asked them whether or not they agreed or disagreed with 11 knowledge and attitude questions.

Knowledge statements such as “the pill produces cancer”, “the pill affects the foetus”, “the pill affects the nerves” and “the condom is uncomfortable” changed the most. Attitudinal statements including “the pill is easy to use”, “the pill produces abortions” and “the condom is easy to use” changed little. The authors claim that the street theatre significantly reduced misinformation but did not have a significant impact on attitudes. Their evaluation suggests that street theatre can be useful for providing information but a more participatory approach is needed to influence attitudes.

Valente TW et al. (1994). Street theatre as a tool to reduce family planning misinformation. *International Quarterly of Community Health Education* 15: 279–289.

balanced one and are able to kill the monster. The facts of nutrition are introduced in a humorous way.

Box 22 looks at the way street theatre in Peru was able to improve knowledge about the contraceptive pill and other contraceptive methods. However, other methods are needed to influence attitudes and change behaviour.

When you know what effect the different methods are likely to have on the audience, you can plan your communication campaign to include the mix of methods needed to reach your objectives. For example, the theatre play in Box 22



could be followed up with a face-to-face intervention through a number of channels to influence attitudes and behaviour.

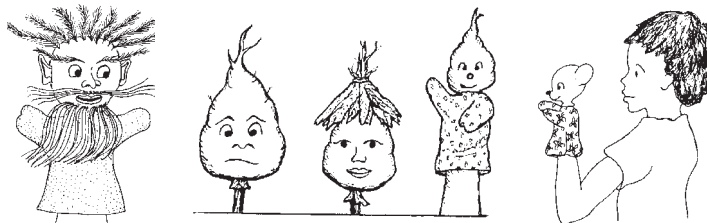
Theatre can be used to investigate the perceptions of the audience because it deals with emotions. For example, the Women's Collective in Matagalpa, Nicaragua, has created different dramas about the importance of women deciding over their own bodies, a fundamental right to gain access to health.

After a play about teenage pregnancy that shows the lack of sex education, mistrust within the family and the anguish a teenager goes through, the Collective interviewed women who had seen the play. These were

organized women from the 10 rural communities where the Collective works. To be able to talk about the play's characters allowed them to touch upon taboos and bring forth opinions and contradictions beyond stereotypes and prejudices.

Puppets

Puppets come in many forms including: simple ones made from paper bags, shadow puppets made from cardboard outlines, glove puppets, string puppets and more complex puppets.



The educational children's television programme *Sesame Street* has been shown worldwide. It uses complex puppets operated by persons hidden from the camera. Real people sing and talk to the puppets. The characters introduce simple educational concepts such as letters and numbers through song, humour and dialogue.

Many communities have traditions for puppet shows such as the shadow puppets of Indonesia and stick puppets in India. Even in communities where puppets are not traditional, they have been successfully used in health communication.

While puppets are immediately popular with children, adults have also enjoyed them. The strength of puppets comes both from their entertainment value and from their ability to bring out sensitive issues that would be more difficult to discuss if live actors were used, for example about the need to use contraceptives, or about stigma related to TB or HIV and AIDS. Despite this, some care must be taken when using puppets with adults. They may consider puppets only suitable for children and not pay attention when they are used for more serious communication. Also, in some cultures, puppetry is a highly advanced communication form, so how it fits into the cultural tradition needs to be considered. Involving the audience in the planning of such performances will help to establish whether the method is acceptable to them.



Music, songs and dance

Music, songs and dance can add interest and excitement to any health communication activity. They can draw a crowd that may then be willing to listen

BOX 23. PUPPETS AGAINST AIDS

The Puppet Power Team is a project of the Namibian Red Cross Society that spreads HIV and AIDS awareness. The project uses puppets to disseminate information on HIV and AIDS in an informal and often humorous way. The themes of the show revolve around how HIV and AIDS is contracted, can be prevented and how certain behavioural patterns can increase the chances of getting infected. Based in Windhoek, the team performs at schools, mines, prisons, companies and villages around the country. The show often triggers discussions about sex and HIV and AIDS, and during the performance there is interaction between the audience and the Puppet Power Team. Organizers say that the puppet show helps to break the barrier of illiteracy and language when delivering its message to the audience.

<http://www.comminit.com/africa/soul-beat-42.html>

to a health communication message. The words of songs can be used to convey ideas about health and be easily remembered. Music is very flexible and can be performed live and played on recordings in open air settings, communities and clinics. Many societies have traditions for songs and music so opportunities are created for community participation in singing and making music.



In Nicaragua, a song was used to close community theatre performances about essential drugs by AIS-Nicaragua. The theatre performances and song were part of a nationwide campaign to improve the quality of health care and the use of drugs.

Each part of the song illustrates a characteristic of essential drugs, the public (community health promoter or health personnel) received a leaflet including the text of the song and was invited to sing it together with the facilitators and to use the song together with

performance for further communication activities. An illustrated 440-page learning and action guide called *Buscando Remedio* (Seeking a remedy) was produced as further support for local health workers.

Storytelling

Storytelling is a part of many cultures. Stories including traditional characters who emphasize aspects of life and highlight morals and appropriate behaviour are common in many countries. Such stories have been used to make abstract

BOX 24. MADAM POKTA LEARNS HOW TO PREVENT MALARIA

A woman had a son who was always sick. She sold cans and bottles. Cans and bottles holding some water could be found all over her yard. Mosquitoes used the water as a breeding ground.



The woman was surprised that her son was always getting fevers. One day the boy had a terrible headache and a high fever with chills. Madam Pokta went and bought Cafenol (caffeine and aspirin) for the boy but it did not bring the fever down. So she took him to the native healer who took a knife, cut the boy's chest, and drew blood.

A few days later the boy died. Madam Pokta talked endlessly about how she had given the boy Cafenol...but it had not helped. She couldn't understand why the boy had contracted

malaria so often. She thought perhaps the boy was not meant to live.

Madam Pokta was bothered for a long time by what had happened. One day she heard about a health worker close to her village and she went to see him. She told him about the death of her son. The health worker went to see Madam Pokta's house. When he got there he saw mosquitoes everywhere because it was late afternoon. The health worker saw the cans and bottles lying on the ground with water in them. He also saw mosquito eggs in the water.

He explained to Madam Pokta that the tins and bottles were breeding places for mosquitoes. He said this was the reason she had so many mosquitoes in her house. He told her that mosquito bites had caused her son to get malaria and die. He said: when the mosquito bites, it puts a poison in the body that causes fever. He told her to bring the rest of her children to the clinic so they could receive a medicine. Afterwards, they all became healthier and happier.

Hilton D (1980). *Health teaching for West Africa – Stories, Drama and Song*, Illinois: MAP International.

concepts more real. Storytelling is a recognized approach to health communication.

A common method is to tell a story to a group and then invite the audience to comment on the story and give opinions on what the characters should do. The story may be told using only words, but it is often a good idea to show pictures on a flip chart. Box 24 describes a popular story from West Africa that has been used to communicate about malaria prevention.

Stories can also be told in an interactive way. The audience can propose an ending to the story or introduce different characters who might respond to the issue being discussed in a different way.



Magic shows and other light entertainment

In some countries there are traditions of magic shows in markets and public places which can attract a great deal of attention and interest. Box 25 illustrates how traditional medicine showmen can help improve knowledge about breastfeeding and infant nutrition. Traditional performers can be skilled in entertaining people through their words and humour.

BOX 25. MEDICINE SHOWMEN IN MEXICO

Mexican traditional medicine showmen (merolicos) use ventriloquism, telepathy, snake handling, medicinal recipes and clown acts to attract an audience and sell medicinal products. Initial research showed that many community members trusted the showmen and highly valued their ability to explain ideas clearly. Showmen were observed to talk to as many as 250 people and to sell to as many as 70 people in a period of about two and a half hours. A programme was developed to promote the idea of a 'magic meal' to wean babies with the right mix of foods. Five showmen were selected to work with the project. They were chosen on the basis of their observed expertise, their experience in the targeted regions, their past honesty, and their apparent interest in contributing to improved public health education.

After the medicine showmen had communicated the message for three months while working, there was a two-month waiting period before carrying out the field segment of the evaluation phase. Then 400 hundred women from test sites and 344 women from control sites were interviewed. The data reported focused on breastfeeding hygiene, the 'magic meal' and the first breast secretion, colostrum.

In this project, medicine showmen demonstrated their abilities to effect changes in knowledge. In total, 24% of the mothers retained knowledge about the 'magic meal's' composition. There was a 17% increase in mother's knowledge about breastfeeding.

The medicine showmen were found to be effective in both the rural and the urban areas.

A surprising result of the evaluation was that – contrary to what many thought – people with higher levels of education listened to the merolicos, as well as those from the low-income, low-education community.



Simoni J et al. (1982). *Medicine showmen and the communication of health information in Mexico*; Michigan State University, College of Education, Non-Formal Education Information Center.

Other popular entertainers who can be incorporated into health communication activities include clowns and comedians. In Guatemala, for example, a project is working with indigenous clowns who are travelling throughout the country putting on short performances that introduce issues around HIV and AIDS. This approach was adopted following research that demonstrated a need to raise awareness of HIV and AIDS and develop ways of informing communities in which there is little formal education or access to health services.



A key element of the clowns' performances tackles issues about stigma and discrimination against people living with HIV. The clowns are also involved in working with local community radio stations to develop and deliver radio spots and local radio soap operas to extend the reach of their impact through a widely dispersed rural audience.

In Cambodia, comedy is a strong traditional and popular source of entertainment. Local comedians are respected and play a key role in their communities. A project to increase community dialogue about HIV and AIDS worked with 20 local comedians to develop material based on villagers' life stories. Workshops with the comedians improved their improvisation skills and introduced ideas for role plays that

enabled the comedians and local villagers to explore key issues. Box 26 highlights some of the lessons that emerged from this project.

Recording performance and folk media

Live performances of folk media need to be repeated many times to reach large numbers of people. This can be expensive and time-consuming. You can increase folk media's reach through mass media. For example, you can make a video of a drama or puppet show which can then be shown to others or even broadcast on television. You can record music or a drama on audio cassettes which can be played in public places, clinics, in small groups or broadcast on the radio.

Although a recorded performance will reach many people, it will have less impact than a live performance. Another disadvantage is that there is no direct audience participation with mass media. This reduces opportunities to develop participa-

BOX 26. LESSONS FROM CAMBODIA

- **Audiences were not interested in performances that simply tried to deliver a message.** When the focus was on telling a story, the performance was less mechanical and more engaging. The health messages were seen as 'work', while the dramatization of a situation that threatened health was easier for the villagers to relate to and to understand.
- **Even the lowest-price condoms were too expensive for the villagers.** This finding emerged through the discussions that accompanied the performances. Villagers said that if they were going to use condoms they would have to be much cheaper. This underlines the point that changing behaviour is not a simple linear process that follows the introduction of new information, but depends on cultural, economic and political factors.
- **Gender, power and culture were acknowledged as being part of the HIV and AIDS issue for the first time.** The performances created a space for dialogue and reinforced the idea that it was time to talk more openly about the factors that caused the spread of HIV.

Source: www.healthcomms.org/comms/integ/ic-ld-tfd.htm

tory approaches. However, a skilled facilitator can help you use folk media on video or audio cassette to stimulate discussion and community participation.

You need to pretest carefully a recording of folk media developed for one audience before using it with a different one.

The example of the clowns in Guatemala mentioned earlier illustrates the way in which live performances can be recorded or incorporated into mass media programmes as a way of increasing the reach of a communication approach.



Programmes that empower

Performance and folk media have been used for community empowerment or social transformation by supporting people to have the confidence to change their situation and the skills to make informed choices concerning their health. The use of performance and folk media for empowerment draws heavily on the ideas of the Brazilian educator, Paulo Freire, and experiments with community theatre programmes in Botswana, Malawi and Sierra Leone and elsewhere. When using drama for empowerment, the performance's content should be carefully chosen to reflect the important issues in a community. This style of participatory performance practices is evolving in much of the recent work being done around theatre for development. It involves enabling local people, through dialogue and improvisation, to identify the issues that most concern them, finds ways to dramatize them and through that process to analyse what, for them, are the key messages. This can then be woven together with ideas and suggestions from health workers or other experts drawing on research.

For example, you might have a meeting or carry out a survey including interviews or focus group discussions within the community. You could also involve community members directly in preparing the drama. After the performance, the audience should be encouraged to discuss the content, relate it to their own situation and consider what they can do in their own community to improve the situation.



After taking action, the community members must be encouraged to evaluate what they have achieved and to take further action. The empowerment leads to social action, new community actions and relationships, and becomes a social transformation. Box 27 summarizes the stages involved in using drama for social transformation.

If you want to use folk media for empowerment and social transformation, you need to involve facilitators who are skilled in participatory work. You must build into any folk media programme that has empowerment as its objective, the training/recruitment of facilitators, opportunities for audience participation and follow-up. Box 28 draws this lesson from the experience of using folk media in India to increase awareness about HIV and AIDS. Moving beyond awareness to changes in attitudes and behaviour required additional communication inputs.

BOX 27. STAGES OF USING DRAMA FOR SOCIAL TRANSFORMATION

- **Research:** identification of local problems and causes by community members, using participatory methods
- **Performance:** portrayal of local situation, problems and causes
- **Critical awareness:** audience reflects on problems, causes and possible solutions
- **Action:** as a result of the reflection, community takes action on the problem
- **Reflection:** the results of taking action are evaluated by the community, lessons learned and further action planned.

BOX 28. INCREASING AWARENESS ABOUT HIV AND AIDS IN INDIA

An intervention in Karnataka, India, aimed to increase awareness, and change attitudes and behaviour related to HIV and AIDS through the use of traditional folk media in a rural community. The district had a high HIV prevalence rate.



To promote community participation, 30 community-based folk groups representing eight traditional folk forms were sensitized and trained on different aspects of HIV and AIDS. This was challenging, since many of them usually conduct only devotional performances.

The groups, including both men and women, then developed scripts incorporating messages on sexually transmitted

infections (STIs), condom use, the need to reduce stigma and discrimination against people living with HIV and AIDS, and the importance of sexual fidelity. The scripts were then set to folk tunes that were traditional vehicles for spiritual expression.

About 125 performances were held within a four-month period, with an average audience size of 500–800. There were high levels of participation by key stakeholders. Opinion leaders, village councils and temple priests who hosted the performances within temple premises, clearly indicated the readiness of a community to talk about a disease that had already claimed many lives around them. The performances were followed by interactive discussions facilitated by outreach workers on various aspects of HIV and AIDS.

Lessons learned included:

- folk media can facilitate increase in knowledge and awareness
- changing attitudes and social norms requires skilled facilitation and different approaches
- social and gender hierarchies determine audience participation and message decoding.

Sarma N (2004). Folk media for HIV/AIDS prevention. Presentation at the 4th International Entertainment Education Conference, Cape Town, South Africa. <http://www.comminit.com/strategicthinking/stee4/thinking-868.html>

Producing folk media programmes

The process

The production process involving folk media is similar to that for any communication intervention. **It needs to be based on research into the understanding the community you are working with has about the particular medicine use problem or health issue.** Community members should be involved in the development of the drama or the performance so that the content reflects their concerns and feelings and their perceptions of the problems, their causes and their solutions. Health workers or other experts should be consulted over the accuracy of the

content. It is essential to pretest the folk medium activity by performing before a sample audience, and making sure the content is entertaining and the health-related information is relevant and understood.

Content development

Achieving the right balance between health content and entertainment is crucial. You should allow sufficient time for proper development of the characters in a drama or the plot of a story. The audience should identify with the situation and the persons portrayed. A too-obvious health message can be boring and result in losing the audience's attention. However, a health message can also become too hidden by a story-line that is entertaining but complicated.

A critical issue in planning folk media is deciding on the script's author. Generally speaking, health workers possess technical knowledge about the health topics. Their expertise usually does not include an understanding of community perceptions about those issues or music, drama or art. When health workers develop folk media for health communication the result often includes too much health content, does not reflect communities' interests, and is boring.

Traditional musicians, actors, puppeteers and artists are generally creative, good communicators with an understanding of what communities find interesting and entertaining. They have skills in developing plots, music and stories that will hold an audience's interest.



However, if the development of the folk media is left completely to musicians there is a risk that the performance will be entertaining but the health messages may be distorted or lost.

You should use a team approach involving both health workers and traditional performers to make use of their complementary skills. Box 29 describes the way local media artists were involved in communication activities in Malawi.

Pretesting

You should pretest the drama to ensure that the content is appropriate, understandable and acceptable to the intended audience. This involves bringing together a group that is representative of the intended audience. After they have seen a rehearsal, the audience can be divided into groups of six to eight people and asked a series of questions about the performance:

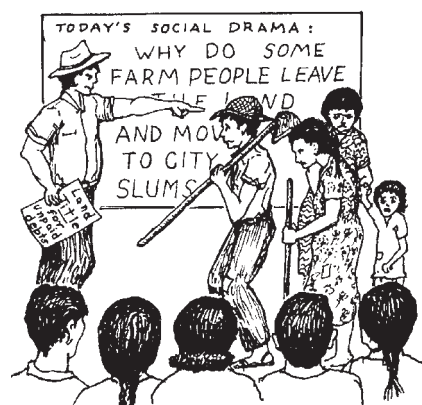
What did you learn from the drama? (And what else?)

What did you like best? Why?

Did the drama deal with issues that are important for you? In what way?

Can you use anything you saw in your daily life? If yes, what, and how can you use it?

Is it likely that you will use it? Why? Why not?



BOX 29. WORKING WITH LOCAL FOLK MEDIA ARTISTS IN MALAWI

Workshops can help tap into local artistic talents. In Malawi, artists were selected for a workshop, based upon their popularity and resemblance to the target audience. Working groups produced communication materials (songs, plays, stories).

Facilitators kept groups focused on the theme when artists started to move away from it. The tendency to try to put too much information in a song needed to be addressed and artists needed to be assured that additional information would be covered in other communication materials. The more traditional folk artists, who tended to use simple messages in their songs, understood this principle better than some other professionals, drama groups and pop artists.

Another concern was creating messages that appeared to accuse people, implying that they were the cause of the problem. At the end of the workshop more than double the anticipated number of songs were produced and performed publicly.

Songs were **pretested** for clarity and audience identification with the issue. After performances, a follow up activity was carried out and contracts were drawn up with the artists for their services, and schedules were set for recording the materials.

Lessons learned

A supportive atmosphere, including flexibility, may be even more important for successful work with creative artists than with other professionals. Facilitators should pay attention to the content of message as well as creativity. Positive messages are more empowering than scare stories.

Conclusion

This experience reflects only one event in an entertainment-education process. However, it demonstrates that local experience can be called upon and that basic communication principles can be followed, like keeping messages clear and simple. And just as with modern communication channels, **pretesting, research and evaluation** of traditional media are also necessary ingredients.

Cohen S (2002). Communication/behaviour change tools: Entertainment-Education Programme Briefs No. 1 New York, United Nations Population Fund. http://www.unfpa.org/upload/lib_pub_file/160_filename_bccprogbrief1.pdf

Did you get the information you needed about the topic? If not, what would you like to know more about?

Was there anything you did not like in the play? (What? Why?)

Do you have any suggestions about what could be changed? (What? Why?)

You should also include questions that check understanding of the specific health messages in the folk media.

What are the symptoms of malaria?

What are the danger signs of pneumonia in a child?

See Chapter 10 for more details about pretesting.

Selecting performers

Folk media programmes have used the following approaches to select performers:

- **Professional actors and singers:** Professionals can help ensure a high-quality performance. You will have to find funds for them. It is important to check that the health messages of their performance are appropriate and responsible.
- **Volunteers:** This could be a group of health workers that does the drama in their spare time. This is a cheaper option. The quality may not be as high as with professional performers. Because volunteers have other time demands they may not be able to carry out many performances.

- **Members of the intended audience:** youth group, women's group, school children. Involvement in the process of developing a drama can have a valuable impact on the performers' own lives. Such involvement also creates ownership of the process and the drama, and is likely to lead to more discussion of the issues dealt with and increase the likelihood that changes will happen. You need to have a facilitator to work with the community to develop the drama. For the drama to be useful in other communities, it may need to be adapted.

Choosing a location

- **Fixed venue:** in a community hall, an open meeting, outside a clinic/health centre, at a school or parent's evening, or in a temple or church. In these situations, the audience is fixed and present for most of the performance which can last for one or two hours. There is more opportunity for dialogue and participation by the audience.
- **Public place:** In streets, markets and other outside locations. The aim is to catch people who are passing by but who may not stay for long because of other commitments. Performances have to be short or include repetition so that those staying only a few minutes will still get a message. The opportunities for questions and participation by the audience are more limited.
- **Events:** Festivals and other public (or private) events can also be used for performances.



Evaluation

The evaluation of folk media involves a number of elements.

Identification of indicators:

- **Coverage** – how many people watched/heard the folk media?
- **Short-term impact** – done immediately after the performance. What were the increases in knowledge, were the messages understood and accepted, were they relevant to the audience's needs, were there any negative reactions?
- **Long-term impact** – after two or three months or longer – do people still remember the message, have they started to put the message into practice, was there a change in behaviour, do health facilities' records indicate changes in use by the community, sales of medicines by pharmacists, amount of dumped, unwanted, expired medicines? Has there been discussion of the issues in the community or among neighbours or family members?

One common evaluation method involves interviewing audience members before and after performances. Another approach is holding focus group discussions with audience members after performances. This is useful to obtain in-depth feedback on reactions.

Further information about the design and monitoring and evaluation of communication interventions is included in Chapter 11.

Additional reading

Cohen S (2002). Communication/behaviour change tools. *Entertainment-Education Programme Briefs*, No. 1. New York, United Nations Population Fund. Available at: http://www.unfpa.org/upload/lib_pub_file/160_filename_bccprogbrief1.pdf

Hubley J (2004). *Communicating health: an action guide to health education and health promotion*. 2nd ed. Oxford, Macmillan.

Kakan CA et al. (1988). *The use of folk media for community motivation – A process and experience in the promotion of family planning and health*. Nairobi, Family Planning Private Sector programme/National Council for Population and Development, p. 46.

*McIntyre P (1998). *Puppets with a purpose – using puppetry for social change*. New York: United Nations Children's Fund.

Edutainment for development and sexual health. *Sexual Health Exchange* 2002, No 1.

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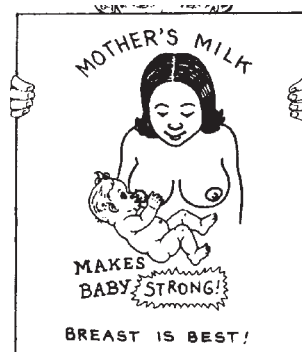
Developing effective print materials

Print materials can be used to support various communication interventions. This chapter looks specifically at how to develop relevant materials as part of efforts to create awareness and support behaviour change at community level. Other chapters, such as working with journalists and advocacy, will address some other uses of print materials. By themselves, print materials do not change behaviour. However, they are valuable tools to increase awareness and interest in a topic. When materials are used together with other methods, such as face-to-face communication, they can influence attitudes and behaviour. As part of an integrated communication strategy, they make a valuable contribution to changes in policy and practice.

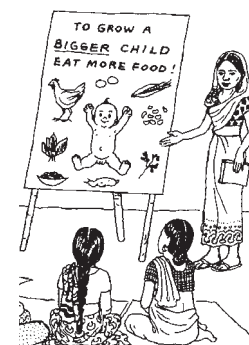
Whatever materials you produce, the key steps are the same. Experience and research from around the world have been used to put together this chapter. Box 30, for example, identifies some basic lessons from more than 25 years of experience of reproductive health communication work. The additional reading section includes several publications and websites that provide further evidence and lessons.

This chapter aims to help you to understand and work with the key principles of designing effective printed communication materials. It will help you to:

1. identify the key principles of effective printed communication materials
2. understand the role that print materials can play in an integrated communication strategy to improve rational drug use
3. understand why and how to pretest print material and how those principles apply to pretesting any communication product.



By themselves, print materials do not change practice, but...



Together with e.g. Face-to-face communication, they can influence practice

Introduction

Before you start developing any type of communication material you should be able to answer six basic questions:

1. **WHY?** What is the **purpose** of the material? What is the need for it? What are you hoping to achieve?
2. **WHO?** Who is the **audience**? What do you know about the audience? What do they know about the topic?
3. **WHAT?** What is the **content** or the main idea that you want to communicate?
4. **WHERE?** What is the **setting** where the material will be used? What other materials or activities can support what you are trying to communicate? Is there anything that will work against your efforts to communicate ideas on rational drug use?
5. **WHEN?** What is the **timing** for your communication? Does it come before the reader is about to start a new activity? Will it be during an event? Is it a reminder to be left with someone? Is it to introduce a topic, or to reinforce existing information, knowledge or learning? Are you trying to prevent something from happening, or trying to change an existing practice, policy or behaviour?
6. **HOW?** What **medium** is best to use? Print, face-to-face, audio-visual, theatre, radio or other mass media, electronic are some of the options. (Combining different media has been shown to be the most effective way of communicating.)



BOX 30. LESSONS ABOUT PRINT MATERIAL FROM REPRODUCTIVE HEALTH COMMUNICATION



Simple, inexpensive print materials can be useful and more cost-effective than more expensive and elaborate products. For example, reminder cards are helpful for use by health workers.

Also, graphic materials for home use can be important, especially in empowering women to negotiate their reproductive health needs. Materials like fotonovelas (similar to comic books but using photographs) have been used to assist women in Latin America, for example, to negotiate with their sexual partners.

It is important to move beyond the “I need a poster” syndrome in developing print materials. **Choosing the right print product** can be difficult and requires rigorous exploration and selection. Be sure to tailor materials to the appropriate literacy level, even when developing materials that only contain visuals.

Clift E (2001). *Information, education and communication: lessons from the past; perspectives for the future*. Geneva, World Health Organization. http://www.who.int/reproductive-health/publications/RHR_01_22/information_education_communication_lessons_from_past.pdf

Printed materials come in all shapes and sizes. They can include:

- posters for display in health centres or public places
- manuals and guides for health worker and community training programmes
- leaflets, brochures or fact sheets for prescribers, patients and community members
- newsletters and bulletins for a variety of audiences
- wallcharts, flipcharts and other communication aids
- T-shirts, folders, banners, signs and other promotional tools
- reports and articles.

Print materials have some distinct advantages, but they also have some disadvantages, as Table 7 shows.

Table 7. Advantages and disadvantages of print material

ADVANTAGES	DISADVANTAGES
• Wide range of formats • Ability to print on different materials • Very adaptable – can be used on its own to inform (newspaper, newsletter), as support for other activities (training manual, campaign material), as a long-term material (book), as a short-term material (leaflet, handout), can be used for individuals (patient information), or for groups (posters or flip charts) • Can be produced to any level of quality and sophistication (from black and white photocopied to full-colour with photos) • Can be produced without electricity (screen printing) • Does not require special equipment to use • Can be used again and again by the same user or by different users • Provides tangible examples that people can discuss and relate to	• Is susceptible to wear and tear when used • Can be difficult to store (takes up space) • Long-term storage may be difficult due to damage caused by damp, heat, dust • Can be costly (depending on the type of production and the numbers) • Distribution may be difficult (and needs to be carefully planned in advance) • Requires a level of literacy or the use of mainly illustrative material for those with low literacy • May come across as impersonal and cold • Difficult to interact with

An often cited disadvantage of print material is that it is difficult to use with non-literate audiences. Research carried out in Ghana, Myanmar, Nepal, Nigeria, Somalia, Uganda and Viet Nam has found that when combined with good face-to-face communication, print material can be effectively used with non-literate audiences. Furthermore, when materials are developed and pretested for use with audiences that have low levels of literacy, comprehension can be very high (ill).

Box 31 discusses a small-scale, successful project in Cameroon which demonstrates the value of visual aids and wider-scale communication about how antibiotics work in the body, using an agricultural analogy, to improve adherence to treatment by patients.



Basic principles

Effective printed communication material is easy to read, easy to understand, and encourages the reader to take some action and use the information it conveys. Basic principles apply to developing any effective print materials. These principles relate to six main areas:

BOX 31. INVOLVING CLINICS TO IMPROVE ADHERENCE TO TREATMENT IN CAMEROON

Culturally-sensitive visual aids were designed and pretested to convey instructions for use of prescription antibiotics for non-literate women in Cameroon. An “advanced organizer” – a tool used to introduce key information and explain the main points – was also developed. It used the example of farming to explain antibiotic use – a body as a crop field, disease as weeds, and antibiotics as a farmer.

Women attending three health centres were divided into three groups. One group was given the visual aids, a second group received the visual aids and some explanation and the third group was only given standard treatment without the visual aids. Follow-up tested compliance with short-term prescriptions of antibiotics (ampicillin, sulfamethoxazole, trimethoprim, metronidazole and tetracycline).

The two groups receiving education (one with only visual aids, one with visual aids and the advanced organizer) had greater understanding and were more likely to comply with the antibiotic treatment. Use of the advanced organizer improved scores significantly. The study concluded that, to be effective, visual aids must be specific to the audience and must be used properly to achieve the desired result.

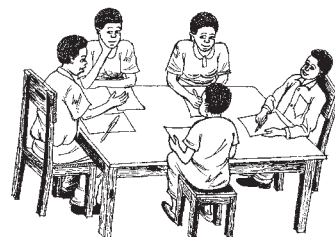
Ngoh LN, Shepherd, MD (1997). Design, development and evaluation of visual aids for communicating prescription drug instructions to non-literate patients in rural Cameroon. *Patient Education and Counselling* 30:257–270.

- planning
- identifying and researching the audience
- developing the draft material (research, writing, editing, design)
- pretesting and revision
- production and distribution
- post-production evaluation.

Planning

The six basic questions mentioned in the introduction to this Chapter are part of the planning process for any printed materials. Planning also needs to provide answers to a number of key questions in these main areas:

- review existing materials and resources: are there any that could be used or adapted to meet the identified need for a print material? (Box 32 provides a checklist of questions you might use to assess existing materials.)
- review the principles of understanding visuals and principles for developing effective print materials
- develop a communication objective: what will the material be used for? How will it be used? Who will be using it? What skills do they have for using the materials? Do they need any training? What do you expect users to do as a result of working with the material?
- create a workplan: what are the stages for developing a material? Who needs to be involved? When does it need to be completed?
- develop a budget: how much will it cost to research, write, edit, design, pretest, revise, print, distribute and evaluate the material?



BOX 32. ASSESSING PRINT MATERIALS

1. Is it clear who the material is for? (intended audience)
2. Is it clear what problem it is trying to solve or address?
3. Is the information clearly presented?
4. Is it easy to understand?
5. Is it relevant to the target audience?
6. Is the quality good?
7. Is it visually interesting? (design, layout)
8. Can you identify the key message or main point easily?
9. Do you trust the information (is it from a credible source?)
10. Is this relevant for use in your situation?
11. Could you adapt it for use in your situation?
12. What would help to improve this material?

Identifying and researching the intended audience

Who is your intended audience? Is there a primary audience and a secondary audience with whom you want to communicate? What do you know about the audiences (age, gender, education and literacy levels) and about their knowledge and understanding about the particular rational medicine use problem being discussed in the print material? These are some of the basic questions that you need to be able to answer. You also need to deal with three further important questions:

1. How can you involve and engage with the audience?
2. What are the causes of the problem, as identified by the audience, and do they see a need for something to change?
3. What decisions or actions will lead to change?



Involving the users from the early stages can give you valuable information and make the materials relevant

1. Involve the user

Effective printed material is relevant to the user. The best way to ensure relevance is to involve the user in developing the material. It is essential to know what materials prescribers, patients or community members would like to have, and what information they most need. Start with their perception of the severity of the problem, its causes and possible solutions. Based on this, open up a dialogue to build a bridge between the local perceptions and the 'expert' knowledge that will start to formulate some action.

Use local experts to help identify key information needs. They could be colleagues in your own organization who have expertise in the topic or they could be clinical pharmacologists at a leading medical school, with knowledge about prescribing problems.

Check with the users of the material and discuss the areas you plan to cover. This might mean asking prescribers what information they need or discussing with patients or community members what questions they have. Informal discussions in a clinic can generate useful ideas. If you are working regularly with a particular

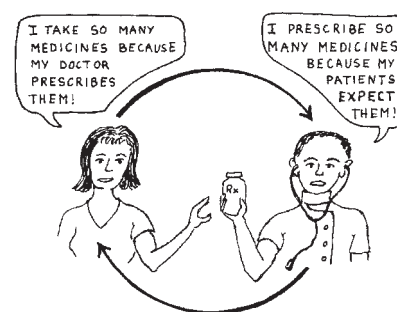


group of people – women, young people, patients with a particular illness, staff at a health centre – with whom you can meet easily, try a brainstorming session with them to identify key concerns and ideas. The more collaboration there is in developing the material, the greater the commitment to distributing and using it widely, and the greater the potential impact on people's health.

2. Understand the causes

Effective communication materials cannot be developed without knowing why incorrect drug use occurs in the first place. (The companion manual to this one, *How to investigate the use of medicines by consumers*, provides a clear explanation of the methodologies to use (WHO, 2004). For example:

- Are there local beliefs that injections are more powerful than pills, capsules or liquid antibiotics? Do health workers ignore the risks of possible infections caused by injections? Or are they unaware of the possible risks?
- Do health workers give expensive stronger pain killers for mild pain to satisfy demands from patients for powerful pain killers? Or are they unaware that aspirin is just as effective? Or is there a policy that a particular drug should be used? Or is that the common practice because a senior colleague always does it that way? Or has pharmaceutical company promotion had a strong impact on prescribing choices?



THE VICIOUS CIRCLE THAT LEADS TO THE OVERUSE OF MEDICINE

From your initial investigations, such as interviews or group discussions, you can identify some of the main reasons for a particular behaviour. Then these reasons can be targeted in the communication materials. For example:

- If patients and prescribers are unaware of the risks of serious infections caused by injections, materials should highlight the risks and explain what effective alternatives exist.
- If prescribers are giving expensive pain killers due to patients' demands, emphasizing the power of a 'wonder drug' such as aspirin could work.

3. Target decisions and actions

Emphasize what people can do (or not do) about the problem. Invite people to suggest what solutions to the problem would be practical, acceptable and affordable to them. Find out with the audience what they can do. For example:

- Which infections can be treated safely with home remedies and which require more drug therapy. What is the best drug to use? When should someone be referred to a health centre?
- What is the preferred treatment for children under 12 with mild pain? (The answer is: paracetamol instead of aspirin or more expensive painkillers).

Learning is easier and more relevant when information focuses on the correct treatments or actions for specific problems, and this action is practical, acceptable and affordable. Explaining the benefits people will receive from adopting a particular behaviour also attracts interest.

Whenever possible, use a positive approach. Negative messages ('Do not use injections. Do not give young children aspirin.') tend to discourage people rather than motivate them to take action. A positive approach would be 'Tablets or capsules cure the disease and are safer than injections', and 'Give children paracetamol, not aspirin. Aspirin can cause problems for children's stomachs'.



In the past, health educators have tried to improve health practices of consumers by using strong scare tactics, such as showing sections of cancerous lungs to smokers, or demonstrating the consequences of diarrhoea by using pictures of malnutrition and death. These practices are controversial and research suggests that mild rather than strong fear appeals are most effective because people tend to deny the possibility of rare, but terrible outcomes (such as sudden death and disability). A more positive approach would be to show how an ex-smoker is now healthier, or how a child with diarrhoea gradually recovers by being given ORS. Similarly, prescribers may not react favourably to strong fear appeals that overstate the possibility of serious adverse effects due to incorrect prescribing. Nevertheless, a realistic appraisal of these risks (antibiotic resistance) may sometimes be useful.

Developing the material

Researching the content

What sort of content do you need for the material? Different sources of information provide different kinds of information. For example, you are more likely to find life stories or human interest stories from community members (ill.) or newspapers than from textbooks or in journals. You are likely to find disease-specific or drug-specific information from recent journals.

The type of content you may need can include:

- factual information
- case studies or examples to illustrate points
- life stories, success stories and other human interest stories that show how people have solved a problem, or how they model new behaviour
- information on local beliefs and practices
- photographs
- drawings or other illustrations
- graphs or statistical tables.



Writing and editing

Whether you are writing or editing text, there are some general principles and some good practices to follow. These include the need to:

- use brief, simple, clear, active language
- focus on a few key messages

- repeat or reinforce key messages
- avoid jargon.

Brief and simple language is the easiest to read and to understand. Use understandable and clear language instead of complex words and ideas that are difficult to understand. Use short sentences. This principle is often ignored in print material.

An example of a common way of writing:

Aspirin is indicated as an effective, mild analgesic in patients able to tolerate potential gastrointestinal disturbances.

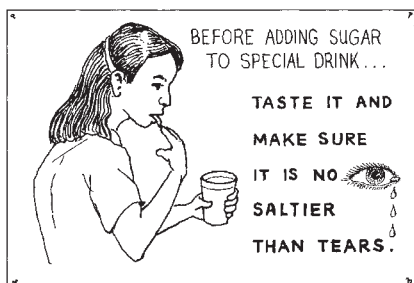
A clearer way to express the idea is:

Choose aspirin to treat mild pain in patients without stomach problems.

Also, make sure that the language is appropriate for the reader or user of the material. Language in print materials aimed at prescribers is not necessarily suitable

for materials for patients or community members. Audiences also vary depending on specific interests or cultural backgrounds.

Engage your audience through the language and text. Keep your language active rather than passive. Action builds interest. Passive language puts readers to sleep. Most forms of the verb 'to be' (is, be, was, were) produce drab sentences. Replacing them with stronger verbs almost always forces you to start a sentence with a subject.



An example of passive language:

There were a large number of outdated medicines on the shelves in the health centre storeroom.

Active language is clearer and more convincing:

Outdated medicines filled the shelves of the health centre storeroom.

Other techniques for engaging your audience include asking questions, giving examples of problems and encouraging them to think about and discuss issues.

Communication materials should focus on a small number of **main messages** to communicate for each targeted behaviour, depending on the format. For 'awareness-posters', one or two messages are enough (Immunize your child NOW! Come to the x clinic on ... date); for leaflets, three to five and for flipcharts between three and eight messages.

For example, printed material produced in Kenya includes two major messages to pharmacists: for diarrhoea, promote oral rehydration solution and refer complicated cases.

Prescribers and patients throughout the world need easily accessible and objective information about appropriate medicine use. Complex and lengthy materials are expensive to produce and difficult to digest. If at all possible, messages should include:

- The behaviour you wish to promote (such as the use of oral rehydration therapy).

TOO MUCH SALT
IN REHYDRATION
DRINK USUALLY
MAKES CHILDREN
VOMIT.

TOO MUCH SALT
IS DANGEROUS!



- The behaviour you wish to modify (such as overuse of antibiotics).
- Key information or knowledge gaps (for example, that injections can cause serious infections; or that antibiotics are not effective in treating viral illness). These messages are the major 'selling points' that support the actions you wish readers to take.
- Other behavioural/motivational forces (such as ways to convince patients that unnecessary injections are dangerous).

Repetition increases memory and learning. Repetition of the most important messages is a foundation of advertising and communication. If at all possible, include the main message in both the major headline at the front of an educational material and in the concluding section.

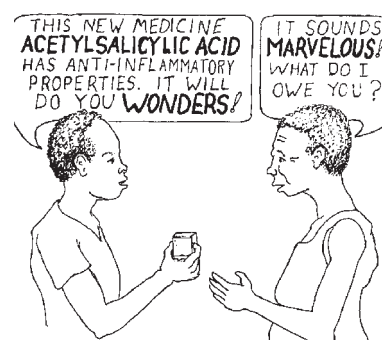
Technical terms are often used in writing about health. These terms may have a specific meaning for specialists, but to those who are not specialists, they become barriers to understanding. They are seen as **jargon**.

For example, the statement 'Apply digital pressure' might be appropriate for medical doctors, but the statement: 'Press with your finger' will be better understood. If you have to use a large number of technical terms:

- define them in simple language the first time you use them;
- give your reader a chance to learn the words by using them again, consistently, in the text;
- include a glossary of abbreviations and technical terms.

Another popular form of jargon is the use of acronyms – initials rather than the full name. This practice can make a simple sentence completely incomprehensible to most people.

The solution to avoiding jargon is to write simply. Write to express, not to impress.



Editing

When the writing is done, it is time to check the content. First, it needs to be checked (by you, or an editor) for consistency and to eliminate any spelling or grammatical errors that inevitably creep into all writing. Making use of a simple 'house style' can help. A house style is simply a list of consistent rules that everyone in an organization should follow when they are writing or editing. Some things it can include are:

- how certain words are spelled – organisation or organization, for example
- how numbers are displayed – 2 or two
- how hyphens are used – one-way or one way
- when italic or bold is used
- how references are displayed
- how logos are used.



Using a logo can increase the credibility of your material.

Layout and design

Layout is the use of spaces, different typefaces, headings and other techniques to make the words on a page have more meaning and interest. Layout is an essential part in the design of any educational material.

Good layout will:

- capture attention
- encourage the user to read the material
- guide the user through the material
- emphasize important information
- make information easy to find.

Ask yourself: if you can only get one message across, what would it be? Then turn that message into the title or the main headline of the material. Advertising industry research shows that four out of five readers do not read past the main headline. If your message is not there, you may have missed a chance to capture people's attention and encourage them to read the rest of the text.



This is negative and cluttered...

A cross is often not understood as danger ...

The positive, simple approach often works best

Different type sizes make educational materials more visually interesting to read. However, it is good practice to only use about four or five different sizes in a material. Typefaces also have their own character: some appear more authoritative, some modern, some traditional. As with sizes, it is good practice to use a limited number of typefaces in any material. Two or three typefaces should be sufficient for most uses.

Solid blocks of text are not easy to read. You can use several ways of displaying information that help to break up text and make it easier for people to find key information. These include:

- bulleted lists (like this one)
- numbered lists or numbered sections
- boxes to draw attention to something or to give more detail
- illustrations.

Boxes can also interrupt the flow of reading. Use them sparingly.

Using illustrations

Illustrations are an excellent way to communicate behavioural messages or other information. (In settings where literacy levels are low, pictures may be the only possible way to communicate a printed message.) Visually stimulating, humorous,

or otherwise striking pictures can often capture attention and awaken the readers' interest. Illustrations are also an effective way to visually reinforce written messages. If at all possible, show the behaviour you wish others to adopt.

Illustrations and graphs do not need to be very expensive. Effective educational materials can be developed with simple line drawings or sketches. A golden rule is: keep illustrations simple. Box 33 describes different types of illustrations and their advantages and disadvantages.

Whatever type of illustration you use, there are some basic principles that will help improve their effectiveness. For example:

- Simplify the illustrations and avoid extra details.
- Use an illustration to present a single message.
- Link the illustration to the text and keep the illustration close to the point in the text to which it refers.
- Use expressions, clothing, objects and settings in the illustration that people would normally see in their day-to-day life and with which they can identify.
- Use humour with care. Not everyone responds to humour in the same way.
- Clearly explain any symbols that you use. (Crosses, arrows, check marks, inserts and balloons that represent conversations and thoughts may be misunderstood).
- Make your illustration large enough for people to see it easily, but be careful that you do not change the scale of an object. (A very large picture of a mosquito on its own can prompt a comment that 'we don't have any that size around here'!).
- Avoid unusual angles and drawings with too much perspective.



Use colour wisely and naturally

Use of another colour can be an effective way of drawing attention to important messages, can improve attractiveness of the material, and can aid understanding. As with most things in layout and design, a little goes a long way.

Overdoing the use of colour – by using several colours, or by using it indiscriminately – turns it into an obstacle to understanding and use. Use colour naturally. For example, a black and white drawing of a TB patient who spits red blood can have a dramatic and useful effect. Using red to colour parasites in otherwise black and white drawings will also draw attention to these parts of the picture.

Remember that colours can have different meanings in different cultures. For example, in parts of Africa, power is signified by the colour red. When antibiotics were first introduced, pharmaceutical companies who produced them in red capsules had better sales.

The major disadvantage of using colour is the extra printing cost but these days colour printing has become cheaper, and in many places is not much more expensive than black and white. Choose colours that are easy to read and that reproduce easily if they are photocopied.

BOX 33. TYPES OF ILLUSTRATIONS

- Shaded line drawings – easy to reproduce; most likely to be understood. They have a similar level of reality as a photograph, but less cluttered. Only the main detail needed to communicate the message is included; however, it probably needs a skilled artist to prepare such a drawing, or you can use a photograph, trace it and then fill in the details.



- Simple line drawings – also easy to reproduce and well understood.



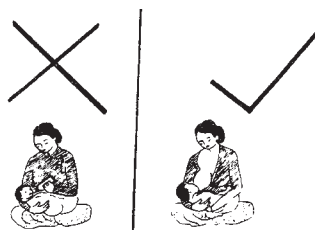
- Photographs – show real situations; often difficult to find appropriate photos to accurately illustrate the point and can be difficult for readers to understand the meaning; they may also reproduce badly unless very high quality printing and paper are used. Cut-out photographs, where the background is taken out, are easier to understand. You need to get permission from the person photographed to use their picture.



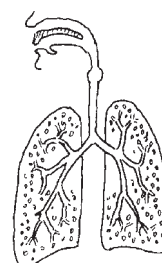
- Symbolic or stylised drawings – similar to a line drawing, but less realistic. Traffic and other transportation signs are a good example. However, they require skill to prepare, and are not always easily understood because they are not life-like.



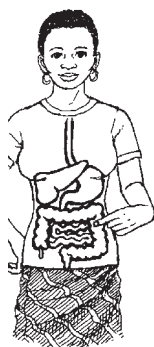
- Abstract symbols, like ticks and crosses to indicate right and wrong, are usually not understood by audiences with low literacy. Any symbol needs careful testing.



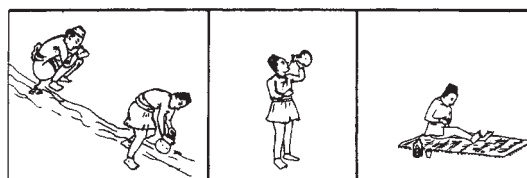
- Cross-section drawings – used extensively in medical textbooks to demonstrate internal views of the body. These require skill to portray the information accurately, and some skill in being able to read and understand what they show.



- 'X-ray' drawings – such as the body of a child with worms showing in the stomach – are usually well understood, especially by children and people with low literacy skills. This can be a useful way of showing how diseases act in the body and is a good alternative to the more abstract parasite life cycle diagrams.



- Pictures in a series are not always understood in the way intended – many people start reading pictures in the middle, or from an image that interests them.



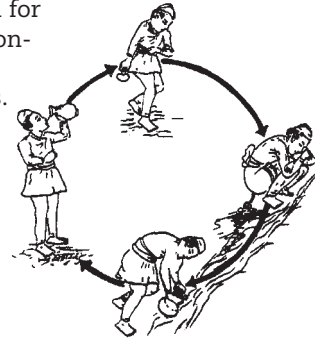
Continued

Box 33 continued

- Expressions on people's faces often are not picked up. Body language, such as a hand to show 'stop!', is more effective.



- Flow charts – useful for illustrating a decision-making process or a set of instructions. Simple flow charts are usually easy to follow; more complex charts may provide more information than a reader can take in quickly.



- Bar charts and pie charts – effective way to show numerical data with more impact than tables; can also be used to reinforce text.

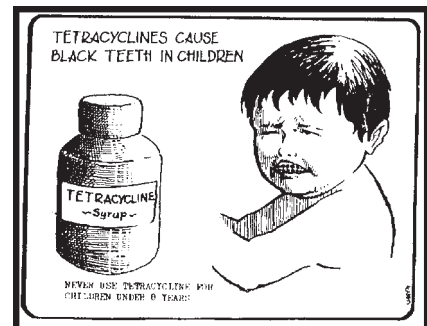
Layout

The text is written. The illustrations are chosen. The typefaces have been selected. Now it is time to put it all together on the page. One of the most important ingredients to the layout of communication material is space. The amount of space around a page, between blocks of text or around an illustration helps to make it easier for the user to read the material.

Space improves the structure of a piece of text. It breaks up the information so that the user's eyes can rest between sections. Space provides a pause, like a pause for breath, or a pause to reflect on the information.

Let the information in the material guide your decisions about layout.

- What are the most important points? Put them in a headline, in the subheads, or summarize them in a key topics box.
- Are there obvious sections where a break could occur? Space or a subheading might help.
- Are there essential points that the user needs to remember? These may need to be highlighted in some way (bullets, bold text, a short summary, illustrated, put in a box).
- Are illustrations used to reinforce messages? Make sure they are close to the point in the text and are captioned so that they refer to the text.



Pretesting

Above all, test the text and illustrations with end users, and revise and re-test until it is well understood by a majority (more than 70%) of the users. People interpret illustrations in different ways. You always need to test that the meaning you hope to convey is the one that the reader “sees”.

Pretesting is an essential step in the development of any communication inter-



vention. Pretesting serves two main purposes. It tests draft materials for recognition, acceptability, familiarity and relevance among the intended audience. It also opens a dialogue with the individuals and groups for which the material is being developed, and often gives the pretester new knowledge.

Experience shows that pretesting actually saves time and money. Projects that skip this step often end up with communication material that does not appeal to the intended audience or does not match its views on the problem. That results in wasted resources and

time, and can have negative health impacts. Pretesting assesses:

- **Recognition:** Have the materials been understood? (Are the contents perceived in the way that was intended?)
- **Familiarity and relevance:** Is the problem and situation known to and relevant for the audience? (Do they recognize the personalities and situations and identify with them?)
- **Acceptability:** Are the materials acceptable to the audience? (Is there anything offensive in them? What helps make the material more acceptable from a social, cultural and economic perspective?)

Figure 4 shows an example of an illustration that has been widely used in Kilifi, Kenya as a symbol of child fever and the issues that need to be assessed in any pretesting. The usefulness of this illustration relies on the extensive pretesting that was carried out.

Pretesting should take place early in the process of developing materials when they are in draft form. There are two main reasons for this:

- **The materials are not yet finalized.** The people with whom you test them will immediately see that. This will help motivate them to comment freely. They will more easily believe that you really want their comments, rather than just a rubber stamp on a job 'well done' if the materials are already printed.
- **You are not 'wedded' to the ideas yet.** The more time and energy you have invested in formulating and refining the idea, the less likely you may be to look at it critically (and have others look at it critically).

Figure 4. Issues to assess in pretesting

To pretest this picture you would want to assess:

- **Recognition of the object or activity:** Does the audience see a mother with a child on her lap? Do they see a child ill with fever, and a mother wiping sweat off the forehead with a (wet) cloth?
- **Familiarity** with the object or activity. Do members of the audience feel that fever in children is a problem in the community? Is using a wet cloth to help reduce the fever a common practice?
- **Acceptability** to determine if any aspect of the illustration is offensive to them. Are the clothes the mother is wearing, acceptable? The headdress? The way she is sitting? The child's clothes?

You should also find out if any changes would help make this picture better understood and/or more agreeable to the members of the intended audience.



Pretesting takes time and commitment. However, investing this effort will result in better educational materials and benefit the overall communication effort.

Details on how to carry out pretesting are included in Chapter 10, together with sample forms that can be used.

Production and dissemination

Production and printing processes need careful management. There are usually many different people and organizations involved at different stages of production. Also, materials often have to be produced within a defined period of time. With print material, most organizations will get this done externally and someone needs to liaise with the printer. It is important to remember that the way the whole production process is managed will have a significant impact on the quality of the materials, which affects how successful it will be in communicating the necessary information. For example, a leaflet with spelling mistakes and a typeface that is hard to read will not be taken seriously. Worse still, incorrect information can be dangerous – for example, about drug dosages. Some key questions to consider in producing materials are contained in Box 34.

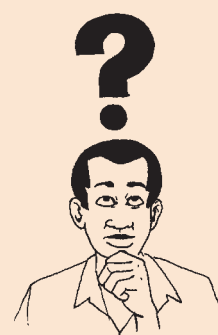
It is important to make sure that the material reaches its intended audience. You should have given some thought to dissemination at the planning stage, and timing is important. If dissemination takes too long the material might become out of date and lose its value. Without good planning, you might lose good opportunities to promote the material and the issues it raises. Box 35 sets out some key questions that will help you in planning the distribution of print materials.

Think carefully about how to ensure that the material will reach the intended audience and be used. Professional and cultural issues can act as barriers to people gaining access to particular information, for example around sensitive topics like drugs and sexual health. It is important, therefore, to identify ‘gatekeepers’, or

BOX 34. KEY QUESTIONS ABOUT PRODUCING PRINT MATERIALS

1. Who is responsible for managing the whole production process?
2. Who is responsible for each of the individual tasks, such as design, pretesting, proof reading, translation if necessary, liaison with printers, and so on?
3. Do you need to obtain permission or approval from anyone before producing materials, for example, permission to reproduce illustrations, logos or particular content?
4. Have you prepared appropriate briefs for any work being done externally? Who is best placed to develop any briefs needed, and to follow up on them to ensure instructions are understood, and followed?
5. Can you produce the materials yourself, or do you need to contract a design and/or print company to do the work?
6. How will you select a printer? Have you obtained quotations and samples of work from more than one printer?
7. What budget is available for printing?
8. What size and quality of paper/material will be used?

Source: Adapted from Healthlink Worldwide (2003) *Quest manual: Guide to effective health communications*. London, Healthlink Worldwide.



appropriate intermediaries – for example, voluntary agencies, community leaders and health professionals.

Take time to identify and nurture professional relationships with appropriate intermediary individuals and organizations. Dissemination will be more effective if such people know about the material in advance and are committed to its message. Materials distributed into a vacuum are less likely to be effective.

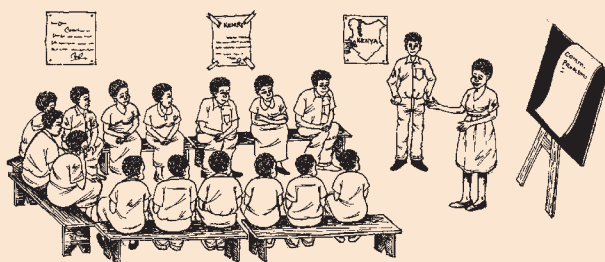


It is often necessary to provide a briefing session, training and/or support to potential intermediaries, who otherwise might act as barriers to effective access to and use of the resource. Among those intermediaries may be journalists (see Chapter 6 for more information on how to work with journalists). It

may also be necessary to orient or train users of the materials to facilitate optimal use. For example, training health workers to use new instruction or information

BOX 35. KEY QUESTIONS ABOUT DISSEMINATING PRINT MATERIALS

1. Do you have a dissemination plan and budget?
2. Who will manage the dissemination of the material?
3. How will you publicize the material?
4. How can you ensure that the material and messages reach the intended audience at an appropriate place and time?
5. How and when will the material be distributed?
6. Can you make use of existing dissemination routes and channels?
7. Do you need to develop a mailing list? How will you do this?
8. Can you combine a print and electronic version and use e-mail as a way of distributing an electronic version of a print material?
9. Can you link the launch/material dissemination with broader local, national or international events or campaigns?
10. Which 'gatekeepers' to the intended audience should you collaborate with? Have you made personal contact with intermediaries and any collaborating individuals and organizations?
11. Do those distributing the material need training, support or follow-up to ensure they do it effectively? Do recipients of the resource need training or support to understand and use it effectively? Would any follow-up be useful?
12. What different factors might affect the dissemination of the material (for example, institutional routines, professional biases/opinions and personal contacts)? How could you deal with any potentially negative factors?
13. Have you considered and catered for potential consequences of the material, for example an increase in demand for particular health services or for access to particular medicines?
14. How could you use the media and other potential opportunities to promote the material?



Source: Adapted from Healthlink Worldwide (2003). *Quest manual: Guide to effective health communications*. London, Healthlink Worldwide.

materials with patients may encourage them to use the materials and to interact more effectively with the patients.

Careful timing of dissemination can help to maximize the impact of the material. For example, there may be opportunities to link the launch with related local, national or international promotional activities and campaigns like World AIDS Day, Africa Malaria Day or World Health Day. Any information needs to be reinforced and repeated over time. The process of distributing print materials usually happens over a period of time and needs monitoring.

Post-production evaluation

Post-production evaluation is the evaluation that takes place after a print material has been produced and disseminated.

When you are evaluating a material after it has been produced and disseminated, you are trying to find out about its *value*. How successful has it been in achieving what you hoped to achieve? What factors have influenced this? What has gone well and what has not gone well? Why? What can you learn from the experience?

For most evaluation of print materials, therefore, the type of evaluation that is most likely to be carried out is **product** evaluation. This looks at issues of language, appropriateness, technical accuracy and design. Is the language clear and appropriate to the target audience? Is the technical content correct and up-to-date? Is the design effective? Are illustrations appropriate?

Process evaluation looks at how the material was developed, reflecting on the process and analysing what could be improved in the future and what lessons can be learned. Process evaluation should involve the wide range of people who have played a role in developing, pretesting, producing and disseminating the material. Process evaluation involves checking whether things went broadly according to plan and the factors that influenced this. How did the processes followed work? What worked well among the decision-making procedures, collaboration with other organizations, team work, use of external reviewers to check outlines and drafts? What did not work well? Why? What might have worked better? What factors influenced work processes?

Impact evaluation or impact assessment is very difficult to undertake for individual print materials (or for any other type of individual communication activity). Because attitude, behaviour and social change only occur over time, some time needs to have elapsed before you can effectively assess the impact of any material or activity. It is also difficult to demonstrate how your particular material or activity (rather than other factors) has contributed to change, as people usually change based on influences from a number of different sources. However, donors are increasingly calling for impact assessments. One way of assessing impact is to consider short-, medium- and long-term changes or impacts.

The first level of change (short-term) often refers to the use of a product. Who has used it? What level of satisfaction do they express about it? What use are they making of the product? Are they recommending it to others?



BOX 36. FROM PROBLEM DRUGS TO PROBLEM-SOLVING

In 1986, Health Action International (HAI) produced a comprehensive pack of information looking at a number of categories of medicines that were not being used wisely. The pack – Problem Drugs – was revised and updated twice, was translated into French, Spanish and Russian, and was reproduced in local editions in several countries. It was used as a reference document for campaigns in many parts of the world, so its immediate short-term impact could be easily assessed. As changes occurred in countries to the information available about some of these problem drugs, and there were changes in the regulatory controls on them, the medium-term impact of the material and the action that it stimulated could be assessed.

A few years after the first pack was produced, a medical student attending a HAI workshop, told the participants that the pack had literally changed his life. It led him to look more seriously at some of the issues in pharmacology, stimulated his interest in essential drugs and rational drug use, and helped him to decide what area of medicine would be his focus. Subsequently, after graduating, he went on to organize regular courses on essential drugs, making use of problem-solving methodologies to arrive at rational drug use strategies. Here was a long-term impact that was unexpected.

Would he have made those decisions without seeing and using the pack? Perhaps. Something else might have led to a similar change. However, the pack was a catalyst, a stimulus that brought about a significant change. This is not to say that the way to get that change is necessarily to produce a single piece of print material!



Medium-term impact often refers to a change in behaviour among the intended audience, for example, less demand for injections or increased use of oral rehydration solution in treatment of diarrhoea. These can be measured and attributed to the overall intervention you have developed, and print material may be a key component of this intervention.

Longer-term impact usually refers to much broader changes, such as changes in health indices. It is very difficult, and often impossible, to establish a direct link between a particular

health communication material and longer-term change, because so many other factors come into play. Personal testimonies and anecdotal evidence are likely to be the main evidence that you can use to relate long-term impact to a particular material. Box 36 describes an unexpected, unintended outcome of material produced by Health Action International.

There are questions of how scientifically valid such qualitative evidence may be and how much can be generalized from such findings. However, there is more work being done in the field of evaluation to strengthen qualitative methodologies that can be used to measure change processes. This topic is covered in more detail in Chapter 11 on monitoring and evaluation.

Additional reading

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5

Mass media

Mass media such as television, radio, newspapers, and electronic media such as e-mail and the Internet have the potential to reach large numbers of people quickly and at relatively low cost. Mass media have been used in both developing and developed countries to promote rational drug use. However, they can also shape the way the public perceives medicines through the influence of drug advertising and the way in which medical advances are reported. This chapter will look critically at mass media's influence – both beneficial and harmful – on medicine use.

This chapter will:

1. Identify different kinds of mass media
2. Assess the advantages and disadvantages of using mass media
3. Explore how to use mass media within a communication strategy to address community drug use problems.

Many people worry about using mass media for health communication because they think it calls for a great deal of money and requires specialist expertise and equipment. It is true that some kinds of mass media can be expensive to use, but there are also less expensive ways of using them. Also, if the problem you are tackling is an important one, you may be able to get help in developing a mass media programme as part of an integrated communication strategy.

Mass media on their own are good for raising awareness and interest in an issue, but rarely result in sustained change in social or individual behaviour. When combined with other communication methods, such as face-to-face interactions, the influence on both social and individual behaviour can be substantial.

Different kinds of mass media

Mass media include anything that reaches a large audience, for example buses, trains, even people! Box 37 provides a list of mass media generated at a workshop on promoting rational drug use at community level that illustrates the variety.

Some of these mass media are highlighted below in more detail.

BOX 37. WHAT ARE MASS MEDIA?

Example of a list of mass media developed at a workshop on promoting rational drug use at community level

- Newspapers
- Public information vans
- Radio
- Billboards, posters
- Wall painting/chalking
- Television
- Internet
- Buses, taxis
- Mobile cell phones
- Town criers
- City bulletin
- Theatre
- Public utility bills
- People and things that move
- Vans
- Comics

Source: PRDUC workshop in South Africa, 2004



Wall chalking is a cheap and effective method in the local community.

Radio

Radio is the media channel that reaches the widest audience in most developing countries. Most people in the world have access to a radio. In developing countries there were an estimated 1.1 billion radios in 1997 or one for every four persons. There can be problems of battery supplies, distance from transmitters and poor reception in mountainous areas. The

increased availability of the new wind-up radio that operates without batteries has provided a practical solution to using radio where there is no electricity. These radios may also give women more access in areas where men control the finances and thus the use of a radio that depends on expensive batteries.

Some countries still depend on centralized production of broadcast programmes. However, local radio stations that produce programmes in regional languages and with locally relevant content are becoming more common. Community radio stations are a growing trend in many developing countries.

Radio also offers the opportunity for interactive social communication on a large scale as Box 38 points out.



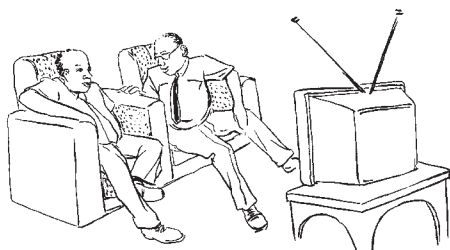
BOX 38. THE ROLE OF RADIO

It is useful to clarify the concept of an *interactive social communication* in order to distinguish it from *interactivity*. The latter is usually applied to the Internet and refers to individual users' ability to interact with a website or directly with another individual or a company via e-mail. Radio also offers this possibility, via the use of telephone calls in programmes, open microphone shows, and letters. However, radio excels at stimulating *interactive social communication* within a community. A local issues programme, for example, informs listeners about a community problem and thus stimulates interactive communication among members of the community as they go about their daily lives (now unmediated by the radio), possibly leading to development of a common understanding of the problem and proposals for its resolution. As time goes on, these proposals can be fed back into the loop in the form of another radio programme, and further discussed, refined and acted on in the community.

Girard B ed. (2003). *The one to watch: radio, new ICTs and interactivity*. Rome, Food and Agriculture Organization [ftp://ftp.fao.org/docrep/fao/006/y4721e/y4721e00.pdf](http://ftp.fao.org/docrep/fao/006/y4721e/y4721e00.pdf)

Television

Most televisions are found in industrialized countries. However, the numbers are rapidly increasing in developing countries – especially in cities and towns and among nearby rural populations. In 1997 there were an estimated 720 million television sets in developing countries – about one TV for every six people. Television ownership is particularly high in urban areas of middle-income develop-



ing countries. The development of satellites has greatly reduced the problem caused by the short range of television transmission.

Television is a strong medium which can inform and influence policy-makers.

Both television and radio have similar programme formats that can be used for health communication work. Box 39 highlights these.

Newspapers, books and magazines

Newspapers, books and magazines reach a more limited audience than radio and TV. Access is limited by illiteracy, cost and problems with distribution to outlying areas. Even so newspapers attract millions of readers daily in some developing



countries. According to UNESCO, the circulation of daily newspapers in the developing world amounted to 261 papers per 1000 population in 1997. The lowest circulations were found in sub-Saharan Africa (12 per 1000 population) and southern Asia (33 per 1000).

Newspapers can play an important role in advocacy because they reach decision-makers in society and are read by people with influence on policy (including people working in other media such as radio and television). As literacy and education increase, so does the potential of print media. Today more magazines

are being published covering a wide range of special interests including football, music, news events, films and health.

Health is a popular topic and is often included in the stories, reader's columns and advertisements in these publications. However, the message magazines promote is often one of treatment and buying medicines rather than prevention and informed self-care.

Billboards

Billboards on roadsides, buses and other public places are already widely used for commercial advertising. Increasing attention is being placed on the possibility of using them for health communication. For high impact, the chosen location must show the message to the intended audience and the design must have impact and appeal. It is usually commercial companies that have the money to pay for billboards and their main interest is selling medicines. While payment is needed to rent billboard space, it is sometimes possible to obtain sponsorship from donors or companies.



BOX 39. COMMON BROADCAST FORMATS

News. News bulletins are an important part of the daily output of most radio and TV stations. Local radio stations usually broadcast local news. Getting your health communication activity mentioned in a news bulletin is highly desirable because it gives it widespread coverage, credibility, importance and costs nothing.

Spot announcements. These can be public service announcements such as clinic opening times, immunization sessions and availability of counselling services. These will usually be broadcast free of charge. Commercial stations may allow you to 'buy time' in the form of commercials.

Slogans and jingles. Slogans are catchy, short sentences designed to attract attention, that are usually based on well-known sayings or rhymes. They can identify a campaign. Slogans set to music are called jingles. They can make a slogan more memorable and be used to identify a programme, person, radio station or theme.

Discussions. There are many kinds of discussion programmes. The one most commonly used on radio is the 'group' or 'round table' discussion. In it, a group of people having different opinions and possibly from different backgrounds discuss a subject under a chairperson's guidance.

'Phone-in' programmes. In this type of programme listeners call the studio either 'live' or 'off air' and give their views, ask questions or request advice. Their calls are taken by the broadcaster, an expert in the studio or by a panel involved in the discussion.

Interviews. Interviews involve a discussion set out in question and answer form between the broadcaster and one (or two) guests. Interviews can also be used to obtain opinions from members of the public, either in a studio situation or outside in the community. The latter method is called 'vox pop'.



Talks and documentaries. A 5–15 minute talk by one person is occasionally used but, unless the broadcaster is very skilled, it can be boring. Documentaries explore a single topic in some detail and give information by filming real-life situations. They can include spoken information from a presenter, interviews with health workers, decision-makers and members of the community, and even music and drama.

Dramas. This method includes long or short plays, soap operas, comedy sketches, serials and drama/documentaries. As discussed in the module on folk media, drama has enormous potential for health education because the audience can identify with the characters and their problems.

Music. Music is an essential part of broadcasting whether it is traditional music, popular local music, musical jingles or background music for programmes. It attracts people to watch and listen. Jingles or songs with a message can become very popular and people will sing them and remember the message.

Quizzes and panel games. Quizzes among a panel of guests are popular and most people watching or listening try to answer the questions themselves and learn something from the answers. A good approach is to ask questions that require listeners to send in the correct answers in order to win a prize. This gives feedback on how many people heard the programme and understood the message.

Magazine programmes. This format combines different elements: music, drama, stories, sketches, interviews, comedy and discussion. They are linked by a presenter and may be aimed at a particular audience such as women, farmers or young people.

Electronic media

Electronic mail (e-mail) and the Internet are relatively new but rapidly expanding mass media. Table 8 shows the relative access to electronic media in different regions of the world. Despite efforts by many institutions to convert the so-called 'digital divide' into digital opportunities, access to electronic media is still very limited, very slow and very expensive in most developing countries. The majority of users are well educated urban men.

Table 8. Connectivity access 2004

COUNTRIES	MAIN TELEPHONE LINES PER 100 PERSONS	PERSONAL COMPUTERS PER 100 PERSONS	INTERNET USERS PER 100 PERSONS	INTERNET HOSTS PER 10,000 PERSONS
WORLD	19.0	12.9	13.6	422.2
Africa	3.1	1.7	2.6	4.9
Americas	33.9	34.5	30.9	2347.6
Asia	14.3	6.35	8.1	74.3
Europe	40.9	28.5	31.1	362.6
Oceania	43.4	50.7	47.9	1408.3

Source: International Telecommunication Union, World Telecom Indicators 2004

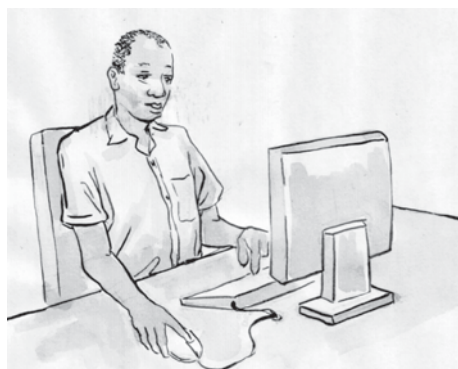
A global survey of opinion leaders conducted by Princeton University, USA, found that roughly one third of them in most regions get their information from newspapers and one quarter get their information from World Bank web sites (PSRA, 2003).

Journalists are another group that make extensive use of the Internet, both to find information and to publish information. A survey by Kaagan Research Associates (2001) found that journalists in Latin America overwhelmingly embrace the

Internet, both as a tool for reporting and a space to display their pictures, video and stories.

Lorraine Woellert, Political Correspondent for Business Week, describes the Internet today as what the fax machine was in the late 1980s. 'Back then, I couldn't imagine doing my job without the fax; now I can't imagine how reporters functioned without the Internet.'

Box 40 demonstrates how new technology can be used effectively. In South Africa, text messaging using mobile phones is helping to ensure that TB patients take their medicines regularly.



Combining media

Combining mass media – radio, TV, print, Internet – and combining mass media with face-to-face communication often provides the most effective interventions. Box 41 shows how this has been done by Soul City in South Africa.

Advantages and disadvantages

The strength of mass media comes from the opportunities they provide to reach large numbers of people quickly. The production and broadcast of mass media can involve expensive equipment. However, the cost per person reached is much lower compared to face-to-face methods.

BOX 40. SOUTH AFRICA: A NOVEL APPROACH TO IMPROVING ADHERENCE TO TB TREATMENT

Tuberculosis is an increasing public health problem in Cape Town. Poor adherence to treatment regimens results in a low cure rate and an increasing incidence of multi-drug resistant tuberculosis. Current usual care is to directly observe patients for all or most of their doses in the short course regimen.

Directly observed treatment (DOT) places a considerable burden on health centre staff. On average, cases require 6.5 months of treatment. Adherence interventions, other than direct observation, are required that improve adherence and decrease the workload of the staff at health centres.

Now with a relatively simple, but innovative idea, a Cape Town doctor, David Green, has dramatically helped the fight against TB. He has introduced a Short Messaging Service (SMS) – a text message service that enables short messages of up to 160 characters to be transmitted between cell phones – to remind patients to take their medicines.

Dr Green has called this system Cell Phone Prompted Self Administered Therapy (PSAT). It is a system whereby selected patients are released from the requirement of direct observation and are prompted by the text message service of the GSM (Global System for Mobile Communications) standard to take their medication daily. This relieves patient loads for DOTS employees whilst not decreasing the cure rates currently achieved by DOTS. The decreased workload will allow staff to focus attention on patients who do not achieve optimal adherence, thereby increasing the likelihood of improving adherence among all TB patients (not only those on PSAT).

Pilot studies at the Chapel Street Clinic in Cape Town have shown cell phone usage among 71% of the target population. Further, widespread patient and staff acceptability of this intervention have been shown. The local health authority is paying the R11.80 (US\$1.3, approximately) per patient per month to run the SMS reminder service.

The system is simple, affordable and flexible – Dr Green enters the names of TB patients onto a database. Every half an hour his computer server reads the database and sends personalized messages to the patients, reminding them to take their medication. The technology that he uses is extremely low-cost – a freely available open source software operating system, web server, mail transport agent, applications and a database. When patients complained that their messages were boring, Dr Green sent them a variety of alerts, including jokes and lifestyle tips, with the result that he now has a database of over 800 messages that he changes on a daily basis. Of the 300+ patients involved in the pilot there were only five treatment failures, and WHO has singled out the scheme as an example of good practice.

The initiative not only uses technology to address a real need effectively, but it does this in a simple, affordable and flexible way.

Source: Dr David Green, The Compliance Service, Cape Town, South Africa. This box is based on the text “Using cell phones to boost TB compliance” published in the E-Drug Electronic Discussion Group.



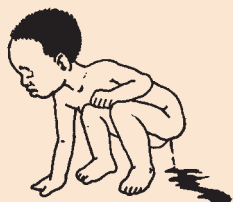
There are some objectives for which mass media are particularly well suited. They can convey very specific information to tell people about something new and to create awareness and interest. Mass media are also very good for raising an issue's profile so that it is talked about and on people's minds when they make decisions. This type of agenda-setting is particularly worthwhile if you are trying to influence policy-makers about the implementation of laws or controls on product marketing. Mass media have considerable power in developed countries and among urban populations in developing countries where more people own radios and TVs and read newspapers. In rural areas, radio is the most used medium.

These advantages need to be balanced against some disadvantages. The influence of mass media is less in rural communities within developing countries because

BOX 41. A MULTIMEDIA INTERVENTION IN SOUTH AFRICA

The Soul City Institute for Health and Development Communication (or Soul City, in short) is a nongovernmental organization based in Johannesburg. Soul City was established in 1992 to harness the power of mass media for health and development in South Africa.

The country faces enormous health and development challenges. An estimated 20% of South Africans (some 4.2 million people) are HIV-positive. For children under five years of age, the largest single cause of death is diarrhoea.



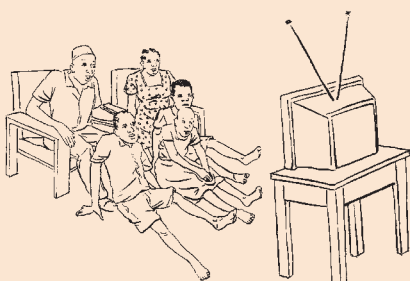
Mainly a legacy of apartheid, this disturbing health record existed despite a highly developed mass media system in South Africa. Some 98% of South Africans access radio, 65% access television, and over 40% access newspapers and magazines.



The bedrock of Soul City's health promotion strategy is **entertainment-education** (also called "edutainment" – see Box 42 for more details). Soul City pioneered several new directions, including the strategy of having an "on-going" multimedia vehicle to address high-priority national health issues. Each year, a series of mass media interventions is implemented:

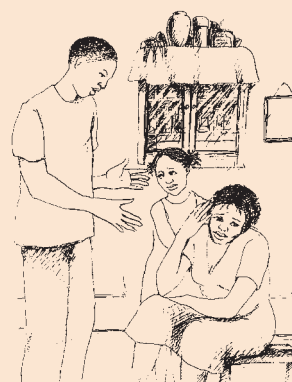
- the flagship "Soul City", a 13-part prime-time television drama series broadcast on South Africa's most popular television channel
- a 60-episode prime-time radio drama series broadcast in nine South African languages, covering all regional stations
- 2.5 million health education booklets, designed around the popularity of the TV series' characters, which are serialized by 11 major newspapers and distributed nationally.

After the television and radio series are broadcast, several campaign activities are implemented to **keep** people talking about Soul City and the issues it covers. Such initiatives include the "Soul City Search for Stars" (to recruit talent for the next year's television series), and the "Soul City Health Care Worker of the Year" (to recognize outstanding grassroots community workers). The ability of the Soul City Project (including its various media components) to attract advertising revenue allows an unusual opportunity to recover the costs of media production.



The first "Soul City" series (in 1994) focused on maternal and child health

and HIV prevention. The second "Soul City" series (in 1996) focused on HIV prevention, housing and land reform, and tuberculosis and tobacco control. The third "Soul City" series (in 1997) dealt with HIV prevention, alcohol abuse, energy conservation, and violence prevention. The fourth "Soul City" series (in 1999) focused primarily on violence against women, youth sexuality and AIDS, hypertension, personal finance, and small business development. Series 5 in 2001 looked at HIV and AIDS, Small Business Development, rape and disability and Series 6 in 2003 dealt with HIV and AIDS, depression, asthma, adult education and literacy. Series 7 was screened in early 2006 and dealt with health and equity, access to ARVs, masculinity, and cervical cancer among its main themes.



HIV prevention, youth sexuality and violence against women are central themes for Soul City programmes

Source: Soul City. <http://www.soulcity.org.za>

of the decreased access to media and the presence of strong cultural traditions. Because the content must be suited to the general listener or viewer, it may not be relevant to the specific needs of a local community.

The content is fixed and cannot adapt to the issues raised by the community, the way that a face-to-face meeting can. If the content is misunderstood, the lack of immediate feedback makes it impossible to correct. In addition, practically – if you are working at the local community level – you may not have an opportunity to use mass media.

Another disadvantage with mass media is that it is frequently used by commercial interests to promote medicines, directly and indirectly. When producing your own health communication material, you need to consider the commercial messages being received by the community and make sure your own material is of sufficient quality to compare favourably with them. A community's behaviour may be reinforced by promotional activities carried out by pharmaceutical companies with large budgets for advertising and promotional staff. Opposing these influences through mass media advertising alone would require huge budgets.

In many countries, newspapers, radio and television receive a great deal of financial support from commercial companies and may be reluctant to do anything which might reduce their earnings. They may be reluctant to cover information that is critical or questions commercial information. For this reason, you may face difficulties in obtaining coverage of more radical essential drugs messages, which challenge the power of pharmaceutical companies.



Use of mass media

Mass media can be used in three major ways to promote health. In the first approach, advertisements, jingles, spot announcements and public service broadcasts are used deliberately and openly to influence decisions. The format communicates health messages and the audience knows that an attempt is being made to influence it. If you use this approach you will have to buy 'air' time or newspaper space – in the same way as advertisers of commercial products. However, in some countries it is possible for public service organizations to obtain radio or TV time for free. Unfortunately, the free time is often only available at times when few people are listening!

The second approach is to seek news or feature coverage for a particular rational medicine use issue. It may be a story aimed at encouraging a change in practice among health workers, consumers or both – oral rehydration treatment saved the lives of hundreds of children and is more effective than antidiarrhoeals; overuse of antibiotics is a public health problem and many illnesses do not need to be treated with antibiotics. It may be a story aimed at influencing policy change (and both of the examples just mentioned could also have a policy angle if the objective was to get new regulations in place) – high drug prices are affecting people's access to essential medicines. This gives the issue greater importance in the eyes of many people. More details on this way of using mass media are covered in Chapter 6 on Working with journalists.

The third approach introduces health concepts within formats mainly designed to inform or entertain the audience. Often there is considerable interest in health issues by the community so it is possible to ask media programmers and writers to include plots involving health issues in their dramas, quiz show questions or in shows with interesting speakers.

This approach is obviously cheaper than advertising. However, its real potential stems from the combination of education with entertainment. It can convey the information in a way that engages audiences and encourages an emotional response to the information.

This approach draws heavily on the concept of entertainment-education or edutainment. The edutainment method was developed largely from work in Latin America in the late 1960s and 1970s, and its use has been expanding in recent years (Singhal and Rogers, 2002). Box 42 explains this in more detail.

Mass media programmes can be recorded on video and audio cassette. These can then be played to groups of people in clinic waiting rooms, community meeting halls, schools,



BOX 42. ENTERTAINMENT-EDUCATION TO IMPROVE HEALTH

'Entertainment-education' is a promising strategy for improving health in many countries. This approach relies on specially crafted media messages to entertain and to educate audiences about an educational issue, to create favourable attitudes and to change behaviour. Radio and television soap operas, popular music, street theatre and comic books have all been used to educate the public about such health issues as family planning, HIV and AIDS prevention, environmental health, female equality, improved sanitation and female genital mutilation.

Entertainment-education typically provides positive and negative role models for health related-behaviours. A popular radio soap opera in Tanzania, 'Twende na Wakati' (Let's go with the times) features a truck driver, Mkwaju, who has unprotected sex with multiple sex partners, including commercial sex workers. His behaviour puts him at risk of contracting and spreading HIV and AIDS and of producing unwanted pregnancies.

Mkwaju also exhibits other negative traits: he has a strong son-preference and is an alcoholic. His behaviour leads to the loss of his family, his job and eventually his life.

In contrast to Mkwaju's irresponsible behaviour and male bias, Fundi Mitundu, a tailor in the soap opera, adopts a contraceptive method

and has one child. He and his wife are financially successful.

An evaluation study found that one quarter of the listeners interviewed said the programme had influenced them to adopt family planning methods and HIV and AIDS prevention, primarily by getting people to discuss the issues.

More than 75 entertainment-education projects have been carried out in Latin America, Africa and Asia and such projects could be

used to influence audiences in more developed countries as well.

Rogers E (2000). Entertainment-education to improve health. *Population Bulletin* 55;1:24.



on village public address systems, at market places and other public gatherings through loudspeakers.

This increases the reach of mass media broadcasts and enhances the efforts to use mass media to raise awareness and interest, and ultimately to influence change. Some health education programmes have used this approach to 'narrow cast'. This involves preparation of videos and audio cassettes tailor-made to specific communities. This approach makes it possible to combine the entertainment value of mass media with a message directly relevant to the local community. It also allows for discussion, to take place where community members can identify what is relevant to their situation and what can be done to improve the situation.

In order to be effective, mass media should be well produced and repeated many times using different, creative formats. While in some countries broadcast time and newspaper space may be given free of charge, this is becoming less common. Often large sums of money are needed to buy slots for advertising at times when the maximum number of people are watching or listening. It would be more cost-effective to build up contacts with the press in order to gain free coverage of health topics and advocacy to enforce controls on drug advertising (see Chapter 6, *Working with journalists*). Another option is to use community radio and/or to establish listening groups connected to regular health programmes.

While mass media can provide information, they are unlikely to develop skills such as decision-making which are best learned by providing opportunities to practise skills in exercises and activities during face-to-face encounters. Empowerment involves fundamental changes in the way individuals and communities think about themselves and their ability to control their own lives. It is generally considered that participatory learning activities carried out as part of face-to-face education are necessary to achieve empowerment.



Community members in Nigeria develop methods to conduct community directed treatment with ivermectin, against river blindness. They were empowered, and carried out the work without assistance.

Planning processes

The basic approach for programme planning for mass media health communication is similar to that for other methods. It requires initial research to define the problem, find the perceived causes and the practical and acceptable solutions, and select and pretest appropriate information, and then to implement and evaluate the intervention. As with other communication methods, no single method is likely to work as well as combinations of methods. So it is important to integrate all mass media projects into a larger communication strategy. Mass media should be one component of a communication intervention, not a separate project.

There are some issues that are of particular importance when planning mass media communication.

Audience research

You need information on the media habits of your intended target audience to help decide which mass media to use, the content and the timing. In particular, you need to find out:

- What do people read, watch or listen to?
- When do they listen or watch? (both time of day and day of week)
- What are their favourite programmes?
- Which programmes and presenters do they trust and respect?
- What are the influences – both positive and negative – on the specific behaviours you are seeking to influence?

You should look to see if this information is already available from other recent surveys. Find out if the TV and radio broadcasters or newspapers are already collecting this kind of data as part of their routine audience research.

Choosing the design

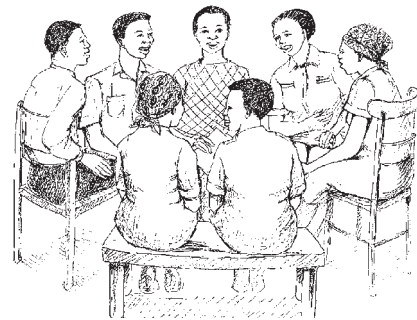
The advice presented in the mass media should be relevant to the health problem. Your audience research will have helped you choose advice which is acceptable, realistic and relevant to your intended target audience.

- It is important to give this advice in an appealing way that will keep the audience's attention and interest and convince them.
- Take care not to put too many facts and figures in your programmes. This can be boring and only appeals to people with higher educational levels.
- Use music and humour to make the programme interesting.
- Have the information presented by people who are respected and admired by the intended audience.

Pretesting

It is essential to pretest any programme before broadcast to ensure that the content is appropriate and clearly understood and that the format engages people's interest and attracts their attention. You can do this by bringing together a group of people similar to the audience you are trying to reach and asking them to listen or watch the programme and give their opinions. The following are typical questions you can ask when pretesting mass media for understanding, relevance and impact:

- What did you learn from the programme? What else?
- What did you like best? Why?
- Did the programme deal with issues that are important to you? In what way?
- Can you use anything you saw or heard in your daily life? If yes, what and how can you use it?
- Is it likely that you will use it? Why? Why not?



Focus group discussion is one method that can be used to find out more about people's listening habits. In-depth information from this method may need to be supplemented by quantitative surveys to detect e.g. trends in listening times.



- Are the people in the programme like you or very different from you?
- Did you get the information you needed about the topic? If not, what would you like to know more about?
- Was there anything in the programme that you did not like? What? Why did you not like it?
- What changes would you suggest?

More guidelines on pretesting are given in Chapter 10.

Timing broadcasts

Timing of mass media activities is crucial. The needs of the health topic and the reading, watching or listening patterns of the target group must be taken into account. Certain health conditions such as diarrhoea and malaria can have seasonal peaks, which makes timing important. People may have more free time to listen to programmes when it is not the busy planting season. You should choose a time of day to broadcast your programme when the target group regularly listens or watches and avoid times when they are busy with other activities. Getting the timing right is not easy. A good approach can be to repeat key messages at different times of the day.

Campaigns

Greater impact can be achieved when mass media is used as part of a campaign instead of as a 'one-off' activity. A campaign is a planned educational activity involving intensive action during a short period. The same message is repeated in different ways and the timing is carefully chosen. It is common to reinforce the mass media with face-to-face activities such as the mobilization of politicians, health services, NGOs and communities to carry out intensive activities such as public gatherings. Drama and musical activities and small group meetings are often carried out as part of campaigns.

The case study in Box 43 from Viet Nam provides an example of a multimedia campaign aimed at promoting the rational use of medicines. It involved mass media, support materials and training for health care providers. The community part of the programme is described below.

Some people criticize the campaign approach. They feel it concentrates too much effort into a short period and results in unsustainable effects. They would argue that it is better to have an educational programme conducted over time within the regular activities of clinic health workers. Such critics say this approach makes the impact more sustainable. Box 44 discusses this issue in relation to a mass media campaign to encourage people with tuberculosis in Colombia to be tested so that they could be treated. Although the campaign was successful, once the communication inputs stopped, the numbers of people coming forward for testing dropped.

There is no right or wrong answer on whether to initiate a campaign. The decision depends on the purpose of your programme, and on the human and financial resources you have available. You can use a short, intensive campaign to create public awareness and follow this up with an on-going programme to reinforce the educational activities performed by health workers and other field workers.

Box 45 describes a short campaign to encourage the uptake of immunization services in the Philippines, which was successful in that it increased the number of children vaccinated at that point in time. However, it failed to increase

BOX 43. PROMOTING MEDICINES IN VIET NAM

Following workshops with community members and health workers, a communication intervention was designed to try to reach 1.6 million people in 12 districts in Viet Nam. Three major issues were identified as the main content for the intervention:

- Decreasing the use of injections where alternative forms of medicines are available
- Ensuring that the complete dose of antibiotics is taken
- Encouraging people to visit their local commune health station (CHS) to seek expert advice when they are ill, rather than starting to self-medicate.

The media used included:

- two posters – five copies of each distributed to every CHS
- four radio programmes (short, five-minute plays)
- four 30-second radio spots broadcast on district and regional radio and distributed as cassettes to be broadcast through commune loudspeaker systems
- four 5-minute TV programmes and one-minute TV spots broadcast on provincial TV
- newspaper advertisements
- a leaflet given to every householder in five communes.

Two hundred households were randomly selected from each of five communes and interviewed. Forty CHSs were randomly chosen and data obtained from the outpatients book, the drug cabinet, the accounting books and some interviews. The last 30 treatments in the outpatients book of each CHS were examined.

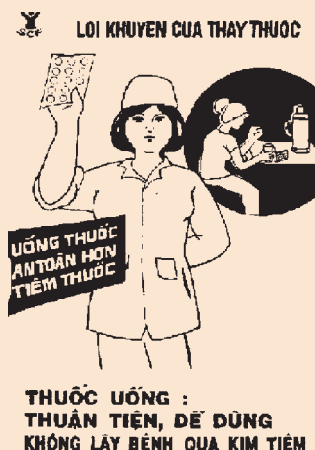
People in nearly 90% of the households could repeat one or more of the main messages used by the programme and 75% claimed to have changed knowledge or practice. Respondents claimed to have heard messages from the following sources: commune public address system (67%); CHS staff (53%), TV (52%, note TV ownership is 51%), leaflet (37%), posters (15%), newspapers (7.5%). The following improvements were noted between August 1994 and December 1995: patients given vitamins (75%→88%); patients given injections (33%→7%); patients given antibiotics (69%→46%); patients given correct doses of antibiotics (29%→91%). Follow-up data in September 1996 showed that improvements were sustained.



This case study is one of the rare examples showing use of mass media for public education on drugs in a developing country. Its evaluation data have limitations in showing an impact for the educational component.

While they demonstrated that the campaign was received, the impact data highlight health worker practices. From the data, it is difficult to establish whether or not the improvements are a result of the training for health workers on improved prescribing or the educational component. However, even if the change is mainly due to improved prescribing, it is important that this is acceptable to patients.

Source: Chalker J (1998). Improving quality of care in Hai Phong Province. *Essential Drugs Monitor* No. 25–26:15–17. http://mednet2.who.int/edmonitor/edition/EDM2526_en.pdf

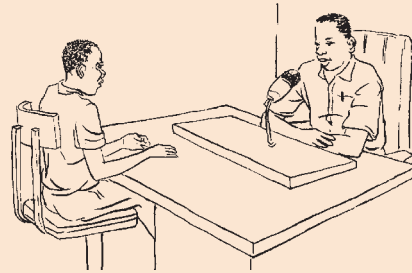


BOX 44. REACHING TB PATIENTS IN COLOMBIA THROUGH MASS MEDIA

A mass media health communication campaign for TB control in Colombia aimed to increase case-finding and reduce levels of prejudice against people with TB. The media campaign was implemented over six weeks and had three components: public service announcements on TV and radio; chat shows on TV and radio involving people with tuberculosis, doctors and health educators; flyers inserted in a Sunday issue of two local newspapers and two feature articles in one broadsheet and two tabloid newspapers.

The main indicator used to measure success was the number of smear tests processed by local laboratories. There was an increase of 64% in the number of direct smears processed by the laboratories and an increase of 52% in the number of new cases of positive pulmonary TB, compared with the previous period. However, the effect of the campaign was lost once the radio and television public services announcements stopped. This raises questions about the sustainability of programmes relying on short-term mass media campaigns.

Source: Jaramillo E (2001). The impact of media-based health education on tuberculosis diagnosis in Cali, Colombia. *Health Policy and Planning* 16:68–73.



BOX 45. MASS MEDIA AND SUPPORT MATERIALS IMPROVE IMMUNIZATION IN THE PHILIPPINES

The Philippine Department of Health conducted a national mass media communication campaign over a six-month period to support routine vaccination services. It involved four television and four radio advertisements, newspaper advertisements, posters, welcome streamers, stickers, T-shirts. Materials emphasized that vaccinations were free and available on Wednesdays at health centres. The campaign slogan was “Protect your baby from measles”.

Pre- and post- campaign surveys and structured interviews with health care staff and patients found that there was a significant increase in knowledge of measles vaccination and some increase regarding other vaccinations. However, the relationship between knowledge and practice remained the same between 1989 and 1990. There was “little evidence for changes” in the way that vaccination sessions were held in the health centre. While the proportion of exit interviewees saying that “someone explained about vaccination” increased from 18.4% (1989) to 75.5% (1990) this was not paralleled by an increase in their knowledge. The percentage of fully vaccinated children increased from 54% (1989) to 65% (1990). Factors contributing to the success of the campaign included: good public access to the media (radio 73%, television 60%, both 50%), the development of high-quality radio and television spots and a routine system ready to serve the increase in demand the campaign generated.

Sources: Zimicki S et al. (1994). Improving vaccination coverage in urban areas through a health communication campaign: the 1990 Philippine experience. *Bulletin of the World Health Organization*, 72:409–422.

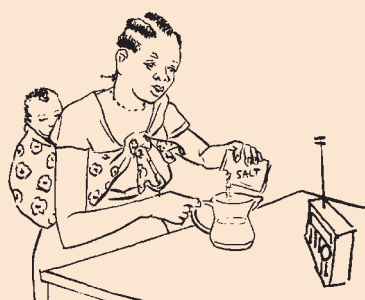
McDivitt JA, Zimicki S, Hornik RC (1997). Explaining the impact of a communication campaign to change vaccination knowledge and coverage in the Philippines. *Health Communication* 9:95–118.

knowledge among patients and parents, which may indicate that the long-term impact of the campaign has not been achieved. Future attempts to immunize children would probably still need further communication support.

Box 46 describes a longer campaign, phased over time, to promote the use of ORS to treat childhood diarrhoea in Honduras. This also demonstrates the importance of combining communication approaches so that there are opportunities over time to reinforce key information and to deal with emerging questions and issues that arise as people try to do something different.

BOX 46. PROMOTING ORS IN HONDURAS

Following research to identify existing perceptions of mothers and grandmothers of how to treat diarrhoea among children under five years of age, a communication campaign was developed. The campaign had five phases, timed to coincide with the seasons and each emphasizing slightly different content matter. The initial research led to a message which stressed the use of Litrosol, the locally produced WHO ORS packet. Radio was used to provide widespread coverage of key new skills and as a regular reminder of critical mixing, administration and feeding advice. Printed materials



carried more detailed instructions and interpersonal channels (physicians, health workers) provided face-to-face education. The integration of broadcast, print and face-to-face support was essential to the campaign. Medical professionals were trained to train community health workers who in turn trained rural mothers. Messages and products were carefully pretested and all inputs monitored through repeated evaluations of selected outputs.

A group of 800 families was interviewed at regular intervals

to determine knowledge and self-reported behaviour. The overall impact was:

- 70% of mothers who had listened to the radio on the day before remembered having heard a radio spot about Litrosol.
- 80% of the sample reported having seen a health poster.
- Nearly 66% of the sample could remember the campaign jingles.
- 90% of the sample who heard the spots could correctly identify Litrosol.
- The reported use of Litrosol rose from 9% at the beginning of the campaign to 26.1% after 12 months. After 16 months 39% of all cases of diarrhoea in the sample houses was being treated with Litrosol.
- Mortality of children under five years of age in the study community showed a drop in the proportion of deaths due to diarrhoea (from 47.5% in 1981 to 25% in 1982).



This study relies heavily on self-reported behaviour change to evaluate the impact. During this period there was a decline in deaths from diarrhoea but it is difficult to tell from the evaluation whether or not the decline was due to the programme. This shows how difficult it is to evaluate large-scale media campaigns.

Source: Seidel R (2005). *Behaviour change perspectives and communication guidelines on six child survival interventions*. Baltimore, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs. http://www.jhuccp.org/pubs/cp/child_survival/BehaviorChangePerspectives.pdf

Monitoring and evaluating

The term monitoring is used to measure progress during an intervention and focuses on activities or progress indicators. Evaluation is used during an intervention or at the end to determine if the objectives were achieved.

The ideal monitoring and evaluation strategy should involve:

- A baseline study before the mass media activity to determine levels of the different factors such as current practices, knowledge, skills you are planning to target in the mass media programme.
- A short-term, follow-up study immediately afterwards determines coverage and influences on knowledge.

- A long-term, follow-up study 6-12 months after the programme's conclusion can check if changes in knowledge are translated into practice and signal other long-term changes (or lack of change!) arising from the study – the sustainability of impact.

You can measure short-term effects by asking the following questions:

- How many saw/heard/read the programme?
- How many could remember key messages?
- What was their immediate reaction?
- How many people believed the message?
- How many believed that they could use the information to change something?

You can use the data collected on the short-term effects to make changes in the broadcasts, which can help overcome any problems encountered while the campaign is still underway.

To evaluate the long-term impact ask questions to find out if the mass media have caused people to change their practice and have improved their health. You should ask questions such as:

- How many people could still remember the message?
- How many accepted the message as true?
- How many people changed their behaviour?
- What other impacts did the mass media have? (e.g. sales of medicines, dumping expired drugs, requests for information).



Evaluation can involve a mix of the following methods:

- Focus group discussions and interviews to obtain qualitative data.
- Surveys of larger samples to obtain quantitative data.
- Observational studies to determine changes in behaviour or skills e.g. preparation of medicines, presence of medicines in households.
- Audience feedback through letters or competitions.
- Monitoring records from clinics and pharmacists.

The ideal evaluation method should involve a baseline (pretest) with post-intervention ('post-test') comparison of the impact made by communication interventions with that of control communities not exposed to the interventions. It can be difficult to use this ideal approach in real situations. This is partly because of the costs involved and also a lack of evaluation skills.

Problems with evaluation

Some evaluations of mass media health communication have not used baselines and instead have relied on self-reported changes in knowledge or behaviour. This method is less reliable because it depends on people's memories. Bias can enter because people tell you what they think you want to know rather than what really happened.

Very few evaluations of mass media programmes in developing countries have compared the impact with those of control communities that did not receive the mass media. This often occurs because the large reach of the mass media makes it difficult to find a control community that has not been exposed to it. Another

reason is the additional cost involved. When it is not possible to assign controls, an alternative approach is to collect data, which determine why people may have changed their knowledge or practices. This could involve:

- Carefully observing the communities to rule out other possible factors which might also influence the community's behaviour and account for any changes you observe.
- Asking people why they changed their behaviour. This can be unreliable because it depends on people's memories. They may have changed for reasons other than your programme and forgotten the real reason.
- Showing that it was only people who were exposed to the programme who changed their behaviour. If you can also exclude other possible reasons for change, this provides reasonable evidence that the programme was effective. Whether or not people really saw the programme is tested by asking people to describe the advertisement or sing the jingle.



Evaluation is not easy and involves compromises between what would be ideal and what is realistic in your situation. Box 47 describes the type of extensive evaluation carried out by the Soul City programme in South Africa, which is necessary for such a complex approach, but is unlikely to be of use in smaller scale interventions. More guidelines are provided in Chapter 11 on *Monitoring and evaluation*.

In conclusion, deciding whether or not using mass media is an appropriate strategy for your activity depends on:

- the issue you want to tackle;
- your overall objective. The following objectives can be achieved by using mass media: provision of knowledge to the community, influencing a cultural norm, countering the influence of drug companies, raising the profile of an issue in public debate (agenda setting), or advocacy for policy change;
- the characteristics of the communities you are trying to reach, including their access to mass media and influences on their current behaviour;
- the resources at your disposal, funds, mass media production skills and opportunities to use and influence mass media.

Additional reading

Hubley J (2004). *Communicating health: an action guide to health education and health promotion*. 2nd ed. Oxford, Macmillan.

Adam G, Harford N (1998). *Health on air – a guide to creative radio for development*. London, Health Unlimited.

DFID (2004). *Radio broadcasting for health: a decision-maker's guide*. London, Department for International Development (DFID).

Radio guide (1994) WHO/CDD/94.48. Geneva, World Health Organization.

Robey B, Stauffer P (1995). Helping the news media cover family planning, *Population Reports J*, (42):1–27.

Church CA, Geller J (1989). Lights! Camera! Action! Promoting family planning with TV, video and film. *Population Reports*, (38):1–31.

BOX 47. EVALUATION OF SOUL CITY IN SOUTH AFRICA

The Soul City III campaign involved: (1) a 14-episode, weekly television drama; (2) a 15-minute radio drama series broadcast in sixty episodes and nine languages; (3) three 36-page booklets serialized in 11 newspapers. The topics covered by this series included HIV and AIDS, alcohol abuse, and violence (see also Box 41, which describes the work of Soul City more fully).

A baseline study was carried out in August 1997 just before the broadcast started and a follow-up evaluation was done in October 1997 just after the broadcasts. Data collection consisted of an 800 sample survey (200 from four sites), focus groups and in-depth interviews with key stakeholders. Questions sought to elicit data on coverage and self-reported behaviour change.

Of the respondents who watch television, 62% had seen at least one episode of Soul City. Respondents with higher levels of education were more likely to have watched Soul City or seen the newspaper supplements. Almost half (49%) of the respondents remembered stories about HIV/AIDS. Forty-five per cent said that they had discussed the programme with others. Focus group responses indicated that viewers claimed to have learned most about topics that affected them directly, especially AIDS, alcohol, parenting and violence. Changes in the post-intervention survey over the baseline were found: a greater proportion of respondents had heard of STDs other than AIDS (68% 81%); greater willingness to disagree with the statement that people with HIV/AIDS should be isolated (63% 46%), greater acceptance that alcohol abuse was a problem in their community (69% 76%). There was no significant change in self-reported condom use.

The evaluation showed that Soul City was widely watched and had an impact on knowledge. The large proportion of people who discussed the programme with others is interesting in terms of demonstrating some influence on public dialogue around issues that are traditionally not discussed widely. However, on its own, it was insufficient to influence behaviour change around the use of condoms. At the same time, it should be noted that persuading people to use condoms is one of the more difficult behaviours to change and it is not surprising that a single mass media programme was not able to accomplish this.

The evaluation of series IV of Soul City, which dealt with domestic violence against women, AIDS, personal finance, and hypertension, confirmed the reach of the approach (at least 79% of its intended audience), and the impact of the programme at both a social and individual level. By partnering closely with the National Network on Violence Against Women, the combined advocacy led to a more rapid implementation of a Domestic Violence Act. At an individual level, 45% of 16-24 year olds who watched, listened to or read materials produced by Soul City reported safer sexual behaviour compared to 28% who had not accessed Soul City at all. Changes in knowledge, attitudes and intentions to change behaviour were also reported in relation to dealing with hypertension and personal finance.

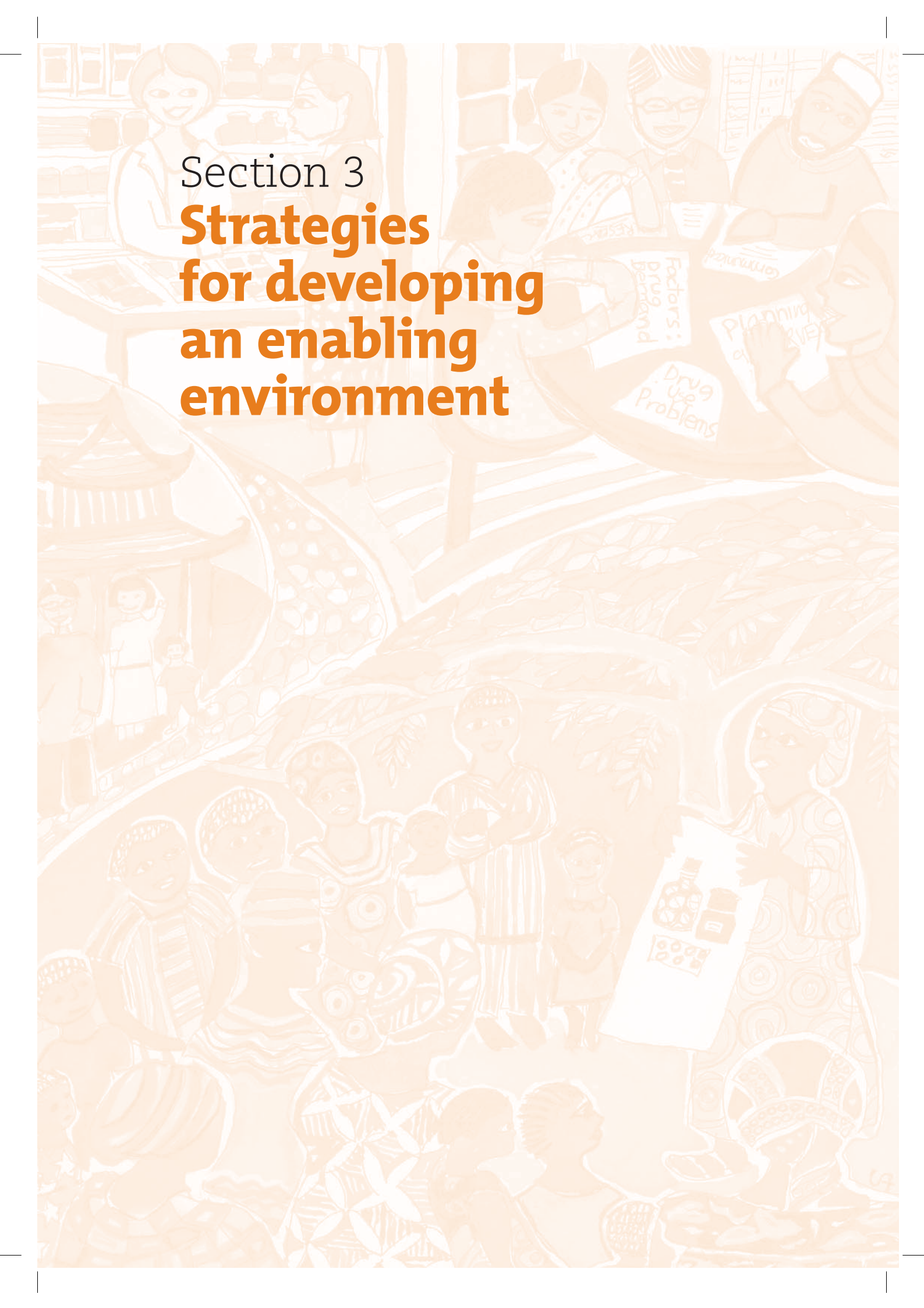
Source: Samuels T et al. (1999). *Learning the easy way II: Evaluation of the Soul City III TV and Print Series* carried out by the Community Agency for Social Enquiry. Johannesburg, Soul City.

Scheepers E (2001). *Social change: the Soul City communication experience. Evaluation of the Soul City IV TV, Radio and Print Series.*

Soul City web site: <http://www.soulcity.org.za>

Girard B. ed. (2003). *The one to watch: radio, new ICTs and interactivity*. Rome, Food and Agriculture Organization. Available at: <ftp://ftp.fao.org/docrep/fao/006/y4721e/y4721e00.pdf>

FHI/AIDSCAP. *Behavior change through mass communication* (2002). Family Health International AIDS Control and Prevention Project (FHI/AIDSCAP). Available at: <http://www.fhi.org/en/HIVAIDS/pub/guide/BCC+Handbooks/Behavior+Change+Through+Mass+Communication.htm>



Section 3

Strategies for developing an enabling environment

An enabling environment is a characteristic of a society or a community that encourages change, supports development and seeks to support those that are innovators and proponents of change.

One of the clearest examples of enabling environments in public health issues is work that has been done over the years to combat the smoking epidemic in many countries. Combinations of legislation and regulations, price controls, information and communication strategies, advocacy, work by self-help groups and a number of techniques developed to support individuals to change their behaviour have led to dramatic declines in smoking in some places.

Box 48 describes the way an enabling environment could be developed to deal with hypertension. This scenario highlights the interaction and synergy of a number of different interventions, taking place at different levels of influence to lead to change.

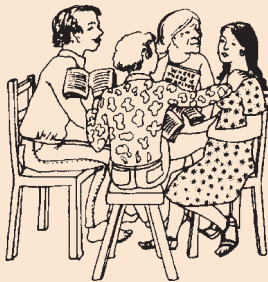
In Chapter 1 we introduced the different levels of influence that affect decisions about rational drug use:



BOX 48. THE ROLE OF AN ENABLING ENVIRONMENT IN A CHANGE SCENARIO

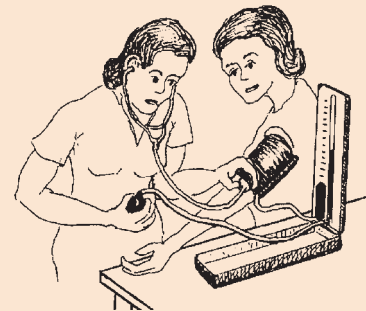
One can imagine how the process of change occurs: a woman sees some public service announcements and a local TV health reporter's feature telling her about the "symptomless disease" – hypertension. She checks her blood pressure in a newly accessible shopping mall machine, and the results suggest a problem. She tells her spouse, who has also seen the ads, and he encourages her to have it checked. She goes to a physician who confirms the presence of hypertension and encourages her to change her diet and return for monitoring.

The physician has become more sensitive to the issue because of a recent article in the *Journal of the American Medical Association*, some recommendations from a specialist society, and a conversation with a drug representative as well as informal conversations with colleagues and exposure to television discussion of the issue.



Meanwhile, the patient talks with friends at work or family members about her experience. They also become concerned and go to have their own pressure checked.

She returns for another checkup and her pressure is still elevated although she has reduced her salt intake. The physician decides to treat her with medication. The patient is ready to comply because all the sources



around her—personal, professional, and media—are telling her that she should.

This programme is effective not because of a public service announcement or a specific programme of physician education. It is successful because the National High Blood Pressure Education Programme has changed the professional and public environment as a whole around the issue of hypertension.

Adapted from: Hornik R (1997). Public health education and communication as policy instruments for bringing about changes in behavior. In: Goldberg ME, Fishbein M, Middlestadt SE (eds.). *Social marketing: theoretical and practical perspectives* (pp. 49–50). Mahwah, NJ: Lawrence Erlbaum Associates. Reproduced by National Cancer Institute, USA, 1999, in: *Making health communication programs work*.

- family/household level
- community
- health service institution
- national level
- international level.

In creating an enabling environment, each of these levels needs to be considered and strategies developed to address what positive changes can be introduced.

This section looks at three key approaches that have been found to be of help in creating an enabling environment for rational drug use:

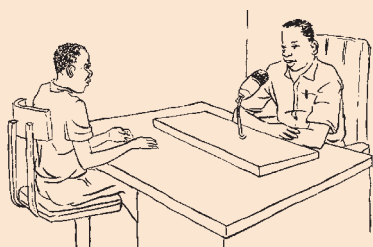
- Working with journalists to increase media advocacy
- Developing advocacy and networking strategies
- Managerial and regulatory approaches.

Media advocacy

Media advocacy is the strategic use of mass media as a resource for advancing a social or public policy initiative. It is an important, and often essential, part of social action and advocacy campaigns because the media focus public concern and spur public action. The core components of media advocacy are developing an understanding of how an issue relates to prevailing public opinions and values, and designing messages that frame the issues so as to maximize their impact and attract powerful and broad public support.

BOX 49. A MORE PROACTIVE MEDIA?

Interviewed for India Together, Professor Ranjit Roy Chaudhury (see next page) states that 'In the area of tuberculosis, the media could run reports or spots on TV that bring home the fact that if TB drugs



are not taken in time and the full course is not completed, then an almost inevitable relapse occurs. Subsequently the patient develops resistance and second-line drugs – which are 400 times more expensive as well as more toxic – would have to be used. It needs to be known that 90% of TB cases can be cured. We have the technology, but it is rarely applied or availed of.' There are standard procedures for the treatment of TB that have been worked out by the Indian TB programme and the media can draw the attention of doctors to these freely available, simple-to-follow guidelines.

The media can also press government to give widespread publicity through hoardings and newspaper advertisements on DOT centres (Directly Observed Treatment centres) about their location and how they operate. 'Such a collaboration between the medical profession, the media and the government will certainly help in combating TB, the ramifications of which are frightening,' the Professor asserts.

Chaudhury feels that the media could also work as an effective pressure group on governments and policy makers. There is a lot in health care that needs to change. For example, 'Today if a patient dies after being administered a spurious drug, the manufacturer can be prosecuted only under the copyrights act, the punishment for which is only two to five years in jail! I feel that it should be a criminal offence that is cognisable. This only requires a simple amendment to the Drugs and Cosmetics Act of 1940 but who will do it? A responsible media could certainly help by carrying stories and putting pressure on law and policy-makers. In a country where spurious drugs and adulterated food threaten the lives of millions, 'surely the press can step in and aid in rectifying the situation?' he asks.

Source: Karlekar M. 2003. Media for medicine. India Together. <http://www.indiatogether.org/2003/jul/hlt-medicare>.

Professor Ranjit Roy Chaudhury in India thinks that a proactive media could be a partner in improving the use of drugs. As former President of the Delhi Medical Council and head of the Delhi Society for the Promotion of the Rational Use of Drugs (DSPRUD) he would like to see the media helping to inform consumers and also influence policy makers as a way of bringing about social change (see Box 49).

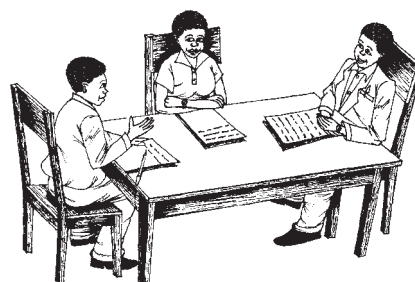
The issues involved in working with the media are explained in more detail in Chapter 6.

Advocacy and networking

Allies are important in developing and sustaining any change process. Changing policy and practice in the use of medicines is not a task that any one institution or organization can do. It takes teamwork, collaboration and a sharing of skills, experience and information

Box 50 illustrates how this worked in developing an international drug price study that has provided comparative information to help make drugs more affordable and accessible.

Developing advocacy and networking activities is covered in more detail in Chapter 7.



BOX 50. BUILDING LINKS TO CHANGE POLICY

Medicine prices vary considerably within countries and from country to country. The same medicine may have a different price in its originator or generic form, from a public agency, a charitable agency or from a private pharmacy. This makes it impossible for people to know what is the best buy and where to find it. If consumers find this difficult, so too do government supply agencies. Reliable information on prices, price differences and the factors contributing to the final cost of a medicine are essential if governments and other purchasers are to find ways to make medicines more affordable.

How can this be done? Because pharmaceutical prices are complicated, only by collecting data in a systematic way is it possible to be able to compare across products and countries. To do that, WHO and the Health Action International (HAI) network joined forces to pool their skills and resources to develop a simple, but effective methodology that could be used by consumers, by academic researchers, by health workers, and by government officials to capture and analyse medicines data in their own countries in a way that would also allow for cross-country analysis. It is explained in a manual and workbook: *Medicine Prices: a new approach to measurement*.

Thirty core medicines were selected – those with very widespread use which makes them needed in most countries. For each medicine, the core list contains one dosage form, one strength and one recommended package size to facilitate standardization and to ensure as few sources of error as possible. Field studies were undertaken in nine pilot countries to test the approach and to gain experience of collecting the data. Once the field data have been collected, they can be entered into specially designed spreadsheets which are part of the manual. Several key analyses are then produced automatically.

An important outcome of the collaboration has been the identification of many of the hidden costs of medicines – these can include government-imposed taxes and duties, which in the nine pilot countries added an average of 68% to the price of medicines. In essence, governments were charging themselves tariffs for public sector health goods. This information provides insights into options for changing policies that can reduce the procurement costs for essential medicines.

Sources: WHO, 2003. *Medicine prices*. Special Supplement. *WHO Essential Drugs Monitor* No. 33. And WHO/HAI 2003. *Medicine prices: a new approach to measurement*. Geneva/Amsterdam, World Health Organization/Health Action International.

Managerial and regulatory strategies

Now in an age of changing realities, the introduction of new antiretroviral drugs is posing additional managerial and regulatory challenges. The experience of introducing antiretrovirals in the Khayelitsha township in South Africa highlights many of the challenges that need to be faced. (see Box 51).

BOX 51. DEMYSTIFYING ANTIRETROVIRAL THERAPY IN RESOURCE-POOR SETTINGS

In recent years, the drop in cost of antiretroviral therapy has shifted the debate on the best way to deliver these drugs, particularly in severely resource-constrained environments. In a poor township 30 kilometers outside Cape Town, South Africa, Médecins Sans Frontières set out to grapple with this challenge. Khayelitsha has around 500,000 inhabitants – 50% are unemployed and more than 70% live in shacks. HIV seroprevalence rates at antenatal clinics are above 24%, having risen with shocking rapidity over the past 10 years.

The provincial government of the Western Cape decided to launch South Africa's first government-run programme to prevent mother-to-child transmission (MTCT) of HIV in Khayelitsha. Zidovudine (AZT), first became available in the township's two maternity wards in early 1999, and the programme has subsequently become one of the continent's biggest, with more than 20,000 women having accepted testing, and over 3,000 having received antiretroviral therapy. Médecins Sans Frontières began supporting this MTCT programme in 1999, before opening clinics to offer treatment to the mothers, their infected children, and others with HIV from the broader community at three government primary health care centres in April 2000. Despite catering solely to those with HIV, the centres were called 'infectious disease clinics', out of a fear that labelling them HIV clinics would generate stigma and deter people from accessing services. This concern turned out to be entirely misplaced, as the community quickly branded them AIDS clinics, and nonetheless the queues steadily lengthened.

Treatment was initially limited to opportunistic infections – the conditions that arise with increasing frequency as HIV erodes the immune system's capacity to ward off infections. But in May 2001, this was broadened to include antiretroviral therapy, making the project the first to use antiretrovirals in government health facilities outside the context of clinical trials.



This step was motivated by both humanitarian and public health principles: despite receiving quality care and prophylaxis for opportunistic infections, patients were getting sick and dying at unacceptable rates and so needed access to the only drugs that have been proven to suppress HIV infection and thus extend life. Further, there was a clear need to develop models for the delivery of antiretroviral therapy in South Africa. Thus the project was intended to demonstrate that the use of antiretroviral therapy at primary health care level was feasible, affordable and replicable.

Impressive survival rates

Preliminary analyses recently presented at the XIV International AIDS Conference in Barcelona provide strong indications that poor black women and men can indeed derive considerable benefit from antiretroviral therapy without undue toxicity. One hundred and eighty patients have been placed on this therapy, selected from among the 3,000 patients who have attended the MSF clinics in Khayelitsha (details of the selection process are given below). These patients were extremely sick when they began therapy, having a median CD4+ T cell count of 43, with as many patients initiating therapy with under 10 CD4+ T cells as above 100. In contrast, a typical CD4+ T cell count in a seronegative person would be in the range of 800–1200, and it is well-established that the risk of death increases significantly as the count drops below 50. Thus if untreated, the prognosis of this group of patients would be extremely poor, with death within a year the sad reality for most.

Continued

Box 50 continued

However, on antiretroviral therapy, their survival was impressive. After nine months of treatment, 88% of the patients were alive. The reason for this dramatic improvement is simple: patients with immune systems weakened by HIV infection are prone to get sick with infections that people with healthy immune systems can normally fight off. On antiretroviral therapy, the rates of these opportunistic infections were significantly reduced. The reduction was particularly striking for tuberculosis, which is one of the major killers of people with HIV and AIDS in South Africa. Reduction in opportunistic infections is largely attributable to the considerable improvements seen in immunologic status. After six months on therapy, the mean increase in CD4+ T cell count was 143. This meant that while 54% of patients had below 50 CD4+ T cells at the start of therapy, only 2% were still below this level after six months; in contrast, none were above 200 at baseline, while at six months 53% had climbed above this important threshold. Interestingly, even patients with severely compromised immune systems at initiation of therapy experienced large improvements after beginning antiretroviral therapy.

These improvements were possible because antiretroviral therapy effectively suppressed viral replication in the large majority of patients, thus allowing the immune system to recover, instead of having to concentrate its energy on fighting off HIV infection. This success was evident whether measuring using the gold standard, of undetectable levels of viremia (less than 125 copies in the test available) or using a higher level that some have suggested is more appropriate to developing country contexts.

These encouraging results occurred with very few serious adverse events. There were no deaths related to drug toxicity, and while 46% of patients reported at least one side-effect, most of these were minor, scoring only a 1 or a 2 on the AIDS Clinical Trials Group grading of adverse events, with 1 being the most mild and 4 the most serious (64% were grade 1, grade 2: 19%, grade 3: 11% and grade 4: 6%).

Three key factors

In analysing the programme's success to date and assessing the possibilities to use it as a model in other settings, three key aspects stand out.

First and most fundamentally, the drugs must be affordable. In this case, it meant beginning with brand-name drugs which, although considerably cheaper than in developed countries (or, indeed, in South Africa a few years earlier), were still much more expensive than generic versions produced in countries such as Brazil, India and Thailand. These alternatives were not registered in South Africa, but after authorization to use Brazilian generic antiretrovirals was received from the South African Medicines Control Council, a change to Brazilian drugs has allowed twice as many patients to be treated.

The second key to success was the involvement of the community. This was facilitated by giving all treatment at primary health care level, rather than at a large referral hospital. Additionally, the community was integrally involved in the process of selecting patients for therapy, which played a major role in guaranteeing local ownership over the project as a whole.

Finally, the involvement of the patients themselves has been essential. They are genuine partners in the project at a number of levels:

- At the political level, when politicians have questioned the validity of using antiretroviral therapy in resource-poor settings, it was the patients who responded, writing letters to newspapers and speaking out in the media.



Continued

Box 50 continued

- At the community level, they play an important role in the support groups run for patients on antiretroviral therapy, with those who have been on therapy for longer periods of time helping mentor those beginning. Also, a number of patients work with a South African NGO, the Treatment Action Campaign, on a major community education initiative.
- At the individual level, patients have educated themselves on the importance of adherence, allowing them to take responsibility for their own therapy, making it unnecessary to use medical staff to observe them taking their pills (see further details below).



The lessons

The project has revealed a number of important lessons: First and foremost, antiretroviral therapy can be safely and effectively used in resource-poor settings, and the time has come to scale up from pilot projects to widespread access. Managing patients on antiretroviral therapy is often easier than managing patients not taking antiretrovirals. Patients in advanced HIV infection are frequently ill with a variety of opportunistic infections, many of which are difficult to diagnose and treat, particularly at a primary health care level. In contrast, patients on antiretroviral therapy typically experience rapid improvements in their health, and, particularly after the first few months on antiretroviral therapy (when the bulk of side-effects occur), they can be followed by nurses. In Khayelitsha, this was facilitated by the development of standardized tools to assist in the assessment and management of adverse events.

The availability of antiretroviral therapy bolsters the entire health system. South Africa and many other sub-Saharan African countries are experiencing a major loss of medical staff, in part as a result of poor working conditions and low morale engendered by the enormous influx of patients with HIV, many of whom are dying, despite the best efforts of the staff. When antiretrovirals are available, the staff's role shifts back from care of the dying to being able to help patients return to good health, with an obvious improvement in morale. Additionally, access to antiretroviral therapy provides an important reason for patients to stay in the medical system: in Khayelitsha, not a single patient on antiretroviral therapy has been lost to follow up, in marked contrast with the general experience in this highly mobile township. Finally, the significant decreases in opportunistic infections (and the resultant need for hospitalizations) suggest that those who argue that antiretroviral therapy is unattainable, based on crude calculations of the cost of drugs, are missing a fundamental aspect of the provision of antiretroviral therapy. This is that a considerable percentage of the costs incurred by drug purchases can be offset by drops in hospitalizations and opportunistic infections. This has been demonstrated in Brazil, and is quite likely to be true in South Africa, a country that spends an estimated R4 billion (approximately US\$400 million) on care and treatment of people living with HIV/AIDS. Research is ongoing in Khayelitsha to quantify the magnitude of this offsetting effect.

Finally, in contrast to those who argue that treatment and prevention are inextricably opposed and competing for resources, in Khayelitsha the synergy between treatment and prevention has been striking, with the availability of treatment providing a powerful incentive to learn one's status. It was thus no surprise that a recent survey of nine sites around South Africa found that Khayelitsha had the highest rates of HIV testing, and desire to be tested among those who had yet to be tested, as well as the highest levels of condom use.

Selecting patients for antiretroviral therapy

Patient selection is one of the more difficult aspects of setting up a programme, as the need inevitably outstrips the supply of drugs available. However, it is important to note that, contrary to popular perception, not all people with HIV should immediately be placed on antiretroviral therapy. In Khayelitsha, the biological and clinical criteria used to select patients include:

- a CD4+ T cell count of less than 200, and a WHO disease stage of 3 or 4, both in line with WHO's guidelines on antiretroviral therapy in resource-poor settings;

Continued

Box 50 continued

- patients must live in Khayelitsha;
- patients must have regularly attended the clinics for at least three months (instituted in light of the highly mobile nature of Khayelitsha's population).

These requirements, plus the fact that some patients chose not to take antiretroviral therapy, mean that the number of patients who were ultimately candidates to be started on therapy has not overwhelmed the resources available. Nonetheless, a system was introduced that involved the community in the process of selecting patients. A number of community representatives – typically people with experience with people with HIV (and including those with HIV themselves) – met regularly to assess candidates and determine who would ultimately be placed on therapy. Deliberations are based on a number of factors, such as the health of the patient, income level, the social support available to the patient and her/ his openness about HIV infection, and if other members of the same family are already on antiretroviral therapy. Although the process is time-consuming, it has proven a valuable way to fairly and equitably allot spots in the treatment programme, as well as an important means of ensuring community ownership over the programme.

Patient-centred approaches to adherence

The issue of how to ensure that antiretroviral therapy is taken regularly and appropriately has generated considerable discussion and controversy. Some even suggest that the use of antiretroviral therapy in poor countries will only lead to the widespread development of resistance. They advocate either that resources are not put into making the drugs available or that they are only administered under strictly controlled conditions, such as in the presence of medical staff (along the lines of the DOTS model for TB, although the comparison is complicated by the greater frequency of dosing of antiretroviral therapy and the fact that it is life-long rather than of a limited duration). However, in Khayelitsha, an approach centred on educating patients and empowering them to be actively involved in the treatment programme has yielded very positive results. This begins with the careful selection of a regimen that is easy to take – for example a combination of nevirapine and co-formulated AZT/3TC, which amounts to two pills twice a day – and setting the health care facilities within easy reach of the patients (for example, at primary health care level). Once patients begin therapy (after an educational process), a tripartite programme supports adherence:

- Individual support is provided in the form of trained counsellors available during clinic hours to answer questions, and, more informally, through “treatment assistants,” a household member or neighbour whom each candidate for therapy is requested to identify as being able to provide support on adherence;
- Peer support comes in the form of support groups run solely for patients on antiretroviral therapy, and which serve both as valuable spaces for patients to discuss barriers to adherence with others sharing similar experiences and as a forum for ongoing education;
- Educational materials are provided to help patients fully appreciate the risks and benefits of antiretroviral therapy, and understand the importance of adherence.

Research is ongoing to quantify the levels of adherence, but the dramatic improvements in the surrogate markers of changes in viral load and CD4+ T cell counts strongly suggest that adherence is good.

Source: Kasper T et al. Demystifying antiretroviral therapy in resource-poor settings. WHO Essential Drugs Monitor No.32, 2003.



This detailed case study demonstrates the importance of combining community mobilization, focused individual patient care, and efficient management to ensure drug availability and a change in regulations to make Brazilian generic ARVs available. This combination of approaches and levels has ensured success.

Managerial and regulatory strategies are dealt with in more detail in Chapter 8.

Overall, these three areas help to develop enabling environments where dialogue about the importance of essential drugs, suggestions on how to ensure availability and access to drugs, and discussion about how to use them wisely and appropriately become the norm.

6

Working with journalists

Journalists can be powerful partners in communicating about rational medicine use and are an important gateway to the mass media. The mass media have a great impact on people's attitudes and knowledge about medicines. Newspapers, TV and radio can be used in various ways; for instance to strengthen and reinforce public education campaigns, to disseminate information, or to put an issue on the political agenda. On the other hand, stories spread through mass media can cause unnecessary alarm or can undermine efforts to promote rational drug use.

This chapter discusses how to work with journalists, as part of a communication plan to achieve particular communication objectives as well as to create an enabling environment where dialogue around rational drug use issues becomes more commonplace. Practical skills needed to cooperate effectively with journalists are identified and discussed.

This chapter will help you to:

1. Understand the role which journalists can play in activities to address drug use problems in communities
2. Be aware of key principles that strengthen cooperation and partnership with journalists
3. Be aware of your rights when giving information to journalists
4. Understand how to write a press release and organize a press conference.

Journalists are professionals working with a variety of different media and at all kinds of levels ranging from local radio/community newspapers to international media. Good journalists deserve our respect and can be important partners. Their freedom to write and express themselves is an important indicator of good governance and democracy.

They can also be very vulnerable in situations where press freedom is not respected. In 2005, there were 150 known cases in which journalists were killed in the course of their work, 89 of whom were targeted and singled out for their professional work, according to the International Federation of Journalists.



This Chapter concentrates on how to work with journalists. However, in recent years the use of the Internet has created a mass media which is directly accessible for consumer and public interest groups. Some attention is given to writing press materials directly for electronic distribution.

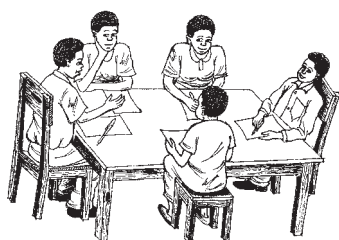
Journalists' role in promoting rational drug use

Depending on your relationships with them and on how you brief them, journalists can:

- be important and informed advocates on health issues;
- help you to get information across effectively;
- undermine or misinterpret what you are trying to communicate.

Chapter 5 looked at different types of media and at some of the advantages and limitations of working with the various types. Your work may involve:

- different media (TV, radio, print, Internet);
- different audiences (local, national, international, lay, professional, poor, vulnerable, disadvantaged groups, women, men, old and young);
- different reasons for working with the media (informing the public, changing attitudes, agenda setting, influencing policies).



If you plan to use the media extensively as part of an intervention on rational drug use, you should involve journalists in your plans at an early stage. You might be able to include helpful journalists in an advisory committee. You could also consider holding special workshops for journalists on drugs and drug issues. If you work in a place where you need to communicate regularly with the public, establishing good relationships with well-informed journalists is a good investment.

Effective use of the media

There are some key principles that will help you to work well with the media and to form useful partnerships with journalists in your work to promote rational drug use. You need to consider the situation and the context in which you are likely to be working to identify how to apply those principles in your situation.

These principles include:

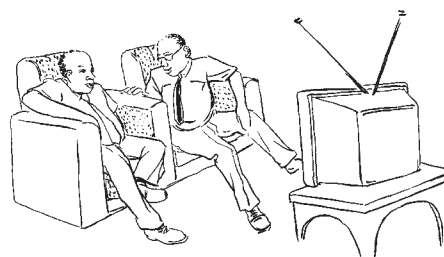
- knowing your media and the role it plays in the society in which you are working;
- focusing on your common goal;
- knowing your own message, what it is you want to communicate;
- being accurate and clear;
- making the issue accessible and interesting;
- facilitating the journalist's work;
- developing and maintaining personal contacts and partnerships.

Finding the right media for your topic

The role of the media in your work will vary enormously in different settings. In rural areas there may be very limited access to mass media. Try to assess which medium will reach your intended audience. In rural areas newspapers may be scarce and literacy rates may be low.

Find out whether or not people have access to television or radio and if they are commonly used. In urban areas the influence of mass media is likely to be much greater and people may be exposed to a wide range of media influences.

Check to see if there are listener surveys or readership surveys, which can give you an idea of who relies on which medium. This will help you to plan and will also give you credibility with journalists who will appreciate the fact that you have done your homework.



Focus on your common goal

Develop a partnership with the journalist you are working with on an issue. Each of you has important – but incomplete – skills to make the story. The role of the journalist is to make complex information understandable and to make it relevant to readers. Your role is to explain clearly what you want to get across and why. **Your common goal is to inform the public.**

Box 51 describes how a Ugandan science journalist sees the importance of communicating on health issues.

BOX 51. GOOD REPORTING CAN BE A MATTER OF LIFE AND DEATH

Patrick Luganda, is a science journalist in Uganda and chair of Climate Journalists of the Greater Horn of Africa. He told participants at the 8th meeting of the International Network on Public Communication of Science and Technology (PCST) that journalists have different roles in different countries. 'Many times the information we publish about a medical subject in our newspaper, the most read in Uganda, can make the difference between life and death.'

Source: International Network on Public Communication of Science and Technology <http://www.pcst2004.org/ing/conclusion.html>

Know your information and audience

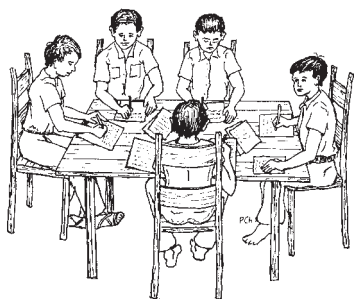
Make sure that it is clear why you are seeking the attention of journalists. Which listeners/readers do you want to reach and why?

- You may want to get a simple message directly to the public warning them of potential hazards of a particular drug or information encouraging appropriate use of drugs.
- You may want to put pressure on a pharmaceutical company to change its pricing policy or to stop inappropriate advertising.
- You might aim to influence the plans of politicians or stimulate discussion about policy.

Knowing who you want to reach and why will help you to decide which channels to use and which journalists to contact.

Accuracy and clarity

The information you present should be clear, accurate and unambiguous. Carefully check all the information sources available to you. Ambiguities can be dangerous and can harm people's health. Inaccurate information will also lead to a breakdown of trust between you and your press contacts.



Retractions or corrections lead to confusion and embarrassment and may lead to dangerous misunderstandings. They can also have legal consequences.

Issues that seem obvious to someone who works in the pharmaceuticals area may not be obvious to a generalist journalist or to consumers reading or hearing the story. Box 52 shows part of a press release from Health Action International calling for a worldwide withdrawal of a particular *indication* or use of a drug which was misunderstood by some journalists. They thought that the demand was for a worldwide withdrawal of the drug, rather than an end to its use as a lactation suppressant. These stories had to be corrected as the drug has other uses, for example in the treatment of Parkinson's disease.

Accessibility and interest

It is not always easy to make interesting news out of issues concerned with rational drug use. It will be easy to get journalists to pick up on a 'drug disaster' story or a story about 'drug dumping'. It may not be so easy to make a good news item out of less sensational material.

News can be news because it is:

- unique
- topical
- relevant to the reader
- surprising
- interesting
- controversial
- emotionally pulling.

It does not have to be all of these things, but if it is none of them it is not newsworthy. People have to be able to relate to the issue and to understand it. Always

BOX 52. EXTRACT FROM A HEALTH ACTION INTERNATIONAL (HAI) PRESS RELEASE

Sandoz stops selling bromocriptine to suppress lactation in the United States; Consumer network calls for action

On 18 August 1994 the pharmaceutical company Sandoz announced withdrawal of the indication of lactation suppression (stopping production of breast milk after childbirth) for Parlodel (bromocriptine) in the USA. Sandoz's move came a day after the US Food and Drug Administration (FDA) announced it intended to withdraw approval of this indication and two days after the US consumer advocacy group Public Citizen sued the FDA because of their five-year delay in banning this indication.

... "the fact that the company is still not willing to withdraw the lactation suppression indication world-wide should be a stimulus for consumer groups to immediately contact their regulatory authority asking for removal of this indication" said a spokesperson for Public Citizen.

To avoid misunderstandings you can suggest to the journalist that you read the story before it is printed or listen to or watch the programme before it is broadcast.



ask yourself why you think it is important for people to have the information you want to get across and what would make them want to read the story or listen or watch the broadcast.

You may be able to make it interesting by:

- highlighting the economic implications
“prescribing of obsolete drugs costs the health service US\$25 million a year”
- emphasizing human interest
“Sharon Mukuka began taking ARVs in June 2004 and since then has been able to return to work and help support her family.”
- stressing public health risks
“Will there be any effective antibiotics in 2020? This is the question posed by the official report into overuse of antibiotics and the spread of resistance”
- getting the support of an important or popular personality
“national football team coach appeals to youth not to use bodybuilding drugs in school sports”.



You can also aim to work with longer feature articles or to contribute to health sections or health programmes. Here the emphasis can be on useful information and news value is less important. But the material still has to be appealing and relevant to the reader/listener.

Facilitate the journalist's work

Journalists are busy people working with deadlines. They do not want to be spoon-fed but they will appreciate it if you anticipate their need for additional information, data to back up your stories, referrals to other key informants and quotes from relevant authorities. Sort out your facts and your story so that you can present it in a convincing way. You can prepare fact sheets summarizing the most important information or use case studies to provide additional information. You can also identify other people who can back up or expand on your story or who can provide personal testimony.

Develop and maintain personal contacts and relationships

Find out which reporters in different media work on health issues. If possible get to know the journalists you want to work with and through. Personal contacts are important. A journalist who knows you, trusts you and understands or supports your work is an invaluable ally. If possible build on contacts and maintain them.

Try to make sure that the journalist deals with the same person from your side – but do not let the contact become so exclusive that you are left without press contacts if the responsible person is sick or changes jobs. With a journalist whom you trust you can talk off the record – provide them with information in confidence for them to use for background rather than something that they can quote directly as coming from you.

The first contact is very important. It is important to make a good impression.



Are you pleasant to work with? Are you reliable and a good source of information? Respect the professionalism of the journalists you work with and give positive feedback.

A good story is often the result of a partnership between the journalist and you as the person with information about medicine use. The journalist may have a different idea about how to get your information out to the audience than the one that you presented. Listen carefully to the ideas – remember, it is the profession of a journalist to communicate well with his or her audience. If the journalist can do it his or her way, and build a story around the information you present, the journalist probably will be more motivated and do a better job.

Organizing formal press contacts

If you have good personal contacts value and foster them. But you will often need to rely on more formal channels to get the interest of journalists. These formal channels include press releases, press kits and press conferences.

BOX 53. CREATING EFFECTIVE PRESS RELEASES

Any press release should contain certain basic information in the first few sentences:

- What is happening?
- Who is doing it?
- Where and how is it happening?
- When is it happening?
- Why is it happening? (What are the expected outcomes or results?)

These are the classic five Ws of journalism. Your press release may not need all five – but often they are all needed to tell the story well. The rest of the press release should tell your news in an interesting and coherent way, giving all the relevant information and stating whom to contact for additional information.

Paying attention to a few basic style rules will keep your release lively and interesting. The following style rules would be commonly applied in English language press releases – but they may vary in different settings and languages. The crucial question is to find out what is needed by the journalists you hope to interest.

- Use active verbs rather than passive ones. (“The FDA withdrew the drug x” **not** “the drug x was withdrawn by the FDA.”)
- Use short sentences.
- Be positive rather than negative if you have a choice.
- Avoid abbreviations, bureaucratic language and jargon.
- Use quotations and examples – they help to bring a story to life.
- Be clear and to the point.
- Be brief.

Check which of these rules would also apply in the setting in which you work.

A press release should be clearly recognisable as such. It should be dated and if you wish to use an embargo (a set release date and time) this should be clearly stated at the top of the press release. Number your pages and keep the full text within one or maximum two pages. Releases that are much longer suggest that you are not sure yourself what is the real story.

Leave wide margins and a lot of space as journalists and editors like to write on the press release. If possible, use double-spacing for easier reading.

Always put the name and contact details of the person who can be contacted for further information at the bottom of the press release.

Press releases

Press releases are short, concise statements that announce news. Box 53 provides a few tips on how to produce press releases that are more likely to be used by journalists.

Press pack

A press pack can supplement a press release and can be particularly useful if you are launching a major campaign. You may also find that you can make use of press packs issued by others to provide key health facts and figures. The purpose of a press pack is to help the journalist to make a full, detailed news item without doing a lot of additional research. It can take the form of a folder containing information relevant to your story. It may contain information about your organization, copies of speeches, and more detailed facts and figures. Do not put too much material into a press pack and make a clear list of contents. See Box 54 for an example of a press pack developed by Health Action International for one of its publications. You can also make an effective online press pack by referring to websites where journalists can find additional information or graphics.

BOX 54. CONTENTS OF A HAI PRESS PACK PROMOTING THE PUBLICATION PROBLEM DRUGS

This press kit contains:

- a press release
- a flyer for Problem Drugs
- six feature-length articles
- facts, figures and quotes
- eight illustrations
- information about HAI

Press conferences

When you hold a press conference, you invite the media to come to a place of your choosing to report on an event or issue. You should only organize a press conference if you have subject matter which is sufficiently interesting for them. Examples of this includes the launch of a major report documenting unethical promotion of medicines, the release of new research to show drug prices are unnecessarily high, or the presentation of evidence by patients and consumers about the adverse effects of a particular medicine. Box 55 provides some tips for developing a successful press conference.

Get online

The growing popularity of e-mail and the Internet has had a huge impact on how news is spread. If you have access to e-mail and the Internet these are very effective ways to get your press materials out quickly, efficiently and with relatively little cost. Box 56 explains how to write a press release for e-mail distribution.

Increasingly, journalists are using the Internet as a quick way of getting information for stories or for checking details. In Africa, for example, information centres working on HIV and AIDS issues in Ethiopia, Kenya and Nigeria have been providing training and free access to the Internet for local journalists.

Media's possible negative effects

Journalists play an important role in shaping people's awareness of drugs. This is not always a positive one. Journalists are often used to promote drugs directly and indirectly and the pharmaceutical industry is adept at using journalists to get its messages across. Through the effective use of pre-launch publicity and well-organized press releases and press conferences, companies are often able to

BOX 55. HOW TO ORGANIZE A SUCCESSFUL PRESS CONFERENCE

Choose a time and location which is convenient for journalists

- schedule the press conference with enough time afterwards for the journalist to write an article or prepare a TV or radio piece before their publication or news broadcast deadline;
- choose a place which they can find easily;
- you may find that lunchtime is a good time – but then provide something to eat and drink.

Get your invitations out to the right people on time. If possible follow up to check that your key 'targets' are coming.

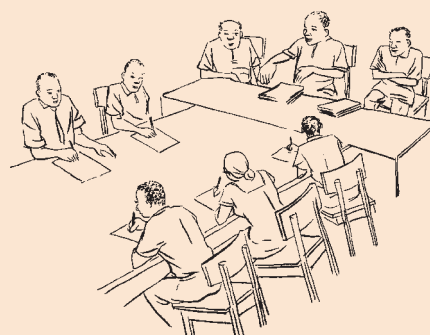
Be properly prepared

- have a press release ready before the press conference starts and hand it out before the event begins;
- have information about your campaign or your organization available;
- have supporting visual material available if possible.

Choose your speakers carefully

- you should have a chairperson who introduces speakers and runs the conference;
- speakers should be interesting and knowledgeable and limited to no more than 2 or 3;
- if possible, they should practise what they are going to say before the press conference;
- make sure all speakers talk briefly (no more than 10 minutes) so that there is plenty of time available for questions.

A press conference usually lasts no more than an hour.



Make sure you know who has attended

- get the names and addresses of all the reporters who attended;
- try to talk to some of them individually;
- this will help you to develop your press list and personal contacts.

create a high degree of awareness about a product before it is even registered. They can even use this publicity to put pressure on regulatory authorities to speed up a drug's approval. Nowadays new drugs are often launched globally rather than initially in one country. This trend together with the growth of electronic communication means that an effective press campaign can get a new drug into the world's newspapers in a matter of days. The launch of Viagra shows how demand for a new drug can be created on a world-wide scale in a very short period of time.

There are no formal or informal guidelines to help journalists ensure that they are not used to promote drugs and to help them maintain the scientific quality and independence of their reporting (see Box 57 for some suggestions). This means that there is a large variation depending on the integrity and knowledge of the journalist, the effectiveness of those providing independent information and on editorial policy.

Consequences of poor communication

You may get bad press. This may be a result of poor preparatory work on your part. You may have a poor communications strategy or you may have alienated a key reporter. You may be working in an area in which important conflicts of

BOX 56. HOW TO WRITE AND FORMAT A PRESS RELEASE FOR E-MAIL DISTRIBUTION

E-mail press releases are usually shorter in length than their print counterparts. The majority of electronic news releases sent are 500 words of text organized into five, short two to three sentence paragraphs. And if you want them read, make sure the subject line conveys the main point of the press release.

E-mail software allows the user to set limits on the size of messages it will download. Since many individuals do not change the default limit on their e-mail software, long messages can be blocked.

Don't ever send a press release (or anything else) to a journalist as an attachment. Journalists usually prefer not to receive photographs and supplemental information files through e-mail attachments. This is because a) they prefer simple press releases in e-mail text and have trouble downloading and decoding attachments and b) because attachments carry much more risk of infection with viruses which means that some companies screen them out altogether. So check in advance if you plan to send electronic attachments.

If you have a lot of additional information such as photographs, reports or studies, and other supporting documents that might usually included in a printed media kit, put them on a website and include the website address (URL) in the press release.

Some reporters have limited on-line access. As a courtesy, always include a contact method for reporters who prefer to have materials mailed to them by conventional means.

Information to include in an electronic news release:

- a compelling e-mail subject header and headline
- first paragraph that covers the five Ws: what, who, where (and how), when and why
- electronic contact information including an e-mail address for the press contact and website address. Reporters working on deadline will often choose to call rather than wait for a reply by e-mail. Be sure that in addition to e-mail contact information a phone number for the press contact is listed and that the person is going to be available
- a short paragraph at the end of the release containing background information about the organization.

Story tips

Electronic public relations (PR) does not differ from conventional PR in that one's ability to write and organize information well is rewarded with press coverage. A creative subject header for your message and a clever 'spin' to your news will help to capture attention.

Many journalists respond to clever writing and news releases that describe a solution to a problem.

Pointing to a new consumer or health trend is another way to position a story.

Electronic press release delivery is an excellent tool when a story is only going to be newsworthy for a short time period.

(adapted from: <http://www.xpresspress.com/PRnotes.html>)

BOX 57. JOURNALISTS' STRATEGIES

Some journalists develop their own strategies for confirming the accuracy of claims or trying to bring balance into their stories. These strategies include:

- being sceptical of claims in company press releases;
- checking information with doctors, patient or disease groups or other sources;
- consulting rival drug companies;
- consulting medical reference books; and
- checking to see if a drug was included in a national or provincial formulary.

interest are present – such as where a research team’s future funding depends on presenting current research as successful and innovative when it may not be – and powerful economic interests are against you – such as a large pharmaceutical company that stands to lose sales and profits if a story comes out that its leading drug is not effective.

You can be subtly undermined in a variety of ways. Here are just a few examples:

- Disparaging attitude:
“but surely **even the consumer movement** would have to admit ...”
- Sexual or racial bias:
“When the Minister had finished his opening address the conference floor was taken by consumer representative, attractive mother of two, Edwina Ruddite.”
- Hidden bias:
“the industry spokesman **said** that ... the community spokesperson **alleged** ...”
- Biased descriptions:
“Activists claiming to represent consumer interests”



If this is the way in which your activities are being reported then you have to work to improve the negative view which the press has of you. But even if you feel you are not being well-treated you should hold your ground and stay polite.

Losing your temper during a press conference, or during an interview, is unlikely to be an effective way of making your point, and it will not help your relations with the media.



Legal issues

Legal action can be embarrassing, expensive and even dangerous. To help avoid it, here is a list of some key points to keep in mind. If you observe them you make yourself less vulnerable to legal or formal complaints.

- Be very careful that you do not unintentionally contravene the law or say something which might be considered slanderous. The same is true for written material.
- In some countries special formalities have to be completed before a press release is issued or a press conference organized.
- You should not use data which you cannot reference and substantiate.
- You should not quote people without their permission.
- If you are quoting from a source make it clear that you are doing so.

Your rights

Working with journalists calls for good communication and trust on both sides. Good communication is easier when you know what your rights are, and know what kind of professional rules and ethics the journalists are meant to follow. To protect yourself and your information, keep the following things in mind.

- If you agree to an interview with a journalist you have the right (according to professional ethical rules in most countries) to read through the text (or have it read to you on the phone) before it is published to check it for accuracy and to ensure that you have been quoted correctly. You have the right to ask for changes in how you are being quoted, but not in the commentary of the journalist (even if you disagree with his or her comments and conclusions).

It is a good idea to say that you want to do this before you agree to the interview.

- If you wish to make corrections do it tactfully and take some responsibility for misunderstandings
- Do not accuse the journalist of misrepresenting you (unless you have real reason). Focus on a good result not on hurt feelings.
- You do not have this right if you are appearing at a press conference – there you are fully “on the record” and anything you say can be quoted and may be quoted partially.
- You can ask a journalist to let you have in advance a list of the questions he or she wants you to answer. This is a particularly good idea if you feel that you are on unfamiliar ground or are unsure of the attitude of the journalist.
- To give a journalist important information, you may decide to talk ‘off the record’. This means that the information is only for them and should not be quoted. If you give information ‘off the record’ the journalist should respect this and not name the source. Make it very clear to the journalist that the information is off the record, and be careful about doing this with journalists you do not know.



“I did not express myself clearly here. What I meant to say was...”

Ethical issues

A journalist has certain professional and ethical responsibilities relating to accuracy of information, to privacy, and protecting sources. Consumer and community advocates also have a responsibility to provide accurate information, to act in the interest of the group they represent, and to respect the privacy of individuals. If in doubt you should raise difficult issues with colleagues or with an advisory committee.

The European Health Communication Network (EHCN) in association with the International Press Institute and the International Federation of Journalists has developed an ethical code for and by health correspondents (see Box 58). It is based very closely on a declaration of principles for the conduct of journalists approved by the International Federation of Journalists in 1954 and revised by its World Congress in 1986 (IFJ, 1986). You might want to share either of these with journalists, editors and media representatives in your country to see if something similar is in place or could be developed.

Summary

The main points in this chapter are:

- Form partnerships with key journalists: you share a common goal – to inform the public.
- Organize your information: be clear and accurate.
- Remember: Who? What? Where? Why?
- Think about what will interest your intended audience – don’t bore them!
- If you are going to be doing a lot of press work it is worth identifying a journalist who might be interested in helping you plan your media strategy.



You and the journalist have a common goal: To inform the public

BOX 58. EHCN GUIDELINES FOR PROFESSIONAL HEALTH CORRESPONDENTS

- First, try to do no harm.
- Get it right. Check your facts, even if deadlines are put at risk.
- Do not raise false hopes. Be especially careful when reporting on claims for 'miracle cures'.
- Beware of vested interests. Ask yourself who benefits from this story.
- Never disclose a source of information imparted in confidence.
- When dealing with individuals who may be sick or handicapped, and especially with children, be mindful of the consequences of your story. They will have to live with it long after you are gone.
- Never intrude on private grief.
- Respect the privacy of the sick, the handicapped and their families at all times.
- Respect the feelings of the bereaved, especially when dealing with disasters. Close-up photography or television images of victims and their families should be avoided wherever possible.
- It in doubt, leave it out.

Apfel F (2001). *Reframing the lifestyle and health debate: enhancing the impact of public health communications*. Paper presented at the XVIIth World Conference on Health Promotion and Health Education, Paris, France, 15–20 July 2001.

Additional reading

Below are some Internet sites which will provide interesting examples of press materials. You will also find sites which give specific tips on working with journalists.

International Federation of Journalists (1986). *IFJ Declaration of Principles on the Conduct of Journalists* <http://www.ifj.org/default.asp?Issue=ETHICS&Language=EN>

The Panos Institute provides materials and training to help journalists report effectively on health and development issues. *PANOS Briefing No. 36.(1999) Diagnosing challenges. Health and the new Millennium*. London: Panos. <http://panos.org.uk/PDF/reports/DiagnosingChallenges.pdf>

Further information about health and media is available at: <http://www.panos.org.uk/global/projectdetails.asp?ProjectID=1060&ID=1001>

Internews trains journalists how to report on health issues in countries in Africa, Asia and the former Soviet Union. <http://www.internews.org/activities/health/default.htm>

The Health Action International website deals more specifically with health and drugs. <http://www.haiweb.org>

International organizations such as WHO and UNDP produce highly professional press briefing materials to accompany publications, for example, the World Health Report and the Human Development Report. It is worth looking at these on their websites. <http://www.who.int/> and <http://www.undp.org/>

There are various sites which offer writers guides. These are not specifically geared towards health and development issues but contain useful tips. Some of them deal specifically with how to use the Internet and e-mail to disseminate press releases. <http://www.xpresspress.com/PRnotes.html>

Beamish J, Vella J (1993). *Developing health journalists. A training manual for improving news coverage of reproductive health*. Research Triangle Park, USA, Family Health International.

Owens B, Klaudt K (1999). *TB advocacy. A practical guide*. Geneva, World Health Organization. <http://www.who.int/docstore/gtb/publications/TBAdvocacy/index.htm>

Jempson M (2005). *Working with the media*. Brussels, European Public Health Alliance. <http://www.whcaonline.org/publications/>



Advocacy and networking

Effective advocacy and networking can be important factors in determining the success and sustainability of interventions on rational medicine use in communities. Collaborating with partners, working to gain and maintain political will, the timely and effective use of expertise, and exchanging experience and information are important in achieving success. This chapter looks at the importance of collaboration and key principles of effective health advocacy. It then examines how networking can strengthen efforts to promote rational drug use and explores the work of a few specific networks.

This chapter will:

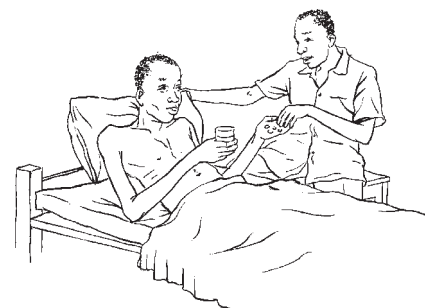
1. Outline key principles of effective advocacy
2. Highlight the importance of collaboration and networking in developing and carrying out strategies for drug use change.

Advocacy is about building a convincing case and getting it across to people who are in a position to influence, formulate or implement policy and affect the decision-making process. However, there is no single definition, as Box 59 demonstrates.

One of the main ways of defining advocacy is in terms of whether it is undertaken for, with or by those most affected by a particular situation. Advocacy may be seen as speaking on behalf of the voiceless (*representation*), encouraging others to speak with you (*mobilization*), or supporting the voiceless to speak for themselves (*empowerment*).

In dealing with access to medicines, it is worth asking whether the advocacy is being done by consumers or patients who lack access, by those consumers and patients together with a network of concerned NGOs or health workers, or by a group of organizations acting on behalf of those most affected.

Advocacy is crucial in shaping policy. Sometimes simply called lobbying, it can be seen as an improper or undesirable activity. In fact advocacy – carried out



Those who are sick often need others to speak on their behalf, until they get stronger, can be empowered, and can speak for themselves and their group.

BOX 59. WHAT IS ADVOCACY?

Advocacy is the process of using information strategically to change policies that affect the lives of disadvantaged people.

(British Organisation of NGOs in Development – BOND)

Advocacy is any effort to influence policy and decision-makers, to fight for social change, to transform public perceptions and attitudes, to modify behaviours, or to mobilize human and financial resources.

Global AIDS Vaccine Initiative (GAVI)

Advocacy is speaking up, drawing attention to an issue, winning the support of key constituencies in order to influence policies and spending, and bring about change.

WHO TB advocacy

The definitions below are all taken from an International HIV/AIDS Alliance toolkit on Advocacy in Action

“Advocacy is a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions.”

Adapted from advocacy skills-building workshop for HIV/AIDS, International HIV/AIDS Alliance, Zimbabwe, July 2001

“Advocacy is an ongoing process aiming at change of attitudes, actions, policies and laws by influencing people and organizations with power, systems and structures at different levels for the betterment of people affected by the issue.”

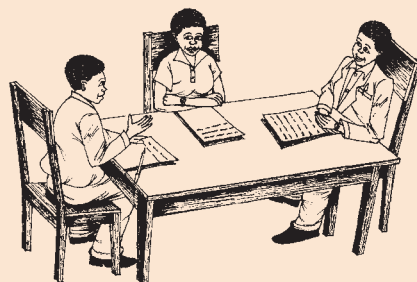
Adapted from an advocacy skills-building workshop, India HIV/AIDS Alliance, India, November 2002

“Advocacy is an action directed at changing the policies, positions and programmes of any type of institution.”

An Introduction to Advocacy, Training Guide, SARA Project

“Advocacy is pleading for, defending or recommending an idea before other people.”

An Introduction to Advocacy, Training Guide, SARA Project



in an ethical and honest fashion – is fundamental to democratic decision-making. Effective advocates work to inform decision-makers, to persuade them, sometimes to support them and create support for their policies, and occasionally to shame them into action.

In the health and pharmaceuticals field the role of consumer advocates is particularly important because powerful economic interests often conflict with the interests of patients and consumers. Consumer advocates provide a balance to the debate and help to defend patients' and consumers' rights.

The importance of collaboration

Collaboration among those interested in promoting positive changes in the way medicines are used at community level is important because:

- it allows for strengths to be multiplied and greater impact achieved;
- it ensures that relevant skill, experiences and facilities are shared;
- it makes certain that limited resources are used in an effective way;
- it can help to make sure that mistakes are not repeated and that good ideas are promoted and adapted;

- it enables established and credible network partners to share learning, experience, skills and credibility which can benefit newer advocacy groups.

Consumer organizations and NGOs tend to have small budgets and they nearly always lack the resources necessary to launch expensive campaigns. In spite of their limited budgets they can exert a major influence through collaboration, the sharing of resources and the careful identification of allies and expertise.

Equally, health ministries in many countries often have limited budgets for education and communication activities or may find it difficult to act on their own to deal with difficult challenges around the rational use of medicines.

Alliances between different types of organizations and groups from different regions can be formed around specific campaigns and can have a powerful influence, as the example in Box 60 from Sri Lanka demonstrates. Here, the HAI Asia-Pacific network has been developing alliances nationally, regionally and internationally to reinforce its efforts on a number of rational medicine use issues.



Key principles of effective advocacy

If you aim to influence decision-makers there are some key principles, which almost always apply, whether you are involved in a local campaign or in international policy advocacy. These are:

- analyse the problem and define objectives
- identify and understand those you want to influence
- get to know the people you want to influence
- build a strong case
- identify allies who share your views
- identify and understand potential opponents
- develop a long-term plan
- take advantage of strategic opportunities
- monitor and evaluate your activities.



Analyse the problem and define your objectives

You need to be able to explain the problem and what you think needs to be done to tackle it. You should also set goals that will help you to monitor progress and measure the success of your activities. This may well require an initial period of background research, data gathering, consultation and preparation. This is time well spent.

For example Médecins Sans Frontières (MSF) launched its Access to Essential Medicines Campaign around three clear pillars:

1. Using public health needs to override trade agreements;
2. Overcoming access barriers;
3. Stimulating research and development for neglected diseases.

The Philippine Drug Action Network (see Box 66) selected five specific recommendations around which to campaign:

BOX 6o. PROMOTING RATIONAL DRUG USE AND ESSENTIAL MEDICINES: HAIAP'S ADVOCACY STRATEGIES IN SRI LANKA



Health Action International Asia Pacific (HAIAP), a network of organizations and individuals involved in health and pharmaceutical issues, sees health as a fundamental human right and aspires for a just and equitable society in which there will be adequate access to essential medicines to all those who need them.

HAIAP promotes the use of essential drugs, and advocates rational and economic use of drugs. HAIAP has formed a broad-

based partnership among health activists, academics, health ministry officials and media practitioners who volunteer their spare time to act as resource persons.

HAIAP also works on the formulation of a national health policy based on primary health care. It works closely with the People's Health Movement and uses the People's Charter for Health as a campaign tool.



National seminar on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement, the Intellectual Property Bill and Public Health

In response to a Supreme Court ruling which determined that the provisions in the Intellectual Property Bill were violating fundamental rights, HAIAP organized a seminar entitled *TRIPS Agreement, the Intellectual Property Bill and Public Health*. The seminar, which was attended by senior health and commerce officials, patients' rights activists and lawyers, proposed provisions for compulsory licensing and parallel importing. This was followed by a series of articles in newspapers urging the Government to include the proposed provisions. In December 2003, the bill was passed in Parliament and later gazetted with the incorporation of the provisions for compulsory licensing and parallel importing.

Regional consultation on the WTO/TRIPS Agreement and access to medicines: appropriate policy responses

HAIAP has been campaigning against certain provisions in the TRIPS Agreement related to patents, arguing that these provisions will have a negative impact on the availability of essential medicines in developing countries. In collaboration with the Third World Network, the Ministry of Health, and the World Health Organization, HAIAP organized a three-day regional consultation bringing together representatives of health and commerce ministries and consumer organizations from 18 countries in the region. The aim of the consultation was to discuss how WTO member states can develop national legislation on patents conforming with the TRIPS Agreement that protects public health. It also created an opportunity for HAIAP to lobby the policy-makers to crucially analyse the impact of TRIPS on access to drugs, domestic production, transfers of technology and regional trade, and to determine coordinated and appropriate policy responses. A manual entitled *Good Practices in Public Health Sensitive Patent Laws: Appropriate Policy Changes* developed by the Third World Network was launched to serve as a useful guideline for the formulation of new national legislation on patents.

Working with mass media

HAIAP presents briefing papers at national, regional and international fora organized by professional bodies, governments, regional and international organizations, academic institutions, consumers, and public health activist groups. These papers promote rational drug use and access to essential medicines and primary health care. Articles urging the Government to promote these concepts appeared weekly in one of the health columns of an English daily newspaper in Sri Lanka.

Continued

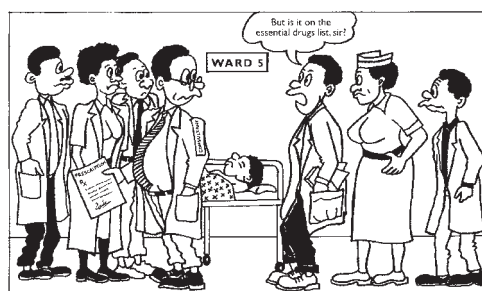
Box 60 continued

HAIAP publishes *HAI News*, a quarterly newsletter for its global network that provides a forum for HAI partners to share their experiences and learn from one another. It contains in-depth examinations and analyses of selected current topics relevant to health and pharmaceuticals. It also reports on developments in the international campaign to more rational and fairer health policies, and reviews selected publications that are of interest to health-related organizations.

Contact: HAIAP No. 5 Frankfurt Place, Colombo 4, Sri Lanka; Tel No: (94) 11 2554 353; Fax No: (94) 11 2554 570; Email: passanna@haiap.org

Source: *Health Alert*, Asia-Pacific Edition No 3, 2004

1. Adopt a national Essential Drugs List (EDL);
2. Encourage the use of generic names and limit the registration of new brand name medicines and 'me too' drugs;
3. Strengthen national drug regulatory authorities to ensure consumer protection;
4. Provide independent and objective information to health professionals and the general public on the rational use of medicines;
5. Initiate steps towards self-reliance in pharmaceutical needs.



Developing a clear statement of your objectives will help you to plan your strategy and prioritize key activities. It will also make it much easier for people to understand your campaign and its focus.

Identify and understand those you want to influence

When planning your advocacy work, ask yourself the following questions:

- Do you know who makes the decisions?
- Do you know the procedures by which they are made?
- Do you know the timing of the decision-making process?

For example, if you wanted to influence a bill going through parliament in your country you should try to find out who is responsible for drafting the law and who is advising them. You should try to get a clear idea of which committees, departments and outside bodies will be consulted. You need to know how many stages there are to the legislation (for example, first and second reading). You also need to know the timetable for these stages. Often a well-reasoned case presented at an early stage can achieve as much, or more, than an intensive advocacy campaign which is started after the basic decisions have been taken.

Get to know the people you want to influence

Do you have contact with them? If not, it is important to do some homework and to invest time in developing a list of key people and how to reach them. Analyse whether you need to concentrate on convincing technical experts (for example those involved in evaluating applications for registration) or policy-oriented people (for example, those who design drug registration legislation).

Do they know who you are and what your purpose is? You may need to spend time making appointments and developing and presenting simple materials such as



a position paper or a short briefing note that explains your objectives. Invite relevant people to address you and let them know that you think they are important.

Do they hear from you regularly? Once you have established contact keep it up. You should not pester people but you should let them know that you are serious

about the issue and want to work with them over a long period of time.



What can you do for them?

You can often establish your own credibility by advising or by being a good and balanced informant on issues. You may also be able to help get good press coverage for positive action. The relationships that effective advocates build up are often based on their expertise and their reliability.

Build a strong case

In the early 1990s, Health Action International published a Problem Drugs pack that included easy-to-read yet detailed information about a number of types of drugs that carried high or unnecessary risks for consumers' health. The pack provided groups around the world with the material they needed to launch effective campaigns to remove these drugs from the market. The well-researched pack contained numerous examples that could be quoted in press material and used in campaign statements. The abundance of up-to-date, factual information about these dangerous drugs made it difficult for critics to dismiss the campaigners' arguments.

Get your facts straight and organize your information. Exaggerated stories or inaccurate figures will be bad for your credibility and for your case. You will not be trusted if you give people inaccurate information. Also, be sure to:

- Anticipate counter arguments and help to answer them.
- Present useful facts and examples, which are relevant and easy to remember.
- Formulate goals, which are reasonable and realistic.
- Respond to criticism with positive suggestions for improvements.



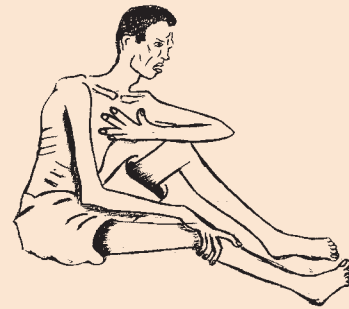
The international relief NGO Médecins Sans Frontières (MSF) often refers to a few key facts that illustrate why the organization launched its access campaign, see Box 61. Note that each of the facts is related to a situation that people face and that there is an emotional component that comes through in the way the information is set out. This helps to motivate people to see the urgency of the situation and the need to act.

Identify allies and experts who share your views

You need to show that others share your views. Try to identify allies from different fields and areas of influence. You may be able to collect signatures, to get other organizations to pass resolutions supporting you or to quote from positions adopted by recognized authorities, such as by quoting WHO publications or resolutions.

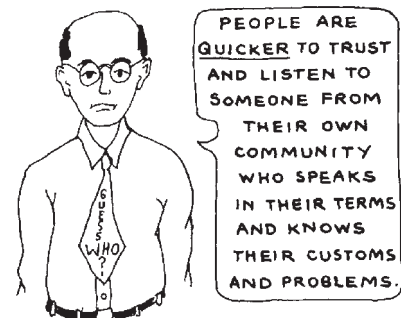
BOX 61. MSF ACCESS CAMPAIGN – KEY FACTS, 2000

- Nearly a quarter of patients under treatment for tuberculosis (TB) in Siberian prisons are dying because they do not have access to expensive, second-line, TB treatments.
- People with AIDS-related meningitis in an MSF-supported Nairobi hospital are being told to go home and die because the price of the only effective treatment is beyond their means. Patent protection keeps the price high (one day's treatment costs US\$ 20 per day in Kenya compared to US\$ 0.70 per day in Thailand, where it is not patent protected).
- In Uganda and Sudan, MSF volunteers are outraged at lack of access to a life-saving medication for sleeping sickness, a fatal, neurological disease endemic in Africa. Production of the drug, DFMO, has been abandoned by the manufacturer because it did not offer enough financial return.



You should try to identify experts and opinion leaders who will make a statement in support of your views. Doctors and 'medical experts' are very influential when decisions about health policies are considered. Try to make the point that consumer and patient views are very important but also make use of supportive, medical experts where possible.

For example: it is interesting to consider how a member of the British Royal family came to make a tough and detailed speech about drug pricing and access to drugs in developing countries (See Box 62).



Identify and understand potential opponents

No matter what your position on an issue, there is certain to be someone who does not agree with it. To help make your arguments as strong as possible, you need to consider the arguments that will be put forward by those with opposing views. You should brainstorm among the members of your own organization and with campaign partners about possible opponents. Who will they be? What are their interests? How will they operate on this issue? What is their goal? What or how much do they stand to lose if a change occurs? It is important to consider what their strategy might be. You might want to include the use of role-play in helping advocates to understand the arguments of the opposition. This will help you to anticipate their actions and be ready with a quick and effective response. Campaigns can lose a great deal of momentum or be completely destroyed by opposing

arguments and actions that catch them unprepared. Take time before you launch your advocacy work to consider how those with different views might approach the issue. This will pay off once the campaign is underway. Make sure you collect any information available from the opposition. This can be found in many forms including leaflets, newspaper advertisements or articles, press releases, speeches, and website information.

Become familiar with their line of reasoning. You should understand their arguments and look for flaws in it. Also,



BOX 62. PRINCESS ROYAL BERATES DRUG FIRMS OVER PRICES

By Alastair Dalton, Science Correspondent, the Scotsman

Drug companies were attacked yesterday by the Princess Royal for their “simplistic philanthropy” which was failing to tackle disease in developing countries. In a hard-hitting speech to the British Pharmaceutical Conference in Glasgow, Princess Anne said firms should focus on effective long-term measures such as cutting drug prices rather than short-term publicity stunts. The princess, who is an honorary fellow of the Royal Pharmaceutical Society, which organized the conference, also warned that basic disease prevention measures, such as immunization programmes, were in decline in many countries. She said donations of medicines often failed to cover their distribution costs, which sapped other scarce health spending.

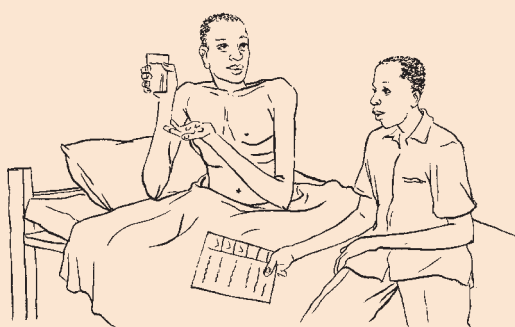
The princess, who is also the president of the Save the Children Fund, said cheap medicines were urgently required to treat conditions such as HIV and AIDS, and urged the drug industry to re-examine its pricing policies.

Princess Anne’s comments echoed concerns expressed at the conference by Barbara Stocking, the director of Oxfam GB, who said drug patents were preventing the production of cheap, generic medicines that poorer countries could afford. The princess said: “The key to public recognition of the pharmaceutical companies’ commitment to human health may lie in their realization that a systematic approach to pricing based on equity can work for everyone. Fair pricing based on the ability to pay would be an important step forward.”

The princess said such a move should be seen by drug firms as creating new markets rather than compromising short-term profits. However, she warned: “If quick results are what companies want, then they run the risk of being accused of simplistic philanthropy rather than rising to the greater challenge of social responsibility”.

“Drug donations may raise a company’s public profile and share price, but the transport, distribution, training and administration costs are usually not covered by the donor.” The princess said this could place a heavy extra burden on health systems and take money away from other important health programmes.

Princess Anne said more than 150 children were born every day in South Africa with HIV, but even the cheapest remedies to ease their suffering, such as from breathing and fungal infections, were beyond reach. She said that to them, the so-called anti-AIDS “wonder drugs” being used to prolong the lives of sufferers in richer countries were a “cruel mirage”.



The princess also called for more resources and research effort to be switched into neglected areas of health. She said: “There is a very long list of neglected diseases peculiar to the poor world that are ignored by the research community, which must move up the political agenda. Malaria still kills more children than HIV and AIDS.”

The princess added that too few pharmacists were working in countries where they were most needed, such as in parts of Africa. She said immunization campaigns had waned since the political commitment to them peaked in the 1980s,

and resources had declined dramatically. She said a shift in focus to individual diseases, such as polio, had caused a collapse of regular vaccination programmes.

Source: Dalton A. *The Scotsman*, 2001

<http://www.essentialdrugs.org/edrug/archive/200109/msg00131.php>

check to see if they are saying anything about your campaign's key messages. It is only by understanding their viewpoint and being able to counter it with a better argument that you will succeed against them.

Develop a plan over a period of time

You can launch a campaign with a great splash of publicity but if you do not develop follow-up activities and strategies to keep your issue on the agenda you may find that the launch is soon forgotten and interest in your issue fades. Develop a time-line which takes into account the need for continuity and follow-up but which also plans some events or high points.

Take advantage of developments which create windows of opportunity

Sometimes unexpected events can work in your favour. These may take the form of political developments in your country (an election or change of government); they may be related to macroeconomic factors or they may be related to local events.

In francophone Africa, for example, a currency devaluation led to a major rise in the price of medicines (see Box 63). The price increase had serious effects on the availability and affordability of medicines. At the same time, it did create a climate in which people were prepared to listen to arguments in favour of the use of inexpensive, generic drugs instead of expensive, brand-name preparations.



Monitor and evaluate your activities

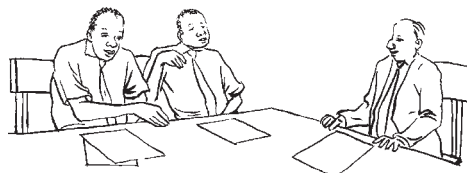
It is important to monitor and evaluate your advocacy activities. You need to know what works and what does not. Feedback and monitoring are especially important in advocacy campaigns. Be prepared to look critically at your activities. What have you achieved so far? Are your strategies working? Do you need to make some changes in what you are doing? Sometimes you may find that your activities are having unforeseen effects. For example, it was reported that a campaign in Pakistan to reduce the use of irrational antidiarrhoeals led to an increase in the inappropriate prescribing of antibiotics in the treatment of diarrhoea.

Sometimes you will achieve your initial objective. For example, you might be advocating for a national drug policy, which the government agrees to and draws up. You then may have to change your strategy or your objectives to focus more on issues of implementing the policy.

Evaluation helps to demonstrate accountability to members or funders and will not only help you to decide on whether your approach was appropriate but will also help to increase your credibility and enable you to publicize your results.

Do you have basic data that will enable you to evaluate your activities?

Chapter 11 provides more information on monitoring and evaluation approaches.



BOX 63. DEVALUATION IN BENIN: PROBLEMS BUT ALSO A FOCUS FOR LIVELY DEBATE

The devaluation of the CFA franc in early 1994 caused medicine prices to increase dramatically; forcing many consumers in Benin to turn to cheaper medicines available in informal street markets and on the black market. ARAMBE KAFU ATA, a consumers' association based in Cotonou, Benin, estimated that informal/black market purchases of pharmaceutical drugs and over-the-counter remedies had increased 86% since the devaluation.

To raise governmental and consumers' awareness of the dangers of informal/black markets for medicines, ARAMBE launched an information campaign which included a seminar for 150 participants (police, customs agents, members of the military, and officials from various ministries) from various provinces in the country.

Presentations covered the role of the police in combating fake drugs; the essential drugs concept; generic drugs and prices; and an explanation of what a drug is. Videos highlighted the dangers of skin bleaching and self-medication. Participants met in working groups to discuss and make concrete suggestions and recommendations on how to fight against the informal/black market drug selling that had taken on alarming proportions in Benin.

Participants made the following suggestions:

- The Government should be more vigilant and take more responsibility for enforcing current national laws concerning the supply and sales of pharmaceutical drugs;
- The Government should use all available means to reduce illicit drug selling;
- Health workers should prescribe more generic drugs;
- ARAMBE should continue to provide information to consumers about the risks and complexities of pharmaceutical drugs;
- Information sessions should be organized in the different enforcement agencies in Benin.

(Summarized from HAI News, August 1999).



Networking and networks

What do we mean by networking?

Networking is most simply defined as communication and cooperation between groups and individuals sharing a commitment to a common goal, ideal or objective. Individuals share resources and ideas and make efforts to support, encourage and strengthen each other.

A leading analyst of networking, Paul Starkey, makes the point that the process of networking is more important than the development of a structured network (Starkey, 1998). He also notes that not all information exchange or collaborative

action is necessarily networking. Dissemination of information is not by itself networking. There needs to be some dialogue, some reciprocity, some mutual interaction.

Paul Engel, Director of the European Centre for Development Policy and Management (ECDPM), says that networking is more than simply working together, but includes achieving "social synergy". He says, "networking adds a fundamentally new quality to human cooperation. It enhances inclusive thinking, creativity and dialogue." (Paul Engel, 1993).



Networking is a form of communication, and is a powerful way to communicate key information and research. It is essential for advocacy. Effective communication relies on feedback, interaction, the quality of the relationship, the level of trust, and the degree of willingness to explore options and share understanding. So does effective networking.

Networking builds links and connections among people who have different perspectives on the world they see. When they start communicating about those perspectives, the opportunities to discover new insights, new ideas and to shape new approaches come to life. Box 64 illustrates the importance of maintaining and strengthening the links in a network.

Networks can take many forms:

- Some networks are informal, others are much more structured, but in general a network does not have a conventional, organizational structure.
- Some networks form in response to a crisis and may be very short-lived. Other networks begin around longer-term objectives and may survive and grow for years.
- Some networks are local or national, others form on a regional or international basis and some combine to work on all levels.

BOX 64. THE STRENGTH OF WEAK LINKS

By itself no piece of string or knot alone can catch even a stupid fish. It is hard for a single voice to be heard. It may cry out and be heard for a moment but then, usually, it is drowned in a sea of other cries and events. In a network however, although the strength of individual knots and links can be quite weak, together they can hold the fish.

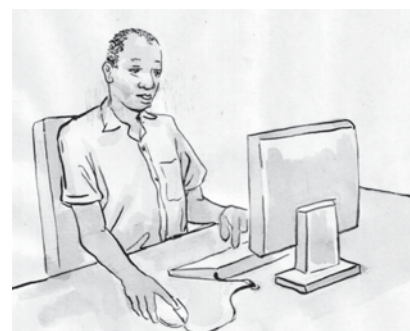
If we go back for a moment to a fisherman's village we'll see that people spend a lot of time caring for and repairing their nets. Maybe as much time as they spend actually using them. The fishermen know that a hole or a tangle will allow the fish to escape and cause them losses. So for the sake of the whole net the weak parts must be constantly strengthened, re-knotted and given support.

(Extract from training material used by the Consumer Educators Network, Consumers International, 1987).

Different types of networks

Networks can be physical or virtual (electronic), national or regional/international or a combination of these. Boxes 65, 66 and 67 provide examples of three different types of networks active in rational medicine use.

- **Health Action International** is an example of an international network, which works to promote a more rational use of drugs.
- **The Philippine Drug Action Network (PDAN)** is an example of a national network, which was highly effective in the development of the Philippines National Drug Policy and in supporting generic policies.
- **E-Drug** is an e-mail discussion group which has many of the characteristics of a network and which brings together people from around the world interested in essential medicines.



BOX 66. THE PHILIPPINE DRUG ACTION NETWORK (PDAN)

The Philippines has a long history of activism on health issues, dating back to the Marcos government in the 1970s. At that time, NGOs were active in organizing communities for health programmes. After a change in government in 1986, NGOs became active in lobbying for health reform through parliamentary means and through direct contact with the Department of Health.

Activist NGOs organized themselves into a Task Force for People's Health which convened a series of symposia to identify the areas for reform and make specific demands. Pharmaceuticals was one such area. Fortunately, the Health Department of the new administration also identified the pharmaceutical sector as an area for reform and the President spoke out in support of a National Drug Policy to be built on four pillars: quality assurance; rational drug use; self-sufficiency; and targeted procurement.

The government recognized medicines as a sensitive concern for many Filipinos. The NGOs also read public sentiment and created The Philippine Drug Action Network (PDAN), a nation-wide, ad hoc coalition that carried out training, publishing and advocacy.

In 1987, Congress proposed a generics law that would require the use of generic names in labelling, prescribing and dispensing. The pharmaceutical companies and the Philippine Medical Association, launched a campaign against the law, claiming it would violate 'physicians' rights' and that use of generics would endanger public health.

PDAN teamed up with the Department of Health to refute the anti-generics lobbying. It was able to get media support and to counter arguments from industry and the doctors. There were many debates in Congress, in the media and in various public forums. PDAN lobbied with members of Congress, pointing out public support for the new law, especially because of possible savings in medicine costs. The law was passed without a single legislator opposing it.

However, even after the law was passed, lobbying against the new law continued. For example, at one point, companies announced they could not shift to new generic labels and that there would be a shortage of drugs if the government insisted on a deadline for the new labels. PDAN again stepped forward to defend the new law. It threatened to organize a boycott of companies that were not cooperating. When the Philippine Medical Association filed a lawsuit against the Health Department to stop the new law, PDAN criticized the association for being 'anti-people' and also corrected some of their claims.

Most importantly, PDAN mobilized its members in different parts of the country to explain the new law and to help people to use it. These teaching sessions were made part of the training workshops on rational drug use organized by PDAN.

Unfortunately, with time, the generics law fell by the wayside. At one point, some 80% of prescriptions followed the law's provisions requiring the use of a generic name. By 1998, this had dropped to less than 40%. The law's decline has been blamed on changes in Health Ministry priorities and reduced support given to NGOs to work on the National Drug Policy. PDAN itself disbanded because of the lack of support. While the NGOs continued doing training in rational drug use, the momentum for advocacy had been lost.

Since 1999, national drug policy has received renewed priority. The Ministry of Health has tried to mobilize NGOs to help with formulating reforms. Individuals have responded but the coalition itself may need time before it forms again. The history of PDAN shows how when NGO and government interests coincide they can form a powerful alliance in support of public health but that when political and financial support is withdrawn NGOs are very vulnerable. Networking requires financial support if it is to compete with the many resources of the commercial sector.

BOX 67. E-DRUG: AN ELECTRONIC NETWORK

E-Drug is an electronic Internet conference about essential drugs issues, which was started in 1995 to stimulate contacts between health professionals in developing countries. E-mail was seen as an affordable and efficient communication tool, as a satellite connection was possible even for people in rural areas without telephone connections. E-Drug is hosted by Satellife, an NGO which assists health workers in developing countries with free or affordable access to e-mail and to its Healthnet information network.

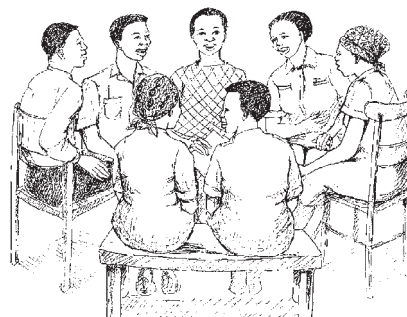
E-Drug is an easy way to obtain and discuss current information on essential drugs, national drug policies and standard treatment guidelines. It is also a good source of information on upcoming conferences and courses, new publications, recent articles, and broader political and community aspects of the essential drugs movement. One response to the notice on the list celebrating the 10th year of the network at the beginning of 2005 made the point 'E-drug is a wonderful meeting place and a key tool for exchanging information and rapid action.'

At the beginning of 2005, 2640 people from more than 90 countries subscribed to E-Drug, which is free of charge, and can be accessed by all health workers using off-line, ordinary e-mail messages. Access to the Internet is not necessary. E-Drug is moderated by six volunteers, based in Africa, Australia, Europe and the USA, who standardize submissions and ensure consistent quality.

The main difference between participation in this type of electronic conference and in a tighter network is that an electronic conference is almost exclusively for the purpose of sharing information. It does not develop campaigns, coordinate activities or involve definition or pursuit of shared goals, other than the goal of improving access to information.

What makes a network effective?

- **Mutual trust and solidarity** between participants – some networks are “loose” ones which require only a common interest such as the need for information. Others are “close” and the strength of these networks is that they provide not only a product such as information but also support, trust and solidarity.
- **Active participation** – a network does not have a hierarchical or vertical structure but a structure resembling a net or a cobweb. The more horizontal links there are between participants the stronger the network will be.
- **Decentralized activities** – a network may have one or more focal points or coordination points but in general it is built around the principle that activities should be decentralized.
- **Clearly shared goals** – how broadly these are defined will vary from network to network.
- **Coordination** to facilitate the work of participants – in a network such as E-Drug there are voluntary moderators who share the task of screening messages, commenting where appropriate and keeping the discussion group on track. The HAI network has regional coordinators who are there to facilitate and support the work of the HAI Regions.
- **Flexibility and the ability to react quickly** – a network, by nature of its structure can respond quickly to new developments or requests for information. If necessary support can be mobilized in a very short time.
- **Expertise and experience which can be shared** – because of their breadth and informal way of operating, networks can often involve a great variety of expertise and bring in the views of different stakeholders.



- **Cooperation and collaboration with others** – networks create opportunities for collaboration and cooperation in an informal and non-bureaucratic structure.
- **Resources for key activities** – networks can also be helpful in mobilizing resources and also in distributing them among participants for key activities.

Threats and pitfalls for effective networking

- **Lack of money** – networks are not expensive structures but they do need resources. Networks are not easy to fund and the search for funding to guarantee continuity of activities can become a time-consuming and demotivating process.
- **Lack of openness** – the attitude that knowledge is power and that information should not be shared freely is undermining to the fundamental purpose of networking.
- **Lack of focus** – a network without focus has little purpose.
- **Inability to agree on priorities and important strategies.** To counter this, E-Drug regularly invites participants to think about what should be included in its contents. HAI has had several discussions about whether the focus of its activities should be “health” or “rational drug use”.
- **Domination by one, or a few, partners** – every participant in a network should feel that they “count”. A network may have “leading” partners or groups that shoulder considerable responsibility for the continuity of the network but they should not squeeze others out of the priority-setting or decision-making process.
- **Tendency to centralize power,** responsibility and expertise. If the “centre” becomes more important than the “net” the network may turn into a more formal organization. This can be a logical strategic outcome but it will have implications for the extent to which it is open and participatory.



How can you use existing networks? What can you contribute to them?

There are a variety of international, regional and national networks that are concerned with issues relating to drugs and drug use. If you are planning activities to promote rational drug use in the community you may be able to get help and support through these networks. (A brief description and contact details for several of the networks are included in Annex 2.)

They may help you by:

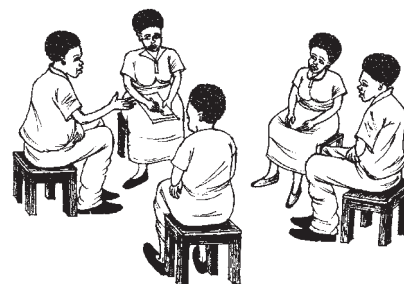
- identifying others doing similar work;
- giving you ideas and examples of successful and unsuccessful interventions;
- contacting supportive experts and potential allies;
- publicizing your efforts;

- identifying potential funders for your work;
- encouraging you;
- mobilizing support for you if you encounter opposition.

Box 68 gives an example of how an existing network of journalists was mobilized to support efforts around the access to antiretrovirals campaign.

On the other hand you might have a lot to contribute to others in the network by:

- telling people of your successes and failures;
- training others who are starting in the same area;
- sharing expertise;
- making information available;
- encouraging and supporting others in the network.



BOX 68. BUILDING A STRONG COALITION FOR ESSENTIAL DRUGS IN NIGERIA

Nigerian journalists have called on the Federal Government to provide legislation that would ensure easy access to essential medicines for all Nigerians.

At a Media Advocates Meeting on Access to Essential Medicines in Nigeria held at the Media Resource Centre on HIV and AIDS in Lagos, the journalists also pledged their support for the campaign to secure access to essential medicines in the country.

Journalists Against AIDS (JAAIDS) Nigeria convened the Media Advocates Meeting on behalf of the Coalition on Access to Essential Medicines in Nigeria, a network of over 25 organizations who support the vision of improving public health. The objective of the meeting was to inform members of the press about the activities of the Coalition and to seek their input on the campaign's strategies. The meeting also examined how to build a network of journalists to work with the Coalition to achieve the common objective of securing easy and affordable access to essential medicines for Nigerians.

Two Coalition members – Dr Pat Matemilola, Coordinator of the Nigerian Network of People Living with HIV and AIDS and Mr Olatubosun Obileye of Médecins Sans Frontières (MSF) – briefed the journalists. They covered the provisions of the TRIPS Agreement, basics of Intellectual Property Rights (IPR) and MSF's work in other countries on the access campaign, as well as providing practical, personal experience of how lack of access to essential drugs affects the survival of millions of Nigerians living with life-threatening diseases such as HIV and AIDS and malaria, and how the press could be supportive of the access campaign in the country.

The journalists called for parallel importation and compulsory licensing to be emphasized in the Intellectual Property Bill being developed by the Government. Many of the 14 journalists who attended the meeting promised to join members of the coalition at their next meeting.

Besides individuals, corporate members of the coalition include: Journalists Against AIDS (JAAIDS) Nigeria, Centre for Right to Health (CRH), Lifescope Africa, Network Project for the Disabled, International Network for Rational Use of Drugs (INRUD), Medical Rehabilitation Centre for Trauma Victims, Educare Trust and the Nigeria AIDS Alliance (NAA).

Others include: Society for Women and AIDS (SWAAN), Health Matters, Communication for Change, Save the World Organisation, Huri-Laws, National Network of People Living with HIV and AIDS, STOPAIDS, Development of Africa through Law, Project Shield, Social and Economic Rights Action Centre (SERAC), Civil Society Consultative Group on HIV and AIDS in Nigeria (CiSGHAN), Access to Justice and Médecins Sans Frontières (MSF).

For further information about the Coalition, see: <http://www.nigeria-aids.org/reports.cfm?read=74> Also see: <http://www.nigeria-aids.org/reports.cfm?read=75>

Some networks have broad goals (such as a more rational use of drugs), others have a narrower focus such as “promoting better prescribing practices through better medical education”. Many of the more important networks are described in some detail in the *WHO Essential Drugs Monitor* no. 24. <http://mednet2.who.int/edmonitor>

Additional reading

World Bank Advocacy manual

Int. HIV/AIDS Alliance advocacy manual

Essential Drugs Monitor (no. 24). Geneva: World Health Organization.

Walt G (1994). Can interest groups influence government policy? In: *Health policy – an introduction to process and power*. London and Witwatersrand, South Africa: Zed Books and Witwatersrand University Press.

Mintzes B, Hodgkin C (1996) The consumer movement: from single-issue campaign to long term reform. In: Davis P, ed. *Contested ground*. New York: Oxford University Press.

EPN publication

Owens B, Klaudt K (1999). *TB advocacy: a practical guide* 1999. Geneva: World Health Organization.

WHO (1999). *Advocacy: a practical guide, with polio eradication as a case study*. Geneva: World Health Organization.

8

Managerial and regulatory strategies

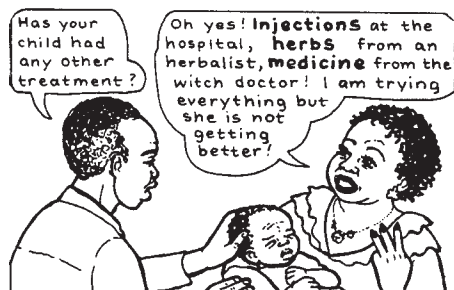
Introduction

The problems and possible solutions to rational medicine use are complex. The strategies needed to deal with them are also complex. After identifying, measuring and understanding the problems through careful investigation, identifying initiatives to deal with these problems comes next. They may include managerial and regulatory strategies as well as strategies designed to influence peoples' behaviour and increase their understanding of drug use issues.

This chapter explores the way managerial and regulatory strategies can be used in interventions to improve rational drug use.

Managerial strategies help to **guide** choices and create a framework to guide policy implementation. Managerial strategies for rational drug use usually involve:

- developing standard treatments, essential drugs lists and dispensing standards
- training, supervision and follow-up strategies to support human resources
- ensuring technical resources, such as laboratory, testing and quality control systems, are in place and functioning well.



While most of these strategies are aimed at health workers or at changes within health care facilities, their ultimate objective is to ensure that consumers have access to the right drugs and the right information about drugs, and are therefore more likely to use them wisely. Managerial strategies are demanding and ongoing and require consistent efforts over a period of time.

Regulatory strategies tend to **enforce** choices and create rules and laws to support policy implementation. They need to ensure the efficacy, safety and quality of drugs, and the quality of the information about drugs. This includes determining who is allowed to prescribe and dispense what drugs. This may involve protecting consumers from

misleading promotion of medicines, from poor quality products or from drugs that are found to have higher levels of risk.

Regulatory approaches may, however, have unintended consequences. In some countries, for example, when ineffective but popular and inexpensive antidiarrhoeal drugs were banned, people began to use more antibiotics – which were readily available and affordable.

Managerial strategies

Almost all health communication programmes involve a number of different organizations that need to work together effectively to achieve common goals. Managing the interactions and the different dynamics that occur is a challenge. Usually this needs to be coordinated by a national institution. In some cases, it may be a governmental department (Ministry of Health, National Drug Control Administration) or a quasi-governmental body (National AIDS Control Commission, Malaria Control Unit) or even be delegated to a nongovernmental organization or an academic institution acting on behalf of the national government (Drug Information Centre, Institute of Health Communication Studies). Box 69 illustrates some of the issues that needed to be considered to prepare for the introduction of antiretroviral therapy in Rwanda.

In developing interventions to improve rational drug use, there are some common areas of activity that need to be covered. The national drug policy should provide the broad policy framework that will highlight some of the major communication and managerial challenges. The factors that are known generally to influence drug use provide a useful starting point. Some of these include:

- availability (supply)
- accessibility (cost)
- prescribing and dispensing practice
- patient information.

Availability and accessibility

An adequate and affordable supply of essential drugs is an important element in translating a national drug policy into practice. Communicating about rational use is futile if the medicines are simply not available or affordable.

Box 70 looks at a strategy used in Nepal to combine training of staff of private drug shops with a supply agreement that helped to determine prices. The drugs were both available and affordable and the information helped to improve some practices.

Guiding practice

The Nepal intervention also sought to guide good practice (see Box 70). Another practical approach that helps to manage the drug use situation and guide practice in a country, a health care facility or in a community is the use of standard treatment guidelines.

In thinking about what strategy to use, it is important to remember that no single strategy is likely to work on its own. Various strategies and interventions have been used to promote better prescribing: education and communication including training and print-only materials; managerial interventions include standard



BOX 69. PREPARING FOR AN ARV TREATMENT PROGRAMME IN RWANDA

Family Health International (FHI) is developing pilot programmes in ARV treatment that also provide counselling and psychosocial support in Ghana, Kenya and Rwanda. They are meant to serve as models for antiretroviral treatment that can then be expanded to a national level. Before the drugs could be dispensed, however, Rwandan physicians needed training in HIV management, medical centre staff needed to learn the fundamentals of ARV therapy, patients required counselling on drug adherence regimens, and the medical centre's laboratory equipment needed upgrades to permit ongoing patient monitoring.

Major challenges and lessons emerging from the three programmes include:

- Introducing care and treatment programmes in resource-constrained countries requires collaboration and coordination between NGOs and public agencies
- Critical areas to address include: community preparedness; systems to ensure drug security; proper drug administration by clinicians; and strategies to facilitate patient adherence
- Drug selection and procurement is a process that must start early in programme planning since it requires data, coordination and approvals from government and private sources, both locally and internationally
- Programmes must address health care workers' concerns about workload and pay, as well as their fears about HIV and AIDS
- With proper preparation, it is possible to avoid overwhelming sites with demands for treatment
- Creativity is required to establish referral linkages and to respond to the long-term needs of people living with HIV and AIDS (PLHAs) for diverse services, such as home-based care and psychosocial support
- Once a site has been established, countries can move more quickly to set up multiple sites. An important contribution to the programme is developing locally feasible standards to efficiently replicate programmes and scale-up access to care
- Financially strained governments must be convinced that treatment is a worthy investment (advocacy).

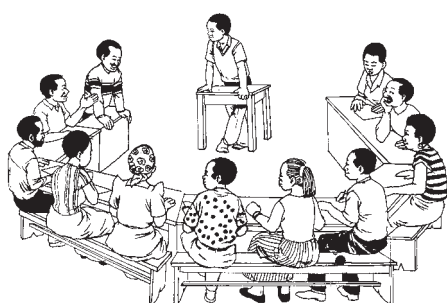


Source: Ritzenhaler R (2005). *Delivering antiretroviral therapy in resource-constrained settings: lessons from Ghana, Kenya and Rwanda*. Arlington, VA, Family Health International. <http://www.fhi.org/NR/rdonlyres/ej5r3pyybpqewqtqinm6qlso4lhav7bvceqlqvwxjldycjhlhu5bg7z2ur73q2rczwt5tfqw7tp/ARTLessonsLearned083106.pdf>

treatment guidelines and selection of drugs; regulatory interventions include prescribing control by level of use and banning of unsafe and doubtful drugs.

The example of improving rational drug use in Tanzania (see Box 71) demonstrates the importance of combining print and face-to-face communication with managerial and regulatory strategies including the use of standard treatment guidelines. Research looking at the impact of interventions has found that face-to-face education focused on a few prescribing problems as well as standard treatment guidelines plus education are effective, but that printed materials alone or unfocused education are ineffective.

Effective interventions include problem-oriented, repeated and participatory training, supervision and peer group-oriented guideline development.



BOX 70. CHANGING THE PRACTICE OF DRUG SELLERS IN NEPAL

In Nepal, the Britain-Nepal Medical Trust (BNMT) has a long-running programme operating with private drug shops. It uses a combination of training, supervision, and access to buying drugs at cost price to improve the quality of care. Private drug shops are a predominant source of primary health care for many people in Nepal (and many other developing countries).

Since the early 1980s, BNMT operated a scheme in which it formed contracts with shop retailers chosen by communities. Under these contracts, BNMT undertook to sell essential drugs to the retailers at cost price plus 10% for handling; the retailer was allowed to sell the drugs for a further 12.5% mark-up. This total mark-up of 22.5% was considerably less than that found in many commercial shops. In addition, BNMT subsidized transport costs and arranged for training and supervision of the retailers. The shops were only accepted into the programme on the condition that they sold only essential drugs (including prescription-only drugs provided a health facility was within half a day's walk) at the agreed price and handled drugs to an adequate standard.

A comparative study of BNMT supported and non-supported drug shops in 1996 found that the average mark-up was 36% and 80%, respectively; the percentage of patients issued a bill was 31% and 2%; the percentage of customers sold antibiotics was 28% and 23%; the percentage of antibiotics sold in adequate amount was 76% and 86%; and the percentage of drugs belonging to the national essential drug list was 87% and 59%, respectively. In both types of shops, the average interaction time between retailer and customer was 3.6 minutes, 76% of customers knew their correct dosing schedules, and 63–66% of prescription-only drugs were sold without prescription. Retailers supported by BNMT stated that they could not avoid selling prescription-only drugs without prescription because of competition from commercial shops that often started up within 1–2 years of the BNMT-supported shop.

The shop support programme was associated with lower mark-ups, greater issuing of customer bills, greater use of essential drugs, and a slightly lower rate of antibiotic underdosing. However, many poor practices such as selling prescription-only drugs without prescription could not be changed due to commercial competition.

Source: Holloway KA, Gautam BR (2004). *Impact of an NGO-supported supervisory program on quality of care in private drug shops in rural East Nepal*. Presentation at the International Conference on Improving Rational Use of Medicines, 2004. ICIUM, Chiang Mai, Thailand. <http://mednet3.who.int/icium/icium2004/poster.asp?keyword=Access+and+Use>. An article on the study was also published in *Nepal Pharmaceutical Association Bulletin*, 1998, vol.19:4–12.



Although the Tanzanian example was based on efforts to change behaviour of prescribers, there are lessons here for attempts to change use of medicines by consumers as well.

Supervision is another managerial strategy that can help to improve the performance of health workers, which in turn can improve access to medicines for consumers. Box 72 looks at how supervision on medicines management was used in this way in Zimbabwe.



Patient information

Patients are likely to receive information about drugs from a number of different sources. These may include:

- package information
- leaflets
- radio and television programmes

BOX 71. IMPROVING RATIONAL DRUG USE IN DAR ES SALAAM, TANZANIA

Availability of essential drugs is futile without rational drug use. A drug use indicator study in Dar es Salaam public health facilities revealed over-prescribing of antibiotics and injections as well as non-adherence to National Standard Treatment Guidelines (STGs). Based on the findings, interventions were selected (development of new STG, training) with the aim of improving prescribing, and the performance and quality of health services. Good quality of care reduces suffering, increases the confidence of patients in the health care system, and the willingness to pay for services and thus enhances the sustainability of a drug supply system. Treatment guidelines are used to optimize limited resources and to guide practitioners towards clinical paths known to have good outcomes. The process of elaborating and implementing STGs has been shown to be critically important for the success of the intervention.

Redefining Standard Treatment Guidelines

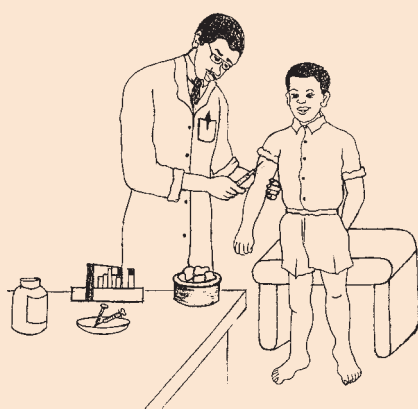
The National STGs were associated with insufficient involvement of health providers, poor dissemination and lack of training. New STG for Dar es Salaam were launched with the objective to improve the process of guideline elaboration and implementation and to measure impact of the intervention.

The STG programme was a collaborative effort by medical and pharmacy staff. Active collaboration of targeted prescribers at all levels was sought. The National STGs were used as a basis while format and contents were updated, improved and made more user-friendly. The draft was distributed to local reviewers. Twenty health facilities were randomly paired into intervention and control facilities. An introductory workshop was conducted for 25 prescribers from the intervention group followed by continuing education. Prescribing indicators and adherence to STGs were measured before and after the intervention.

Shift focus from guideline development to guideline integration

In a pre-post design analysis, compliance with STG norms improved significantly after the intervention in all health facilities.

The process of participatory and monitored STG elaboration and implementation with training had a positive effect on prescribing patterns of all prescribers by ensuring better compliance with STGs.



However, the number of antibiotics and injections prescribed did not change by the intervention. This behaviour is deeply ingrained and rooted in socio-cultural conditions. A major finding is that the development of guidelines alone is not sufficient for behavioural change. An active elaboration and implementation strategy is important.

To assure ownership of treatment guidelines, practitioners must be involved in the process of elaboration. Printed material has little effect on prescribing behaviour but needs to be accompanied by training. To be effective, training must be focused, participative, repeated and ongoing, take place in small groups and it must be followed by supportive supervision. It is of paramount importance to shift the focus from STG development to guideline integration.

Source: Wiedenmayer, K. 1998. Improving rational drug use in Dar es Salaam, Tanzania by elaborating and implementing Standard Treatment Guidelines (STG). *Bulletin Medicus Mundi* No.68 available at: <http://www.medicusmundi.ch/bulletin/bulletin688.htm>

BOX 72. IMPACT ASSESSMENT OF SUPERVISION ON MEDICINES MANAGEMENT IN ZIMBABWE

Allocating resources to supervision is likely to result in improved performance of health workers with regard to the rational use of essential drugs, resulting in improved efficiency and effectiveness, according to a study carried out in Zimbabwe. This, in turn, improves access to medicines for consumers, one of the prime issues in effective use of drugs.

Significant improvements in medicines management had been achieved through training of health workers throughout Zimbabwe. However, these achievements could not be sustained and new sustainable interventions for improving stock management and appropriate medicine use were needed.

A study compared three different groups of district level peripheral health facilities: those that received supervision for either use of Standard Treatment Guidelines (STG) or stock management and a comparison group of facilities which received no supervision. Supervision comprised two visits about three months apart.

The study showed that, following supervision, overall stock management improved significantly when compared to the control and comparison groups. Similar improvements were demonstrated for adherence to STG, although the effect was confounded by other interventions.

The study also showed that supervision has a positive effect on improving performance in other areas than those supervised, and demonstrated that pharmacy technicians with limited clinical skills can be trained to influence primary health care workers to positively improve prescription practices.



Source: Trap B, et al. (2001). The impact of supervision on stock management and adherence to treatment guidelines: a randomized controlled trial. *Health Policy and Planning* 16(3):273–280. http://mednet3.who.int/PRDUC/Resource_Mats/Africa_papers/Trap_supervision_stock.pdf

- educational sessions organized as part of primary health care programmes
- community health workers
- drug sellers in small shops or markets
- traditional healers who have incorporated pharmaceuticals into their approach
- magazines, newspapers and comics, re-used prescriptions and popular health books
- advertisements and drug promotion at health centres, pharmacies and shops.

In West Africa a research-action-capacity building model has been used around the introduction of insecticide treated bednets (ITNs) to reduce the spread of malaria. Box 73 highlights the process which demonstrates how the research, communication and managerial activities continually interact to share learning and manage the process. Although this deals with the introduction of a technology rather than the use of a drug, it has lessons for the introduction of any new therapy that could be applied to a number of interventions involving infectious diseases.



Community members in Uganda studying instructions on a package of Coartem tablets (against malaria)

BOX 73. LESSONS FROM MALARIA CONTROL IN WEST AFRICA

A Swiss-funded project to support management of deprived urban areas by their inhabitants has included a WHO-supported component since 1997 to introduce and promote the use of insecticide-treated bednets (ITNs) for malaria control in N'Djamena, the capital of Chad.

Activities related to the nets aimed to:

- use a participatory approach to introduce, promote and maintain the use of ITNs
- create and sustain commercial centres for sale and impregnation of nets
- identify the advantages and disadvantages of using a Research-Action-Capacity-building (RAC) approach
- empower grassroots initiatives
- develop knowledge and capacities of the organization and communication of local people.

In the RAC approach, the people who are intended to benefit from the results control the research, planning, execution and the ongoing evaluation, as well as the redefinition of the activities, rather than having an externally driven intervention. In addition to obtaining information, RAC is also concerned with enhancing local people's active participation in the research and development process. The RAC approach overlays elements of assessment with action and puts capacity-building and acquisition of knowledge as the main focus of the process through the exchange of common experiences and value attributed to people's own creativity. RAC sees social change as the ultimate goal.

Partnership and collaboration at various levels were considered crucial for the project in order to increase and strengthen relationships and exchanges of expertise in the field of urban environmental management. The development and sharing of ideas, concepts and activities between local people, national institutions and an international non-governmental organization (NGO) was a key element.



However, the main engines of the project were three community associations, two of which were women's groups, active in health and environment management.

Through regular meetings and workshops, the members of the associations had many opportunities to develop their capacities for communication and negotiation with institutional actors. The process demonstrated strong potential for:

- empowerment of participants to manage their own problems
- acquisition and exchange of knowledge and experience
- improvements in malaria control activities at local and city level.

The project identified positive benefits in three main contexts: the technical, economic and social.

On the technical side, an innovation was successfully introduced and adopted by the local actors organized within associations. Mutual research activities between members of the associations and facilitators demonstrated that there was demand from residents for ITNs. After training on technical issues concerning impregnation, the associations were able to provide services of adequate quality and manage the introduction of the nets themselves. This contrasted with many conventional approaches where the transfer of knowledge and techniques is often top-down, one way and at one level – from specialists in the North to specialists in the South – excluding the local populations and beneficiaries from the process.

On the economic level, the sustainability of selling nets and establishing impregnation centres was found to be very fragile. This was mainly due to the high prices of nets and impregnation services, making them too expensive for the majority of the urban poor and most vulnerable groups. Other solutions were needed which could include regulations to exempt nets from importation taxes.

Continued

Box 73 continued

Despite the difficulties, an outcome of the project was that local association members acquired knowledge in commercial thinking and management of micro-enterprises, capacities and skills that are very transferable.

On the social level, the RAC framework valued not only the visible 'successes' such as a high number of services and items sold, but also skills and capacities in communication and negotiation. The activities initiated were able to strengthen the organizational and negotiation skills of the associations, new ways of reflection, knowledge about economic issues and about handling techniques and technologies. These skills can be very useful in the field of urban environmental and social management as well as for personal activities of the association members.

The project also showed how collaboration, partnership and communication between popular and institutional actors govern sustainable management of the urban environment. Key events in the process of action research are the regular meetings and workshops at local, regional and international levels, with all partners and actors involved. They provide an efficient platform for exchange, dialogue and refinement of the activities, findings and consequences. More importantly, they create an interface for donors and organizations that can help with the solutions and initiative of the urban inhabitants.

Source: Felber G et al. (2001). Lessons from malaria control activities in urban West Africa using a research-action-capacity building approach. *PLA Notes* 40:18–21.

Regulatory strategies

There are a number of factors that inhibit rational drug use at community level that are likely to respond to regulatory strategies. These include:

- Lack of coherent policies on drug availability and use
- The impact of commercial interests
- Professional interests
- Lack of resources.

Lack of coherent policies

Many countries need to strengthen their national policies on drug availability and use. Without a clear policy, it is difficult for communication about rational drug use to take place in cohesive manner and be adequately supported. A fragmented approach can confuse the public with conflicting and competing messages.

However, as Box 74 shows, the development of a drug policy in India has led to a more coherent approach to the availability and use of medicines in the state of Delhi.

Commercial interests

Commercial interests do not always match public interest. Particularly in developing countries, where control of drug promotion may be non-existent, weak or unenforceable, industry may contribute to inappropriate drug use by conducting promotional activities based on inaccurate information. The example of action taken in Nepal (see Box 75) to control the marketing of an analgesic followed years of promotion of the product. It shows the time it takes, even after a regulation has been put in place, to change practice.

BOX 74. IMPACT OF DRUG POLICY ON IMPROVING ACCESS TO MEDICINES IN INDIA

The implementation of the drug policy in the state of Delhi has led to increased availability of essential drugs.

In 1994, when efforts for developing a drug policy were made, the availability and use of medicines in Delhi government hospitals was poor. Most of the prescribed drugs expected to be given free to patients were not available at the hospital pharmacy.

Unnecessary medicines such as drug combinations, herbal medicines, and tonics were stocked in the stores. At this time the Delhi Society for Promotion of Rational Use of Drugs (DSPRUD) was formed to improve the situation. This group assisted the government in framing the drug policy and its implementation through support from WHO.

Record of patients in two public sector hospitals in Delhi – one with 1350 beds (large) and the other with 550 beds (medium) – were reviewed comparing data from 1993–1995 with the situation in 2000–2002. Retrospective data were collected through record reviews. The data for two years before (1993–1994, 1994–1995) and two years after (2000–2001, 2001–2002) the drug policy were assessed.

After the implementation of the drug policy, the availability of drugs increased by 25% in the large and 98% in the medium hospital. The drugs procured from the EDL increased from 62% to 78% in the large and 74% to 87% in the medium hospital. Of the total expenditure, the money spent on essential drugs increased from 73% to 85% in the large and 87% to 93% in the medium hospital, whereas money spent on nonessential drugs decreased from 27% to 15% in the large and 13% to 7% in the medium hospital. The average number of stockout days for key drugs decreased from 33 to 16 days in the large and from 143 days to 33 days in the medium hospital. The utilization pattern of health services by patients increased by 8% in the large and by 35% in the medium hospital.

This type of intervention can serve as a model for improving access to medicines by implementing an effective drug policy through an NGO working with the government, and involving political commitment.

Chaudhury R et al. (2005). Quality medicines for the poor: experience of the Delhi programme on rational use of drugs. *Health Policy and Planning* 20(2):124–136.



BOX 75. EFFECT OF A REGULATORY INTERVENTION ON DRUG AVAILABILITY IN NEPAL

A ban on the analgesic analgin (dipyrone) was introduced in a phased manner: a ban on export/import from the date of notice; ban on local production three months from the date of notice; and ban on transportation, storage, sale, and distribution six months after notice. A study to determine the effect of the ban surveyed retail outlets in three districts one, five and 16 months after the ban was introduced. It found that there was a gradual decrease in availability with no availability after 16 months. The study recommended that a variety of measures, including inspection and monitoring of customs, importers, and retailers and information about banned drugs through different media, should be taken by a country's drug regulatory authority to stop the sale and distribution of banned product from a specified date.

Dangechhetri GB et al. (2004). *Effect of a regulatory intervention on drug availability in Nepal*. Presentation at the International Conference on Improving Rational Use of Medicines (ICIUM), Chiang Mai, Thailand. An article on the study was also published in *Nepal Pharmaceutical Association Bulletin*, 1998, vol.19:4-12. <http://mednet3.who.int/icium/icium2004/poster.asp?keyword=Access+and+Use>

Professional interests

Resistance to change within professional groups can constrain efforts to improve communication about appropriate use of medicines. Prescribers tend to hold influential and powerful positions, and they may not perceive the need for, or the importance of, public dialogue about medicines. In turn, they may not have the necessary communication skills to provide advice on the appropriate use of drugs on either a personal or an organizational basis.



And it may be, in order to increase access to some medicines, changes in who is able to prescribe and dispense the drugs may need to be introduced. This was one of the challenges faced in Uganda around the introduction of antiretroviral drugs (see Box 76).

Lack of resources

Effective public involvement in efforts to improve rational drug use requires sufficient funding and the allocation of trained staff to enable targeting of population groups through appropriate strategies. Communication about medicines requires an extensive programme to train health workers and other field staff in communication skills and appropriate drug use.

When the resources are not available, successful initiatives can sometimes fail, as the example from the Philippines demonstrates (see Box 77).

Rules and regulations may exist, but they may have little impact if the target groups are not educated and informed, if they lack an environment that is supportive of change, and if management and supervision systems are not in place.

Equally, if regulations are not enforced, problems may still occur as the news report from Pakistan quoted in Box 78 demonstrates. This example shows the importance of combining simple community research, advocacy and networking, and effective relationships with the media to ensure that managerial and regulatory strategies have more likelihood of success.

BOX 76. SCALING-UP ANTIRETROVIRAL THERAPY: EXPERIENCE IN UGANDA

In its efforts to scale-up access to ARV agents in Uganda, the Ministry of Health appointed a National Committee on Access to ARV Therapy with 24 members to oversee ARV therapy. The Committee is multidisciplinary, and its members have initially been appointed for 2 years. It has representatives from United Nations agencies, bilateral agencies, people living with HIV and AIDS, nongovernmental and community-based organizations, faith-based organizations, the Ministry of Health and leading physicians in HIV and AIDS care both in government and private health facilities. The Committee can co-opt other members as it deems appropriate.

The Committee's tasks included:

- developing a policy document for ARV therapy in Uganda;
- overseeing the development of technical guidelines for ARV therapy;
- quantifying the logistical needs for implementing the ARV therapy programme; and
- monitoring and evaluating the ARV therapy programme.

To carry out its duties more efficiently, the ARV therapy committee formed five subcommittees covering policy, logistics, finance, clinical care and practice and advocacy. The subcommittees hold two working meetings per month, whereas the Committee meets once a month to update all members on the progress of the subcommittees and to build consensus on issues decided by the subcommittees.

The Committee produced working drafts of the following documents within 5 months:

- National policy for ARV therapy in Uganda
- National ARV treatment and care guidelines for adults and children
- Implementation guidelines for ARV therapy in Uganda
- National training guidelines on ARV therapy in Uganda
- Costing of the national ARV therapy programme (including different scenarios of ARV therapy provision)
- Quantification of ARVs for public sector health facilities
- Strategy for ARV therapy advocacy in Uganda

The clinical care guidelines have been pretested in two centres providing ARV therapy services, to assess the ease and feasibility of using them. They have been revised based on the findings.

The building of consensus on the major policy issues has been enhanced by the multidisciplinary composition of the Committee and holding several stakeholders' workshops where other people are invited to share their views freely. Appropriate changes have been incorporated into the documents. Building consensus on some critical issues has been difficult, such as the criteria for deciding who can access free ARV agents in the public sector. The Committee has made recommendations on such issues. The higher authorities in the government will make the final decisions.

In Uganda the delivery model anticipated in the national plan for scaling ARV treatment up acknowledges that, in the long term, tasks customarily performed by physicians will have to be shared and involve other health care providers, such as clinical officers and nurses who exist in greater numbers, and to enlist community organizations and family members in providing ongoing support to people living with HIV and AIDS.

Involvement of community members and people living with HIV and AIDS in the National Advisory Board of the Drug Access Initiative was an important factor in the success of the pilot programme. As ARV therapy is scaled up in Uganda, the Ministry of Health envisages greater involvement of community health workers and organizations in supporting adherence and individual follow-up, such as the Uganda Cares programme.



Continued

Box 76 continued

The Uganda Cares programme

The Uganda Cares programme in Masaka, supported by the Ministry of Health, the Government of Uganda, the Uganda Business Coalition and the AIDS Healthcare Foundation, is an example of an integrated community-based and -driven ARV therapy centre operated by a consortium of partners. Uganda Cares offers three large community-based organizations in Masaka a quota each on the number of people living with HIV and AIDS they could identify to treat with ARV drugs through a system of referral from community based organizations. It trained members of community based organizations, district leaders, local council heads and people living with HIV and AIDS on adherence and support and on issues related to follow-up. In February 2003, Uganda Cares, which employs one physician and one nurse, had 102 people (including 20 children) on ARV therapy in a family-based programme based on preventing the mother-to-child transmission of HIV within the community (the MTCTPlus model), with a 96% adherence rate so far. The eligibility criteria were a CD4 count of less than 150/mm³, having a demonstrable family unit, absence of a history of alcohol or drug abuse and absence of psychotic behaviour.

In working with Kitovu Mobile, a faith-based, community-based organization, Uganda Cares also learned that, beyond treatment support, returning people living with HIV and AIDS to good health also requires support in returning to activities that give them a sense of achievement and purpose. Kito vu Mobile has helped some people start small businesses such as goat-rearing with very positive results.

WHO 2003b. Scaling up antiretroviral therapy: experience in Uganda: case study. (Perspectives and practice in antiretroviral treatment). Geneva: World Health Organization.

BOX 77. COLLAPSE OF AN EFFECTIVE PROGRAMME IN THE PHILIPPINES

Government child health programmes, a community-based research project and a rational drug use programme launched a joint nationwide programme on control of acute respiratory infections (Phil-CARI) in 1989. It expanded rapidly through the early 1990s, training more than 80% of middle managers and frontline health workers on case-management protocols. By 1992, difficulties in maintaining training quality, follow-up and supervision began to occur. External donor support decreased. The health care delivery system was decentralized. Government procurement systems were unable to meet the logistic demands of the programme. The monitoring and evaluation system was inadequate to measure impact.

Dayrit ESN (1999). A national program for the control of acute respiratory tract infections: the Philippine experience. *Clinical Infectious Diseases* 28(2):195–199.

Additional reading

Barker K (2003). Order from chaos: organizational aspects of information, education and communication (a case study from Mali). *Journal of Health Communication*, Vol 8:383–394.

Felber G et al. (2001). Lessons from malaria control activities in urban West Africa using a research-action-capacity building approach. *PLA Notes* 40:18–21.

Holloway K, Gautam BR (2004). *Impact of an NGO-supported supervisory program on quality of care in private drug shops in rural East Nepal*. Presentation at the International Conference on Improving Rational Use of Medicines (ICIUM) Chiang Mai, Thailand.

Quick J et al. (1997). *Managing drug supply: the selection, procurement, distribution and use of pharmaceuticals*. 2nd ed. West Harford, CT, Kumarian Press.

WHO (2001). *How to develop and implement a national drug policy*. 2nd ed. Geneva, World Health Organization.

BOX 78. KARACHI NEWS: BANNED MEDICINES STILL AVAILABLE IN THE MARKET

KARACHI: The government has failed to protect citizens from potentially hazardous medicines freely available despite being officially banned and bearing 'withdrawn from the market' status, said a consumer watchdog organization.

"The killer drug 'Rofecoxib' that was banned worldwide because of its dangerous side-effects, is still available in the market with different brand names like Xib, Corven, Refogesic and Vioxx," A spokesman for the Network for Consumer Protection said on Tuesday.

He said that according to a random survey conducted by The Network these drugs and many other medicines that are not fit for human consumption, because of their reported and documented side-effects, are being sold without any check.

"Pakistani people are virtually defenseless against products like Vioxx that has claimed thousands of lives," said the spokesman. "The Health Ministry needs to strengthen its regulatory system in line with the international guidelines to protect people from the onslaught of dangerous drugs."

Vioxx, a blockbuster arthritis drug, made by American company Merck & Co, was banned in Pakistan after the manufacturers withdrew it from the global market for safety reasons.

New evidence has shown that in the USA alone Vioxx might have caused as many as 139,000 heart attacks and strokes, and that up to 40% of these resulted in death. The drug was available in 80 countries and grossed worldwide sales of US\$2 billion last year.

The Network has reminded the manufacturers and the Health Ministry that to comply with the Drug Act of 1976 companies must ensure the recall of a banned drug from the market within 14 days of the ban and a report to this effect has to be submitted to the Drug Registration Board in the Ministry.

Most of the manufacturers are in contravention of the law, since they have done virtually nothing to effectively recall these dangerous drugs nor sent a report to the Ministry, although it has been over five weeks since the ban was imposed.

The spokesman said that The Network has compiled a list of dubious and dangerous medicines marketed by the industry in Pakistan which are either harmful outright or of dubious nature. These medicines are available in the market, putting people's health and lives at great risk, because the Ministry of Health needs to strengthen its mechanisms to regulate their availability.

The Network for Consumer Protection stressed the need for an independent mechanism in line with international guidelines to avoid a similar debacle in future, and to ensure the safety of medicines in Pakistan.

Source: Karachi News, Wednesday 24 November 2004. <http://www.jang.com.pk/thenews/nov2004-daily/24-11-2004/metro/k7.htm>





Section 4

Bringing it all together

Section 1 introduced the main issues in rational drug use and the theories that underpin efforts to use communication approaches to encourage positive change at community level. Section 2 introduced the main communication methods and channels that can be used. Section 3 has explored the approaches that can help to establish an enabling environment, including the use of managerial and regulatory strategies. This section ‘brings it all together’ by looking at:

- the planning process that can help to develop a successful and comprehensive intervention
- pretesting processes that help to ensure that materials and concepts with promise are carefully tested and validated
- monitoring and evaluation processes that can be used to improve learning about what interventions work best, how they can be improved, and how to assess the impact of different interventions
- a summary of key lessons and conclusions.

Planning

Planning a community intervention is important to ensure that:

- the problem has been identified
- the perceptions of the causes have been explored
- a number of potential solutions have been considered together with the community
- an appropriate selection of a way to move forward has been made
- a process is in place for monitoring progress and evaluating outcomes.

A critical part of the planning process is to clarify what you hope to achieve with your intervention. The greater the clarity you have about the objective of the intervention, the easier it is to formulate activities that are likely to achieve that objective and the easier it will be to measure whether you manage to achieve what you set out to do.

Chapter 9 provides guidance on what to think about when planning, and some tools to help make planning easier.



Pretesting

Pretesting is a vital and all-too-frequently overlooked part of any communication intervention. Pretesting saves time and money. Projects that skip this step often end up with communication material that does not work effectively with the intended audiences.

Pretesting is also part of a dialogue process with the intended audiences. It is a way of discussing key issues, confirming or questioning initial research about the drug use problem, and collecting early views on the likelihood of the success of the planned intervention and ideas for changes.

Chapter 10 gives details of how to pretest communication material.



Monitoring and evaluation

Monitoring and evaluation are part of the normal project cycle and need to be invested in, no matter what type of intervention is being planned. Monitoring relates to how well the activities are being implemented and evaluation assesses the degree to which the project objectives are being achieved. Monitoring and evaluation processes need to be planned and started at the beginning of a project, not handled as an add-on at the end.

Monitoring is a natural component of most communication processes. It is a key way of obtaining feedback on how well the communication is working and of assessing and defining what changes can be made.



In face-to-face communication, for example, good communicators automatically monitor whether they are having the desired effect and vary their style and content accordingly. Many radio and television programmes regularly undertake audience research to track how people are responding to what they are hearing or watching.

Evaluation of communication interventions is more challenging. The usual research goal of establishing links between project activities and particular outcomes is extremely challenging when interventions use a number of actions, are aimed at different audiences, over different time periods, and when effects may not be evident for some time. There is no simple or single way of evaluating communication interventions. Using a number of different approaches, including participatory approaches, is more likely to provide the best information to be able to make adjustments to individual projects or programmes, and to provide policy-makers and programme managers with the best guidance on what type of interventions works best in different settings.

Chapter 11 explores in detail the various issues in monitoring and evaluation, and provides examples of approaches that can be used.

Lessons

Chapter 12 provides a summary of the major points raised in the manual, and is a useful checklist of points to consider when developing an intervention to improve rational drug use in communities.

Planning the process

This chapter summarizes the importance of planning in developing programmes with communities. It provides some guidance on what to think about when planning, and some tools to help make the task easier. It also brings together many of the suggestions made in earlier chapters to show how they fit together in the overall plan.

Importance of planning

Influencing human behaviour is a complex undertaking that requires careful groundwork. To develop an intervention capable of delivering measurable changes requires working with communities to find the answers to eight basic questions:

1. What is current medicine use?
2. What problems are related to current medicine use?
3. What practices put people most at risk and which is a priority for an intervention?
4. What solutions are possible that will build on existing perceptions and understanding to motivate changes in individual and social behaviour?
5. Who needs to be addressed?
6. What channels of communication and what materials/approaches are likely to be most effective?
7. What other measures might be needed?
8. How will the intervention be monitored and evaluated?

Many health communication programmes answer these questions inappropriately or do not examine them systematically. Many programmes have been ineffective because they have targeted practices that may not be the prevalent risk factors, or because they have assumed that educating people about some



Research has shown that educating prescribers is not enough to change injection practices.

aspect of a disease will automatically lead to changes in behaviour (Curtis et al, 1997).

To avoid such a waste of resources, planners need to invest in a modest and focused programme of research to learn from intended audiences and to provide objective data on which to base the design and evaluation of an intervention.

This chapter assumes the research has been done (see the related manual – *How to investigate the use of medicines by consumers* – for details of research methodologies.) A good analysis of the prioritized drug use problem, and participatory identification of perceived causes and possible solutions are essential to be able to develop a successful intervention to improve drug use in the community. Box 79 describes an example of a basic plan to carry out research into a major drug use problem, in this case the factors that might lead to non-adherence to antiretrovirals (ARVs) in Uganda.

BOX 79. RESEARCH INTO FACTORS LEADING TO SUB-OPTIMAL ADHERENCE TO ANTIRETROVIRALS IN UGANDA. (PROJECT PROSPOSAL)

The main objective of this study is to study factors leading to sub-optimal adherence to ARVs in selected government and non-government sites in Uganda.

Specific objectives are to:

- a. Determine patients' knowledge, attitudes and perceptions on the use of ARVs
- b. Establish patients' information sources and communication channels more acceptable to them
- c. Determine beliefs and practices that affect adherence to ARVs
- d. Establish the type of services delivered to patients receiving ARVs in selected sites in Uganda
- e. Establish the kinds of social support given to patients beginning on ARVs
- f. Gather information from ARV users and support groups on improving ARV adherence which can be useful for planning an intervention.



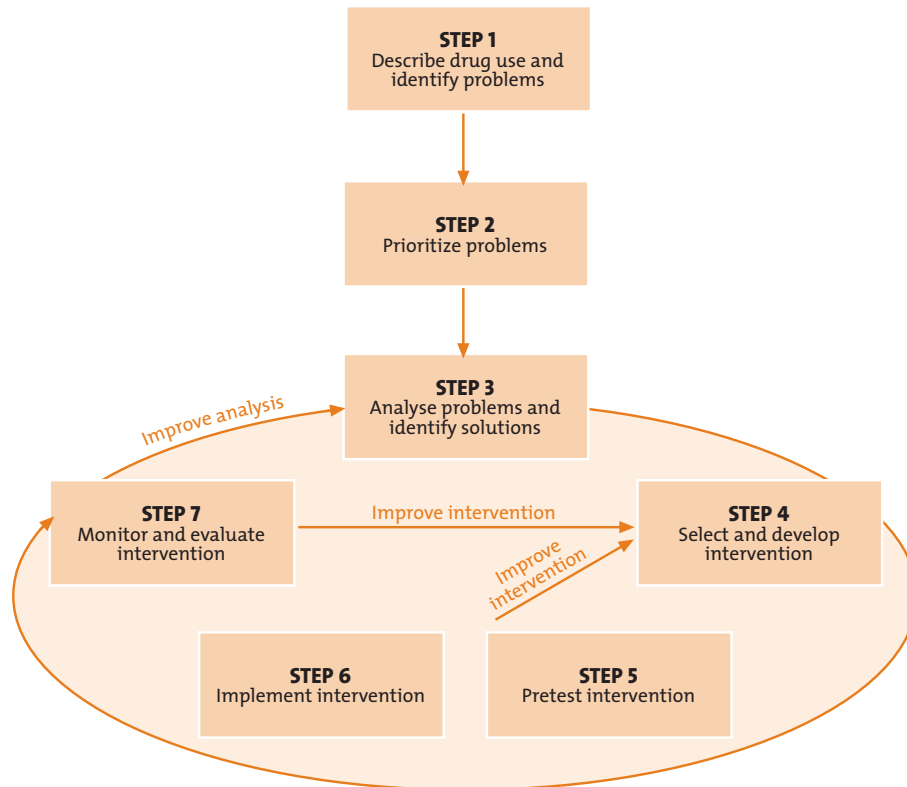
Significance of the study

Findings generated from this study will make several contributions to both knowledge and understanding of the use of ARVs. The study will also contribute to the sociological /anthropological understanding of sub-optimal adherence and be useful in developing interventions that will take into consideration the problems faced by people taking ARV treatment at Jinja Hospital and Uganda as a whole. It is expected that the qualitative and quantitative data collected in this study will be made available to health planners such as the Ministry of Health and it is hoped that this will lead to better designed, better directed and more culturally sensitive intervention programmes to deal with socio-cultural problems associated with sub-optimal adherence. In addition findings will assist the Ministry of Health in efforts to develop a scheme for rational use of ARVs, and also serve as a resource for research teams developing new protocols. Some of the burning issues addressed in this study may be incorporated immediately to help resolve urgent problems that may not require scientific inquiry at Jinja Hospital.

The study will use a variety of quantitative and qualitative methods to collect data. Qualitative methods to be used include exit questionnaires, semi-structured interviews, observations and focus group discussions. Quantitative methods will include retrospective review of patient medical records to extract baseline data.

Nakiyemba A et al. Barriers to antiretroviral adherence for patients living with HIV infection and AIDS in Uganda (project proposal). Available at: <http://mednet3.who.int/PRDUC/FinalProposalARVAdherenceStudyUganda.pdf>

Figure 5. Steps in an effective communication intervention



The approach used in the development of research and in the planning methodology outlined in this Chapter follows the model that was introduced in Chapter 1 (see Figure 5). In this Chapter, we will focus particularly on step 4 in that model – select and develop an intervention. This is a critical planning stage when the communication plan is being developed.

Select and develop the intervention

The key questions in deciding on what the intervention will look like revolve around careful identification of the intended audience(s), understanding of which communication channels or methods are most likely to be effective, and an assessment of whether any managerial or regulatory measures are likely to be needed.

Although research has already been carried out to determine the problem and to analyse some possible solutions, a little more research may be needed to determine which communication channels are likely to be most effective for the particular intended audiences.

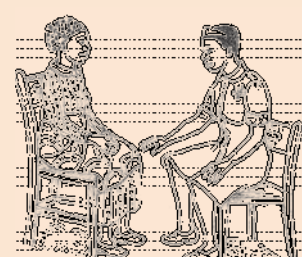
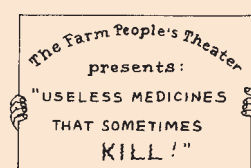
What media do they have access to? What is their preferred way of sharing information and learning about new ideas? What forms of communication do they most trust? What communication channels, given your resources, can you work with? The issues here revolve around balancing the characteristics of the intended audiences, the nature of the methods or channels that could be used, and the resources available.



Box 80 outlines the main components of a communication plan. It is important to be clear about the overall objective of the intervention. Are you trying to increase awareness about a problem (such as the overuse of antibiotics)? Are you trying to improve knowledge about how to deal with a problem (such as how to treat fever in children effectively)? Are you trying to influence behaviour (such as decreasing the use of injections or improving adherence to antiretroviral drugs)? Are you trying to mobilize social support for a major policy shift (such as the introduction of a national drug policy or improved access to antiretroviral drugs)? Or you may be trying to achieve a number of these objectives. Different objectives may have different audiences. They will certainly demand different channels and methods of communication. Refer back to Section 2 for advice on which communication channels are most effective to achieve which objectives. Table 9 provides a simple form to help you to organize audiences, objectives and media for different aspects of your intervention.

BOX 80. KEY COMPONENTS OF A COMMUNICATION PLAN

- Communication objectives (awareness, increased knowledge, behaviours to be influenced/adopted/changed – keep in mind that these may be phased or cumulative and may each involve different channels of communication).
- Intended audience(s) (include extent to which you will involve in programme planning).
- Likely constraints (for each audience).
- Likely facilitating factors (for each audience).
- Approaches to change: power/sanctions, logic/facts, appeal/emotion, incentive/reward, facilitate/remove obstacles, fear or danger/emotion or combinations of these.
- Communication channels. a communications programme should use a combination of channels (known as media mix) to maximize exchange. Possibilities include:
 - visual aids: posters, flyers, pamphlets, brochures, video
 - mass media: radio, television, newspapers
 - folk media
 - interpersonal (or face-to-face).



A combination of communication channels gives the best result

- How materials/intervention will be pretested.
- Collaborating institutions: collaborating with a wide range of institutions in communication activities enhances visibility, potentially increases impact and acts as general advocacy for rational use concepts and the national drug policy.
- Monitoring and evaluation – this should include reporting and publications.
- Timeline (plan of activities).
- Budget with identification of secure source of funding or potential funders to be approached.

Table 9. Preparing a communication strategy
For each intended audience, decide what would be appropriate communication objectives, possible messages to communicate, combination of channels to use, and ways to monitor and evaluate.

INTENDED AUDIENCE	COMMUNICATION OBJECTIVE/ POSSIBLE MESSAGES	MASS MEDIA METHODS	FACE-TO-FACE	SUPPORT MATERIALS	ADVOCACY	MONITORING AND EVALUATION
Young people, children women, men, elders, grand-parents, community leaders, government officials, politicians, health workers, shopkeepers	Reduce unnecessary use of antimicrobials; develop new pricing regulations; encourage generic prescribing; improve use of antimalarial drugs; improve anti-retroviral adherence	Television, radio, newspapers, billboards	Meetings, training, workshops, community events, folk media	Print, audiovisual materials	Working with journalists, developing campaigns, lobbying, networking	Audience research, focus groups, key informant interviews, after-action reviews, participatory assessments, external evaluation

Your intervention is really a pilot study to see what works and what does not, unless you have already tested a number of different interventions, have analysed which are the most likely to achieve the desired results, and are now ready to roll out one of those interventions on a large scale. Because of this, you need to plan both for carrying out the intervention and to make sure that you capture enough information about how it works. This will enable you to make a judgement later about the effectiveness of the intervention and about what needs to be changed to make it more effective or more useable in a different setting or on a different scale.

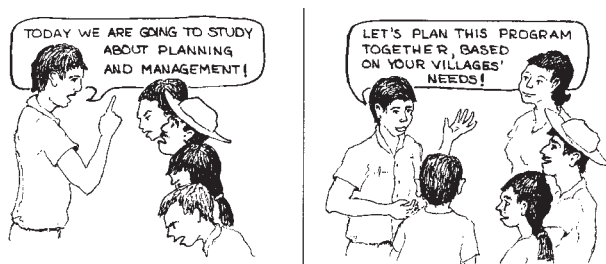
When preparing your communication plan keep in mind the following.

Plan as road map

The communication plan provides the road map for communication activities. When it is first written it is quite broad. Its primary purpose is to establish clear and feasible objectives and to outline how they are to be reached. However, the communication plan should be adjusted or revised over time as more information on the audience is obtained through research, pretesting of communication

materials and monitoring.

Good communication interventions are almost always a case of learning by doing. You should expect the initial plan to change, and need to programme in opportunities to reflect on the lessons learned as part of the intervention.



Resources needed

For all parts of the plan clearly identify what human resources you will need and where these are available. They may include project, NGO, ministry of health staff, or a combination of these. For large interventions, outside expertise in research (exploratory and evaluation), materials development, pretesting and training will almost certainly be needed.

Cost of communication activities

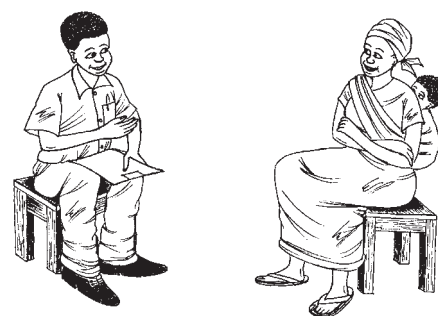
Funding will be needed in order to undertake research, including baseline data on the audience pretesting, monitoring and evaluation. In addition, materials development, broadcasting costs, printing and distribution costs will need to be covered. Funds for training and supervision and technical assistance will also need to be considered and accounted for.

Getting approval

Approval of the plan will be needed, and this may involve government ministries, such as health, education or information, broadcasting authorities, and a formal commitment from participating NGOs. Include getting this approval in the project timeline. Getting the plan formally approved by key authorities helps elicit their commitment and minimizes any possible confusion about objectives and implementation once this has begun.

Formative research

Formative research should provide the data needed to decide on the problems, perceived causes, possible solutions and approaches, communication channels, and the content of communication interventions. It should also provide indications of the language and expressions to be used.



Pretesting and revision

Chapter 10 provides a full explanation of the approaches to use in pretesting materials. This section highlights some of the key issues to pay particular attention to when pretesting materials.

The materials and products are pretested with representatives of the intended audience to ensure that they are understandable, relevant and acceptable. Testing should answer the following questions:

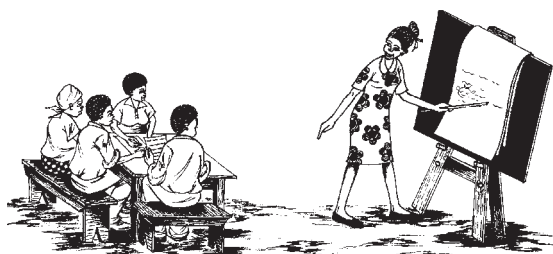
- Does the intended audience understand the materials?
- Do they feel that the materials apply to them or to other people?
- Is there anything offensive or culturally inappropriate?
- Based on responses from the audience, do the messages or their format have to be changed?



Implementation

When implementing a communication intervention, it is important that all the resources, both human and material, are fully prepared. This may mean stockpiling posters, pamphlets, video materials, booking venues and arranging for staff to be available well in advance. It is also necessary to consult with partners well in advance to get their inputs and ensure that they are engaged in planning what and when activities will take place. Keep a careful watch on your timeline which provides a quick visual check of what activities (such as materials' availability) need to be completed before a next phase of the implementation. If delays do occur, inform partners in good time and not just at the last moment when they may have made all the arrangements for their contribution to the programme activity.

You will almost certainly need to engage in some training, particularly if you plan to include face-to-face communication in the programme. Planning for the implementation of training inputs requires careful attention.



Monitor, evaluate and revise

Chapter 11 gives a full description of the issues relating to monitoring and evaluation. Below are some of the important points to keep in mind.

Monitoring

It is vital to monitor that all is proceeding according to plan. Typical monitoring questions include:

- Are the intended audiences receiving and understanding the programme materials and messages?
- Are they using the materials, talking about the contents and learning from the programme messages and the dialogue?
- Are health workers or other intermediaries using skills learned when dealing with patients?
- Is the programme on schedule? If not why not?
- Will programme delays have implications for other activities?
- Is the money budgeted being spent as planned?

As the programme progresses it may be necessary to modify the original plan on the basis of monitoring feedback.

Evaluation

The strengths and suitability of different types of evaluation are discussed in Chapter 11. Even if you are evaluating quantitatively, some qualitative evaluation will greatly increase your knowledge of why the programme achieved or failed to achieve the desired impact. You need to be absolutely clear at the outset about what you wish to evaluate and evaluation indicators must be closely linked to specific programme objectives. Additional indicators may need to be added as you learn how the programme is functioning.

Revision

Good evaluation should give you the information necessary to provide feedback into future work and answer key questions such as:

- Why did the programme (or parts of it) work or not?
- Are there programme changes or improvements that may increase its success?
- Are there lessons to be learned that would help to make future programmes successful?



You will not get answers to these questions from purely quantitative evaluation; qualitative evaluation will also be needed.

Reporting and publishing

It is important to fully document communication activities not only to facilitate proper monitoring and evaluation, but also to ensure that people planning future communication activities can learn from your experience. It is often very difficult, particularly in developing countries, to find reports of even large-scale communication activities. This leads to unnecessary “reinventing the wheel” and waste of experience and resources.

Consider already including in your communication plan how you can report as widely as possible on your work.

- Placing articles in the local press, in professional and NGO newsletters (both local and international);
- submitting an article to an international peer-reviewed journal, if you have a really good, well-evaluated programme, with interesting lessons to share;
- reporting at national (and international) professional meetings and inviting debate;
- suggesting to donors and other collaborating partners that they share lessons learned with other programmes in the region.

A critical element of any intervention plan is the timeline – the diagram that shows when key components of the plan will be carried out. Table 10 provides a sample form that can be used to develop a timeline.

[illegible]

Budget

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Figure 6. Sample activity timetable

Project /Activities	Duration	Period															
		Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Develop proposed first raft	Two weeks	X															
Seek approval with MOH /Facilities	Two months		x	x													
Prepare for stakeholders meeting	TWO WEEKS			X													
Hold stakeholder meeting	One day			X													
Review first draft and send	Three weeks				x												
Finalize draft and send	One day				X	X											
Briefing of team	Two weeks					X											
Selection of data collector & training	One month						X										
Develop tool for data collection	Two months						x	X									
Pretest train	Two weeks							X									
Finalize data tools	One week								x								
Retro review of med records	One month									x							
Data collection FGD	One month									X							
Data collection Interviews	One week										x						
Data collection Observations/ Simulated patient visit /Patient follow-up	Two week										x	X					
Facility observation	One month											X					
Prim data analysis	One month												x				
Feedback to stake holders	One week													X			
Develop survey instrument	One week														X		
Conduct survey	Two weeks															x	
Final data analysis	One month															xxxxxx	
Report writing	One month																x
Stakeholders feedback	One day																x
submission to WHO	One day																x
Send for publication	One day																x

costs). You need to think about the costs of people working in the field (transport, meeting costs, allowances for field staff, local fees for services). And you need to think about any production costs for communication materials (printing, broadcasting fees, audio visual materials). Make sure that you include expenses for pre-testing, monitoring, evaluation and dissemination of any findings or materials. Table 11 provides an outline of some of the major communication expenses that you are likely to incur.

You can design your budget around the activities that will be carried out (research, training, radio programme, print materials, pretesting, monitoring and evaluation) or around the types of expenditure (personnel, transport, materials, consultants/technical advice, administrative services). It does not matter which way you do this. The important point is that you include all the likely costs.

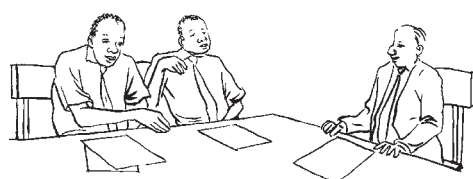
The decision on how you present your budget rests mainly on how you are likely to receive your funding. If you are approaching a number of different donors for

funding, you may want to set out your budget according to discrete activities: one donor might fund the research; another, the production of materials; another, the delivery of training.

On the other hand, if you are receiving funding for the full intervention from a single donor, seeing how much of the budget is going on

personnel, how much is going on field activity and how much is going on administrative costs may be more important for the donor. Table 12 provides an example of this type of presentation. For each of the budget lines – particularly those that describe an activity such as a training workshop or the production of a particular material, you probably want to have developed first a separate, detailed budget of the particular costs involved so that your costs are realistic and if a donor requests further details you have them readily available.

If you are seeking funds for work in your country from external donors (or from donors who usually make payments in foreign currency) you have to remember



to convert any local currency costs into the foreign currency using a consistent exchange rate. If your proposal is for activities to be carried out over more than one year, you may encounter some fluctuation in currency exchange rates. You may have to estimate what the rate will be in future years to avoid being left short of funds.

Table 11. Costs for communication activities

NATURE OF EXPENSE	COSTS
1. Communication research including initial audience research, materials testing, and monitoring and evaluation is absolutely essential. Resources are needed for staff salaries, travel, per diem costs for initial data collection about the audience; and for modest supplies for testing materials and report writing. In some settings, a local university may have a research department, or the Ministry may want to develop its own capacity. Each alternative has different cost implications	• Staff salaries: — interviewers — trainers of interviewers — supervisors of interviewers — data analyst • Transportation • Per diems (field research) • Data processing (computers or manually) • Report writing
2. Broadcast cost. Radio or television requires funds for announcers, actors, scriptwriters, technicians, and programme directors. These services can be contracted, or in some countries cooperation with government stations is desirable. Television is usually considerably more expensive than radio. Costs are higher for both production and airtime.	• Salaries or fees: — directors — producers — technicians — actors — scriptwriters — announcers • Transportation – field programmes • Audio-visual supplies • Studio and/or equipment rental • Copyrights (music) • Airtime
3. Printing costs can be high. Government presses are often less expensive than commercial systems, but their reliability is sometimes unpredictable.	• Designer's fees • Layout and prototypes • Mass production
4. Distribution costs for flyers, posters and pamphlets can include freight and delivery charges	• Freight, transport of print materials and delivery
5. Training and supervision of health workers and other providers in communication skills. Some of these costs, such as training and transportation, can be shared with the overall programme since the health worker training sessions will cover communication and other skills. Supervisors who will visit to follow up on training will not go to a community for communication activities only. Health workers may need to travel to nearby villages. These costs are often underestimated.	• Complementary training in communication skills: — per diem — transportation — supplies/communication materials • Transportation for community involvement activities • Transportation for supervision activities: — means of transportation — gas — spare parts
6. Technical assistance	• Communication coordinator's salary • Fees for other communication resources • Consultants (national or outsiders).

Table 12. A sample budget

PROGRAMME NAME: ENCOURAGING ADHERENCE TO ARVS IN RURAL COMMUNITIES						
DESCRIPTION	NO.	DAYS/UNITS	RATE	AMOUNT US\$	TOTALS US\$	NOTES
Personnel						
Programme manager	1	50	200	10,000		
Research director	1	40	200	8,000		
Programme assistant	1	100	100	10,000		
Sub-total					28,000	
Activities						
Formative research and needs assessments	10			18,000		1
ARV workshops	5	4 days ea	2800	14,000		2
Trainers – ARVs	4	20	100	8,000		3
Counselling workshops	10	5 days ea	3400	34,000		2
Trainers – Counselling	10	30	100	30,000		3
Community support workshops	20	3 days ea	2500	50,000		2
Trainers – Community support	20	30	100	60,000		3
Production of training materials						
ARVs – participant manuals	1	300		6000		4
ARVs – trainers modules	1	10		2000		5
Counselling – participant manuals	1	600		7500		4
Counselling – trainers modules	1	20		2500		5
Community support – participant manuals	1	1250		12,500		4
Community support – trainers modules	1	30		3000		5
Information materials	3	10000	5000	15,000		6
Community theatre group		20 perfs.		20,000		7
Radio programmes		3x15 mins		35,000		8
Sub-total					317,500	
Project administration						
Communication costs				5,000		
Office costs				12,000		
Finance and admin costs				8,000		
Sub-total					25,000	
Monitoring and evaluation						
Monitoring costs				15,000		
Final evaluation				20,000		9
Dissemination of findings				6,000		
Sub-total					41,000	
Totals				411,500		

Notes: The project time scale is 24 months. In that time, a total of 200 healthcare providers will be trained in appropriate use of ARVs, 500 counsellors will be trained to work at VCT sites, and 1000 community support workers will be trained (most of whom are HIV-positive). Training materials will be adapted and pretested from materials developed in a nearby country; research will be carried out to determine community knowledge and understanding about the causes of HIV, the reasons why there has been little uptake of VCT, and attitudes toward those who are HIV-positive. Information materials will be developed, pretested and distributed. Community theatre and short radio dramas will be developed.

1. Includes costs of local researchers and transport
2. Workshop costs include facility hire, local transport costs, accommodation, food
3. Trainers are part-time consultants working on particular workshops
4. Manual costs include writing/editing; pretesting; design; printing
5. Module costs include writing/editing; revision after piloting; photocopying
6. Information materials includes cost of writer, editor, designer, pretesting and print and distribution
7. Community theatre group includes costs for development of scripts, pretesting, revision, transport and fees for performers
8. Radio programmes includes costs of developing scripts, pretesting, and production costs; the radio station has donated the air time
9. Evaluation includes cost of external evaluation consultant.

Additional reading

Curtis V et al. (1997). Dirt and diarrhoea: formative research in hygiene promotion programmes. *Health Policy and Planning* 12(2):122.

JHUCCP 2003. *A field guide to designing a health communication strategy*. Baltimore: Johns Hopkins University Center for Communication Programs. Available at: <http://www.jhuccp.org/pubs/fg02>.

Hubley J (2004). *Communicating health: an action guide to health education and health promotion*. 2nd ed. Oxford: Macmillan. See: <http://www.communicatinghealth.com> for summaries and case study material used in the book (accessed Aug 2006).

US Department of Health and Human Services (2002). *Making health communication programs work: a planner's guide*. 2nd ed. NIH publication no. 89-1493. Bethesda, National Cancer Institute. Available at: <http://www.cancer.gov/pinkbook>.

An illustration in a warm, orange-toned style depicting a community health survey. In the foreground, a person holds a sign that reads 'DRUG USE SURVEY'. Behind them, a diverse group of people, including men, women, and children, are shown. Some are looking at the sign, while others are engaged in conversation. The background features stylized trees and foliage, creating a sense of a community setting.

10

Pretesting

Pretesting is a method of taking draft information and communication materials to an intended audience before it is produced, to find out if and how it can be improved. It is an essential step in the development of any communication intervention.

Pretesting serves two main purposes. It tests draft materials for recognition, familiarity and relevance, and acceptability among the intended audience. It also opens a dialogue with the individuals and groups for which the material is being developed.

This chapter will help you to understand:

- the importance of pretesting
- when, where, with whom and with how many to pretest
- who can conduct a good pretest
- attitudes and skills needed by pretesters for collecting quality information
- how to conduct a good pretesting interview
- how to record and analyse the information
- how to advocate the importance of pretesting to programme managers.

What does pretesting a communication product assess?

Pretesting is a creative process. It needs to be done systematically during the life of a project. In many cases, pretesting materials once or twice will be enough to make the most important changes. For the best results, pretesting must have clear goals and be flexible.

Pretesting assesses:

- **Recognition:** Have the materials been understood? (Are the contents perceived in the way that they were intended?)
- **Familiarity and relevance:** Is the problem and situation known to and relevant for the audience? (Do they recognize the personalities and situations and identify with them?)
- **Acceptability:** Are the materials acceptable to the audience? (Is there anything offensive in them? What helps make the material more acceptable from

a social, cultural and economic perspective?)

Research shows that people are most likely to consider or adopt changes if these factors are considered.

Interviews with members of the intended audience help to improve the materials being developed before they are produced. It is crucial that pretesting takes place early in the development of the material so that community feedback can be put to the most use. It should never be seen as criticism of those who developed the materials.



For this drawing, made in Kilifi, Kenya, pretesting would assess whether respondents have interpreted this drawing as: A mother with a child with fever on her lap, wiping his forehead with a wet cloth? Is this a familiar method to them, is this a common and useful thing to do? Is the mother's position and clothing acceptable?

Why should you pretest?

Communication materials benefit from high-quality pretesting in a number of ways, including:

- Ideas given by the target audience help move the material and communication intervention 'closer to the people'. This increases possibilities for the intervention to be realistic and meet people's needs, and ultimately to be successful.
- Focused testing can help project staff co-operate. Field staff members should discuss pretesting results with project planners, managers and artists.
- Pretesting can motivate the staff. They feel 'useful' working so closely with the intended audience, and get direct feedback on ideas and materials.
- Incorporating this step gives project staff (including artists) new skills which will be useful for later projects. (Artists learn how people see pictures and can use this information to ensure their next assignment's first draft is more acceptable).



Experience shows that pretesting actually saves time and money. Projects that skip this step often end up with communication material that is not understood, does not appeal to the intended audience or does not match its views on the problem. That results in wasted resources and time, and can have negative health impacts.

See Box 81 for an example of how pretesting in Pakistan helped to pick up negative audience response to a television campaign about immunization.



The first version of this teaching poster (UNICEF, Nepal) showed respondents interpreting the photo as "urban mother", and they did not identify with her. Hairstyle, clothes and the way of feeding the child were seen as urban. The second version was identified as a typical rural mother, feeding the child the traditional way. (95% of the country is rural).

BOX 81. PRETESTING IN PAKISTAN

Two television spots devised in Pakistan used Imran Khan, the famous Pakistani cricketer, to deliver immunization messages. Pretesting, however, found that 72% of rural respondents did not know him. Of those who recognized him, many commented – and quite rightly – that as he was unmarried, he could not have first-hand knowledge of infant health problems.

Adam and Harford (1999)

Planning for pretesting

Before pretesting begins it is crucial to prepare carefully for the fieldwork phase. Do not overload respondents with too much material. Develop checklists if you are an experienced pretester and use an open interview method, or detailed recording sheets if you are unfamiliar with the method. Both methods enable you to remember respondents' views on various topics. Table 13 at the end of the chapter provides an example of a pretest data sheet that can be used to record the responses of a number of respondents to a particular content message. You can adapt this to your own topic.

Pretesting must be done among representatives of the intended audience. Use the planning list in Box 82 to assist preparations before going into the field.

Who should do the pretesting?

Often, it is a good idea for project staff to hire a researcher or someone experienced in interviewing for the first (and probably the second) time they carry out pretesting. Once the project staff members understand the principles of pretesting, they can start to pretest on their own.

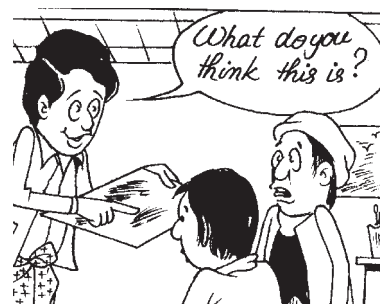
Where can you find people with experience in pretesting and how do you know if they can do a good job? If there are no people with pretesting skills in your organization/ department, you may find a suitable person in a health education department, a research institution, an advertising agency, a media company, or an NGO.

Many different people can carry out pretesting for your project. Researchers, project staff and artists are among the most common choices. Each group has its own advantages and disadvantages. Box 83 offers suggestions on how to choose the type of person you need for your team.

Review what you want to know

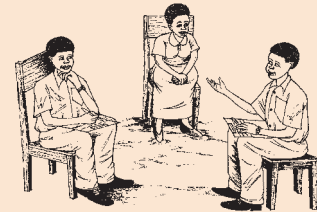
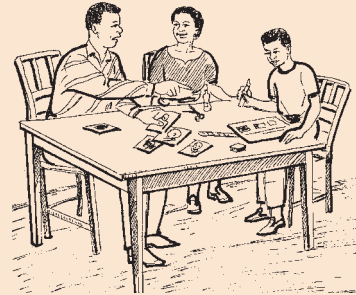
To test your materials, you need to assess recognition, familiarity and acceptability. Use mainly descriptive, open-ended questions when pretesting. The following sample questions could be used to assess visuals. (Similar questions could be prepared to test a text or broadcast programme.)

Recognition: What do you see in this picture?
What do you think it looks like?
How do you think the person feels?
(This can be used if the respondent has already identified a person.)



BOX 82. PLANNING LIST TO PREPARE FOR PRETESTING

- **Choose your team of pretesters and recorders.** It is important to get the right team with the right attitudes and skills, as this has a major influence on the quality of the information you obtain.
- **Choose your materials.** Do not take too many, usually two or three text items is enough. If you are developing a flyer, limit the text to one full page of content. For pictures, take a maximum of five to 10. Rough sketches can also be used if this is the first time the material is being pretested.
- **Give each picture/piece of material a number** and review what you want to know about each of them.
- **Develop a question guide or recording sheet** for each piece of material. In both cases, note possible probing questions you can use during interviews.
- **Decide whether you are pretesting with individuals (to define problems) or groups (to discuss solutions),** or a combination.
- **Decide how many people you should pretest with.**
- **Decide where you want to go and for how long.**
- **Develop and discuss your methods for how to conduct the pretesting.** Train your pretesters and recorders, formally (a course) or informally (discussion on the job).
- **Role-play an interview with your colleague.** Pay special attention to the introduction and the respondent's motivation. Give each other feedback on good points, and on points to improve.
- **Discuss the tools with the interview recorder or a pretesting colleague** to prepare your work strategy and decide who will do what. Plan to work in pairs, with a pretester and a recorder (who can change jobs in the field if they both know how to pretest).
- **Encourage your recorder to record 'off-the-point' comments.** These may be significant and provide understanding about the context in which the material is being used. For example, when pretesting materials for use with pregnant women, a comment such as 'Of course, Mwajuma (the traditional birth attendant) knows everything there is to know about what medicines to use' suggests that even if your material is well designed, you may need to explore other communication approaches to deal with the existing context.
- **Decide how you will analyse and process the results.**
- **Check that you have the tools,** background materials and checklists you need.



- Familiarity:** **With people/style:**
Where do you think this person comes from? (Or, how does this person appear, compared to people in your area?)
With the idea:
What is happening in the picture? (Or, how do you carry out the activity in your area?)
- Acceptability:** How do you like this picture? (Or, is there anything in this picture you think people in this community would not like? Please describe what it is.)

These aspects ask for a description. After testing for this, you can (if relevant) test for interpretation of meaning, for example, by asking: "looking at this picture, what does it tell (or teach) you?"

BOX 83. CHOOSING PRETESTERS

Researchers

Advantages: Professional researchers know how to ask questions, carry out sampling, and process information. You can give them the materials to be tested, explain the aims, and send them into the field.

Disadvantages: Academics more comfortable with theory may not work well in the field. Some researchers may not understand the purpose of pretesting, and will want to make it an 'academic exercise' interviewing 100 people to make the basis for changes 'statistically sound'. This kind of action is unnecessary and will make the exercise too expensive.

If you hire a researcher, keep in mind that you will not build up pretesting skills in your own department. This will keep you dependent on others to do this work. You can avoid this problem by having someone from your project accompany the researcher and learn skills from him or her that can be used later by the team.

Planners and implementers (and other project staff)

Advantages: These types of professionals know the project and its purpose. They can interpret comments and feedback in a wider context. Members of this group are likely to use the results, and may contribute to a healthy learning atmosphere and a closer link to the audience.

Disadvantages: These people have invested a lot in the present project ideas. They may be defensive about them and biased in their views. In addition, they may not know how to ask good questions, listen well and record the results.

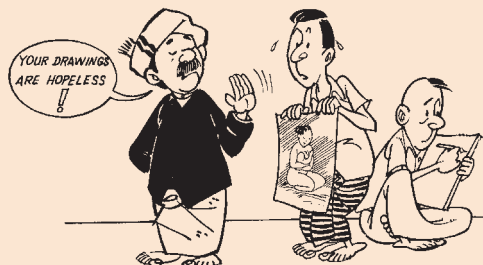


Artists

Advantages: It is advisable to have an artist with you in the field, especially the first time a picture is tested. He or she can make new sketches based on people's suggestions and you can receive feedback on the new material. This reduces the time needed for further testing. Also, people enjoy giving instructions and watching their suggestions being put on paper. This makes them feel that their suggestions are taken seriously. You can also have the artist do the recording at interviews. This helps reduce staff costs. The artist can still make adjustments to drawings at the end of the day.

Disadvantages: Artists must learn how to work constructively in the field. An artist may naturally feel defensive when his or her pictures are being criticised. It is better for the artist not to reveal that he or she created the materials as people may be reluctant to criticise someone's work when they are present, even when they are asked to do so. Once respondents feel their opinions and suggestions are valued and welcome, the artist can start making new sketches based on their suggestions.

Experience suggests that artists should not be sent into the field alone until they have been to the field several times with experienced pretesters.



Testing with individuals or groups?

Testing with individuals and groups can be used for different purposes. Both methods should be used in combination for the most effective approach.

Testing with individuals defines the problem with a picture or a text. This puts the material to the toughest test. Even if the materials will be used later for group discussions, it is best to first test them with individuals.

Testing with groups identifies solutions to problems in a picture or a text. Groups can often suggest how materials can be improved. After testing with individuals, you can gather a group of six to eight people to confirm and discuss the determined problems and search for solutions.

Some questions may help the pretesters decide which method to use in different phases, including:

- How will the picture or text be used? Will the health worker or provider (or someone else) use the picture or text themselves or as part of a group activity? Or will it be handed out for people to study or to use on their own?
- At what stage(s) in the development process (of the pictures/text) is identification of problems essential?
- When could the creativity of a group (such as community women) be used to develop practical, locally appropriate solutions?

When testing with groups, it is usually more constructive to work with men and women separately, because in many cultures perspectives may vary by gender and in mixed gender groups men may be vocally dominant.

How many people should you test with?

The rule of pretesting is: continue testing until you have defined the problem, or seen a trend in the responses. Keep going until you can envisage an improved version of the text or visual.

We recommend testing with 20 people to meet quantitative standards. If you receive many, very different responses, you may have to test with approximately 30 people. These criteria should be used specifically when testing final versions of materials (when the materials should appear in the final layout and size intended).

Often you will get an impression of the materials' problems within the first five to ten interviews, especially when pretesting the first version. For example, if you show a graphic and 10 people say the man in the picture looks sick, and one says she is unsure, you could decide the picture is good enough. (You could also continue testing to be absolutely sure). However, if five people say the man is probably sick, and five say he is just a man, you should go back to the drawing



board and make him look sicker before you interview more people. A 70% 'correct' recognition rate is viewed as acceptable for the final version.

Where will you test, and how long will it take?

The materials should be tested with representatives of the intended audiences. If the materials will be used in several different communities, you should select at



least two or three different sites for the testing.

The rules above apply **within** communities, and **between** communities. That is, test with enough people in one community to determine where there are problems and then repeat this exercise in the next community

If the results in the second community differ greatly from those found in the first, you will need to test in more communities until you see a **trend**, have **defined the problem**, and have

decided what the next version will look like.

The time required for pretesting depends on a number of factors, including:

- how far you have to travel;
- the number of people to be interviewed;
- how many pretesters are in the team;
- how many materials must be tested;
- the sensitivity of the materials (when testing sensitive issues, you will find that it takes more time to find people willing to be interviewed, and to establish a safe, comfortable atmosphere).

Box 84 provides some guidance on how to calculate the time you might need.

How to conduct a pretest

The main influences on the quality of the information from a pretesting interview are:

- the attitude of the pretester
- interpersonal communication skills of the pretester and recorder
- the way the pretester asks (open) questions, and probes
- the way the pretester listens actively to the respondent.

BOX 84. ESTIMATING THE TIME NEEDED FOR PRETESTING

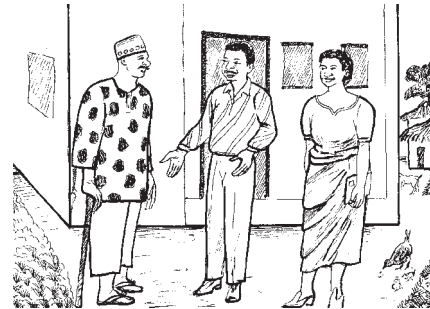
The amount of time a team of two (pretester and recorder) needs for pretesting depends on the material to be tested. The guide below gives an estimate of the time involved for testing different materials.

- A simple poster containing one idea – 10–20 respondents: 1 day.
- A set of three teaching posters, each including some text – 10 respondents: 2 days.
- A simple leaflet (printed on one full page, four to five main messages) – 10 respondents: 1 day.
- A 10 minute educational radio programme – 10 individual respondents and one or two groups: 2 days.

Meet the community leader

It is usually not necessary to inform people in the community about your project before you arrive for pretesting. However, it may be helpful to meet with the community leader and inform him or her about your project's purpose. Stress that you and your team will be testing materials and asking for people's advice on how to improve them.

Show him or her the materials, and ask for comments or opinions, if appropriate. Be careful about testing with the leader, in case the leader sees it as "losing face" if there is anything he or she does not understand.



Work with a recorder

When interviewing make sure the respondents are put at ease. The interviewer must stay focused, attentive and involved in the conversation to achieve the best results. To ensure that, it is best to work in a team and let a co-worker record the discussions. Interviewers should be careful not to give non-verbal cues to respondents or to ask leading questions that can affect the respondent's answers. Keep in mind that there are a number of ways to guide the interview without steering the responses.



Create a good atmosphere and motivate the respondent

Pretesting depends on effective, fruitful interviews with members of the intended audience. Your attitude, and the way you ask questions and listen actively will critically influence the quality of the information you obtain. Keep the following in mind:

- **Select an undisturbed place** for individual interviews. Make sure the respondents will feel comfortable. For group interviews, ask the group members where they would like to hold the interview.
- **Motivate the respondent to participate.** Explain the purpose of what you are doing and the importance of the respondent's contribution and views.
- **Invite participants to ask questions and establish good two-way communication.**
- **Take away the fear of not being able to give the "correct" answers.** Explain at the beginning of the interview, and reinforce whenever necessary, that there are no wrong answers to the questions you ask. You simply want the person's opinion. Make it clear that you are asking many people the same questions.
- **Explain that you are testing the material, not people's intelligence.** People can be concerned that you will find their answers inadequate or dumb. Let them know that you are actually testing your team's ability to portray community ideas correctly! And that you will use their answers to improve the materials.

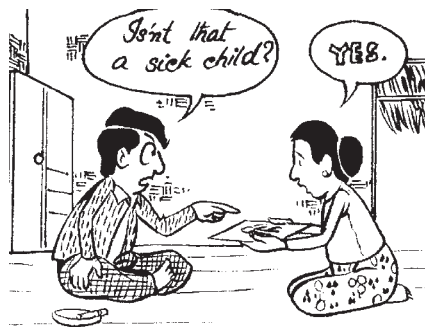


Ask open questions to get quality information

Open questions are the most used in pretesting. Open questions ask the respondent to describe what he or she sees or hears, and will give you the best quality information. This method also communicates the (unspoken) 'message' to respondents: "I am interested in your ideas and opinions. Please tell me what you think." A good open question is: 'what do you see in this picture?' Others are: "and what else?" and "please give me an example".

Closed questions lead the respondent to agree

Avoid asking closed or leading questions that can be answered by a simple 'yes' or 'no' answer. These questions result in little or no information. They can also make



the respondent feel that you are not really interested in his or her ideas, but would like the respondent to agree with your own ideas. A typical closed question is: 'Do you think this woman looks happy?'

'Why' questions ask the respondent to analyse, which can be uncomfortable or challenging. If you use 'why' questions, ask them carefully, with a friendly voice. They are often asked when the pretester disagrees with the respondent. For example, if the respondent has said a woman who is meant to be sad, looks happy and you simply ask: "why do you think

she looks happy?", it could imply disagreement. A better way to ask is: "what is it about this picture that makes you see this woman is happy?"

Ask probing questions to get to the key issues

Probing or follow-up questions encourage the respondent to give more detailed information on a topic raised in response to one of your questions.

Below are some examples of probing questions:

- Could you please tell me more about... (what the person has said)?
- What is it about the man that makes you feel he is sick? (This can be used after the person has identified a sick man.)

Active listening makes the respondent feel valued

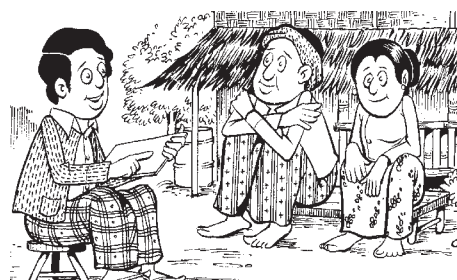
Active listening means giving someone your full attention, while trying to understand what the person means to say from their perspective. This needs to be without judging them, so you will have to set aside your own opinions for a while. Active listening stimulates openness and creativity and encourages the respondent to formulate ideas and opinions about the materials you are testing. It makes the person feel good – because he or she feels respected and valued. Active listening is an essential skill in pretesting and is the best way to get good quality information.

Interviewers' attitudes and behaviour affect the interview

The main influences on the quality of the information from a pretesting interview are the attitudes and behaviour of the pretester and the recorder. A good interviewer is open, neutral, and accepts all opinions and comments from the respondent. Good interviewers keep their own opinions to themselves.

The main rules include:

- **Build up confidence and trust.** These elements are essential to obtain and maintain the respondent's attention.
- **Stay focused on asking questions,** probing, and maintaining good communication with the respondent. Leave the writing to the recorder.
- **Keep a neutral but friendly expression** when asking questions, and throughout the interview.
- **Give neutral but encouraging feedback** throughout the interview (saying 'thank you', nodding, smiling, or whatever is culturally appropriate).
- **Listen carefully and attentively.** Active listening (leaning forward, nodding, keeping eye contact) tells your respondent that you are really interested. To have someone listen intently is very stimulating and it motivates the person to express his or her honest opinion. Such listening improves the quality of information you obtain from interviews. Avoid making a respondent repeat an answer.
- **Use male and female staff wisely.** The gender dynamics involved in pretesting interviews vary from place to place. Ask yourself the question: How can I get the best information from the target audience, and how can I use my male and female staff in the best way?

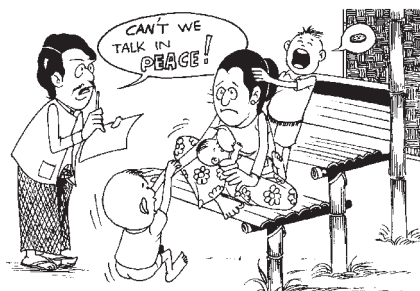


Box 85 provides a list of things to avoid when pretesting.

Dealing with disturbances

People are curious and will gather around the interview. It is an event and most people will find it entertaining! Sometimes this will disturb the atmosphere, other times it may help to relax the situation. You have to decide what will bring about the best interview, without alienating people. If onlookers stay, ask them to allow the respondent to answer the questions without prompting from others. However, if they also want to be interviewed, ask them to stay away until it is their turn – otherwise their answers will be influenced.

Be aware that people may laugh at a respondent who seems to give a 'wrong' answer. Typically this happens when interviewing low-literate women, and the young men or school children listen in, and comment. This can be embarrassing and disturbing for the respondent. Make sure that you are prepared to deal with this type of situation by explaining that your purpose is to test material not individuals' intelligence, and to gain valuable advice from the community. In such cases, it usually works best to ask onlookers to leave, so that you can conduct the interview in peace.



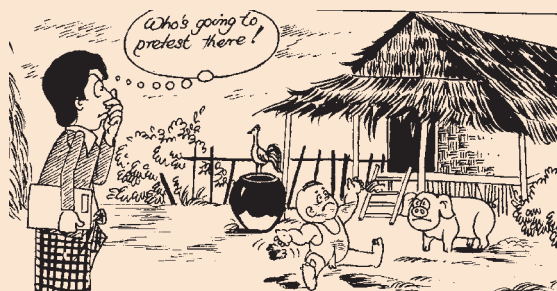
Parents or grandparents may be looking after young children. Ask them to arrange for someone else to watch over the children during the interview. Having a few toys and providing snacks may help.



BOX 85. THINGS TO AVOID WHEN PRETESTING

Don't react negatively

The tone of your voice and your facial expression can betray your feelings. It is crucial to remain neutral even if the respondent has said something you find incorrect. Remember that 80% of human communication is non-verbal, including the tone of your voice. People respond more to the feeling beneath your words than to the actual words. Neither the interviewer nor the respondent may be aware of it, but if the respondent feels you are judging him or her, you may get a negative reaction. This can ruin the contact and the interview.



Do not “assist”

You can always rephrase the question, if you sense the respondent has not understood. However, give the respondent time to think before you do this. People in the community may have a different pace of life and conversation style from urban-based pretesters.

If there are many pictures on a page, or many ‘ingredients’ in a picture, you can help start discussion by pointing to an easy part of the picture or page. Instruct the recorder to note if you give such clues.

Do not give your own views

If a respondent asks how you would interpret a picture or text, turn the question back to her or him by repeating what the respondent has already said. If the respondent insists, repeat what someone else has said about the picture or text. Choose a response that closely reflects one of the respondent’s own comments. This situation arises when a respondent feels insecure about his or her own opinion and needs reassurance.

Never:

- tell people (or show non-verbally) that they are wrong;
- contradict people;
- argue a point;
- teach;
- speak to your recorder during the interview;
- speak to other community members during the interview (except to give information or request them not to help);
- ask challenging questions such as “Did you understand?” ;
- use leading questions (which can be answered by ‘yes’ or ‘no’);
- test too much text or too many pictures with one person – five to 10 pieces of text or pictures are usually the maximum;
- use expressions like “show me”, or “point to” as they tend to be directive or instructional.

Pretesting methods for different materials

Pictures: Test the pictures one by one. If you want to test several versions of the same picture, you should first test each picture individually for content recognition, then for familiarity and relevance and for acceptability. Afterwards, put all the versions in front of the respondent and ask which one he or she prefers and why.

Be aware that for most low-literate audiences without much experience in interpreting or learning from pictures, a visual is seen as **descriptive** (“The picture shows a child getting an injection”), and **not** as carrying **meaning** (“The picture shows it is important to immunize your child”). If you are testing for meaning, do so after testing for recognition, familiarity and relevance and acceptability. An appropriate question is: “Looking at this picture, what does it tell (or teach) you?”.

If you test the materials using an ‘open’ interview schedule with a checklist, comments on acceptability and familiarity usually come up naturally in the course of the discussion. This is especially true when talking about preferences among several versions. Recording such comments is crucial.

Text: Ask the respondent to read through the text, sentence by sentence. Note words that are difficult to pronounce or where the respondent hesitates. Ask if any words are difficult to understand. After each paragraph (or other natural division), ask the respondent what this text means in his or her own words. If the text is unclear, explain what it is supposed to mean, and ask the respondent how he or she would express this idea. Review the whole text this way – sentence by sentence or paragraph by paragraph. At the end, ask the respondent what he or she thinks is the meaning of the full text. Compare the respondent’s understanding to the intended purpose. Explain what the writer wanted to say in the text. Ask for suggestions on how to express these ideas in a clear way and discuss.

Radio programmes: Play the entire programme without interruption. Ask the respondent questions based on the programme’s objectives. Is the programme supposed to convey certain knowledge? Create motivation? Inspire action? Test for recognition of ideas and contents, familiarity and relevance and acceptability.

After discussing what it was supposed to communicate, play the programme again. Ask the respondent to stop the programme when he or she has something to say about it. Ask for suggestions to make the programme better. This is often easier when testing in a group. This process can take a long time.



Recording answers

Experienced pretesters usually prefer not to use a standard answer form. They find it restricting and say it does not encourage probing. However, ‘new’ pretesters often feel more confident with a form to guide their work.

Whether you are using a pretesting form or conducting an ‘open’ interview, it is always advisable to work in a pair. Experience has shown that interviewers ask better questions, probe deeper and listen more attentively when they do not have to write down the answers as well. This results in better quality information.

In an interview conducted without an answer form, the pretester should sit with the recorder before the interview and formulate a few open questions about the visual or text. These questions should be developed based on an understanding of the tested material's objectives.

Once the pretesting team understands these aims well, they can ask the prepared questions first, and then follow up with relevant probes until the full meaning of the picture or text has been explored. At the end of the interview, the pretester can ask the recorder if there is anything he or she has forgotten to ask. Except for such additions, the recorder should be silent during the interview.



While it is not necessary for the recorder to have research skills, it is a definite advantage. A skilled recorder can alert the interviewer (after the interview) to questions that were asked incorrectly, not followed-up, and to any non-verbal signs that were disturbing or encouraging. The

recorder should observe and record non-verbal responses. In this way the team can gradually improve its methods. It is important to keep in mind that learning how to pretest is mostly done through practise, with constructive feedback from the recorder to help sharpen your skills.

At the end of this chapter you will find sample recording forms that can accompany the data recording form. Table 14 provides an example of a background sheet which can be used to collect information about the respondents. Collecting this information allows you to analyse the data collected according to age, gender or education level. Table 15 provides an example of a summary of results sheet, which is a convenient way to bring together the initial findings. When making your own forms, check the following points:

- **Separate answer sheets.** Use one sheet of paper for each picture, symbol or illustration. This system makes recording answers slightly more difficult but will ease analysis of the results and the decision made about each picture. Make sure there is a unique identifier for each respondent.
- **Record answers verbatim.** It is important to record the responses using the respondent's own words as much as possible. Such answers provide much more information than just recording 'understood' or 'not understood', or using checkmarks and crosses. Recording what people actually say will give you an indication of the response 'trend' and let you know the range of expressions/interpretations in which you are operating. This information is needed to decide about the degree of understanding, how a picture or a text should be changed, and also (where applicable) to make comparisons between countries about common principles of perception. Design your recording sheet with this in mind, and leave enough space for verbatim responses. If the person speaks too fast or says too much to record, interrupt them by saying "This is very interesting. I want to be sure my recorder gets this all down. Did you say ...?" Then repeat what was said to clarify and ensure accurate recording.
- **Taping.** Tape recorders should not be used, except in combination with recording sheets.

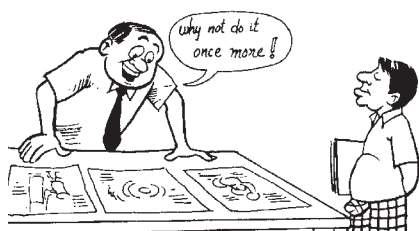
Convincing managers about pretesting

Many managers are reluctant to agree to pretesting of educational materials because of the added time and cost, and because they are not convinced about the need. At the same time, most decision-makers are sensitive to wasted money and resources, and want to prevent this from happening.

Presenting your manager with convincing arguments about the benefits of pretesting is the key to getting approval to carry it out.

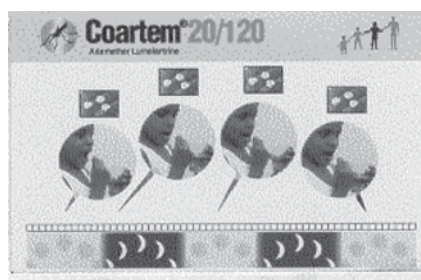
The best way to convince your manager about the importance of pretesting is to show him or her an example of two (or more) versions of the same materials, which were improved through pretesting comments given by the target audience.

Most managers will be convinced when confronted with evidence of target populations not understanding or accepting material produced without their input, and a discussion about the potential consequences on public health of producing such materials.

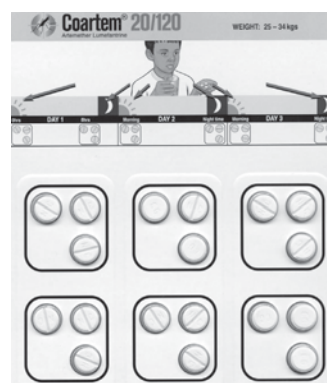
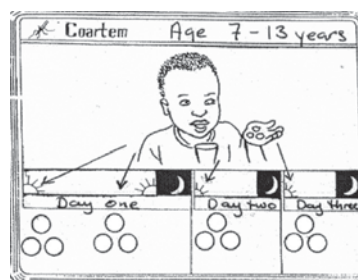


Conclusions

This chapter underlines the importance of pretesting in the development of any communication material. It is a creative process that helps to test for recognition, familiarity and relevance, and acceptability. However, it is also part of the dialogue with intended audiences and through the active listening it requires, pretesting is one of the best ways of getting quality information. Much of what is learned



Pretesting pays. The first version of the antimalarial instructions for Coartem was understood by 0.6% of users ($n=150$) and 20% of health workers in Malawi and Tanzania. The last (6th) version was understood by 57% of users and 90% of health workers. The final version was the basis for developing instructions which are now used globally – see example of global version for 3 tablets from Novartis Pharma. The course was changed from 4 doses over 3 days (at the time of pretesting) to 6 doses over 3 days.



through systematic pretesting can help to bring the communication material and the overall approach much closer to the intended audience, and thus increase the positive impact of an intervention.

Additional reading

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Haaland A with Akogun O. and Oladepo O (2000). *Reporting with pictures. A concept paper for researchers and health policy decision-makers*. Geneva, UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. <http://www.who.int/tdr/publications/publications/pictures.pdf>.

Haaland A (2002). *Pretesting of packages and drug-packs labels for Coartem. Malawi and Tanzania*. Report to WHO/TDR and Novartis (2002).

Murray Bradley S (1995). *How people use pictures. An annotated bibliography*. London, International Institute for Environment and Development.

PATH (1996). *Developing health and family planning. Print materials for low-literate audiences*. Revised ed. (Available free of charge to developing country organizations or individuals from PATH, 4 Nickerson Street, Seattle, Washington, 98109, USA).

Seidel RE ed. (1993). *Notes from the field in communication for child survival*. Washington D.C., Academy for Educational Development/U.S. Agency for International Development.

Table 13. Example of a pretest data sheet

PRETEST DATA SHEET

		Topic of material:						
		Language:		Pretest round:				
		Region:		Date:				
		Interviewers:		Message no.:				
Resp. No.	Describe picture:	Write text:	How do you feel about the picture and or words?	What would you change?	Coding			
	What do you see?	What do the words mean to you?			Picture		Text	
					"OK"	NO	"OK"	NO
1		R / H						
2		R / H						
3		R / H						
4		R / H						

From: *Developing Health and Family Planning Print Materials for Low-Literate Audiences, A Guide*, PATH, 1996.

Table 14. Example of a pretest background sheet

Interviewer(s):

Pretest round:

PRETEST BACKGROUND SHEET

Topic:

Material:

Region:

Language:

[illegible]

From: *Developing Health and Family Planning Print Materials for Low-Literate Audiences, A Guide*, PATH, 1996.

Table 15. Example of a pretest data summary of results sheet

Coder(s):

Pretest round:

Region:

Topic of material:

PRETEST SUMMARY OF DATA RESULTS SHEETS

[illegible]

From: *Developing Health and Family Planning Print Materials for Low-Literate Audiences, A Guide*, PATH, 1996.

11

Monitoring and evaluation

This manual has consistently stressed the need to monitor and evaluate whatever type of intervention you are trying. The main purpose of doing both of these activities, particularly in any communication programme, is to ensure that what you are trying to achieve is having the desired effect.

This chapter looks in depth at the issues involved in monitoring and evaluation. It explores some of the challenges involved in monitoring and evaluating communication or other initiatives designed to influence behaviour and practice or to have an impact on policy decisions. It identifies a number of methodologies that can be used for monitoring and evaluation, and provides guidance on how to select the most appropriate one depending on the situation.

Defining monitoring and evaluation

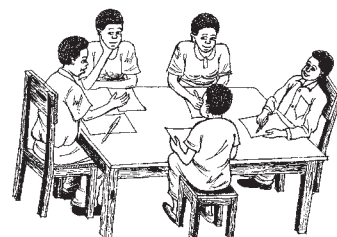
Effective communication relies on feedback. Monitoring is the main tool to check feedback. Monitoring is done during the implementation of the intervention to find out what has been achieved so far, and to identify any constraints. Monitoring relates to activities and uses routinely collected information. Monitoring is continuous.

Monitoring is undertaken by those who are responsible for a project, to:

- check if, as far as possible, everything is going according to plan
- find out if there are unexpected difficulties
- adjust plans, if necessary.

Evaluation is done to find out if change has taken place and if so whether it occurred as a result of the health communication programme. We evaluate programmes for many reasons, to:

- assess how well the intervention worked and what did not work
- determine if the costs were reasonable
- convince others that the intervention was done properly



- document experiences in order to help others replicate successful interventions and avoid any identified mistakes.

Evaluation relates to objectives and whether they have been met. It requires collection of additional data to that which is routinely collected. Evaluation is intermittent.

Taken together, monitoring and evaluation help to ensure:

- good management
- lesson learning
- accountability.

Figure 7 shows where monitoring and evaluation normally fit in the standard project cycle. Monitoring relates to how well the activities are being delivered and evaluation assesses the degree to which the project objectives are being achieved.

Challenges of evaluating communication interventions

Most communication interventions around health-related issues, including the rational use of medicines, can be seen as operating at three levels:

- on individual behaviour
- on the social and physical environment of the community
- on the policies regulating both.

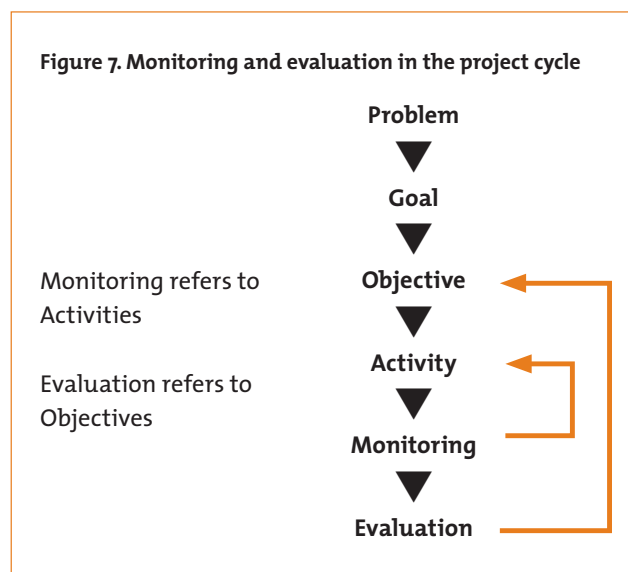
The traditional biomedical approach to evaluation, with the randomized controlled trial as its gold standard, has limited relevance to the analysis of complex health communication interventions, particularly at policy and community levels (Stead, et al, 2002).

The usual research goal of establishing links between project activities and particular outcomes is particularly challenging when interventions involve a number of actions, are aimed at different audiences, over different time periods, and when effects may not be evident for some time.

Using these methods may also mean missing less easily measurable effects that may be desirable and contribute to the overall impact of an intervention. These include increases in community participation, changes in the level of dialogue about a drug use issue, or gradual shifts in a community attitude towards a rational drug use problem.

Laverack (2004) makes the case that a critical indicator of success for health communication activities at the community level is the degree to which empowerment takes place. Yet measuring community empowerment is difficult and not usually included in evaluations of health communication programmes. Community empowerment usually involves:

- personal action
- the development of support groups



- community organizations
- partnerships
- social and political action.

The consequences of community empowerment can take a very long time to show themselves. Laverack suggests a parallel monitoring and evaluation process to track changes in the continuum towards greater community empowerment as a way to assess some of the less tangible, but no less valuable impacts of a communication intervention.

At the policy level, multiple influences affect decision-making and policy development. Attempts to influence policy are often, of necessity, opportunistic and flexible, and hard to keep 'stable' – a key requirement for good control measures.

Much of the measurement that needs to take place in communication interventions relates more closely to monitoring than to evaluation. End of project evaluation provides little of value to project team members who are trying to encourage processes of change through their intervention. They need more immediate feedback to determine if the intervention is having the desired effect. Equally, attempts to measure the long-term impact of a communication intervention need to take place sometime after the intervention has happened to see whether the intended change has occurred and been sustained.

Different expectations need different approaches

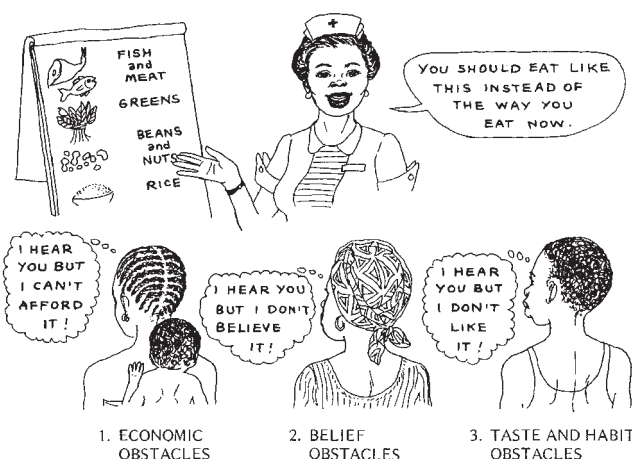
The analogy of a training course provides some understanding of the relationship between monitoring and evaluation in a communication intervention. It also provides some insight into the different expectations that different stakeholders might have for monitoring and evaluation findings, and the different types of approach that might be needed.

During a training course, through each session, the trainers or facilitators need to pay attention to the immediate feedback from the participants. Are they alert?

Are they engaging with the content? Is there strong participation? Are questions being asked? Is everyone making a contribution? Do they understand the content? Negative answers to these types of questions lead good trainers or facilitators to adjust the style, the process and the content of the session, to ensure better understanding.

This is a continual monitoring of the communication process, usually involving observation and response to checking questions to determine understanding. From this, the trainer or facilitator builds impressions of what works, what this particular audience is most likely to respond to, and how to get

THREE COMMON REACTIONS TO STANDARD NUTRITION TALKS



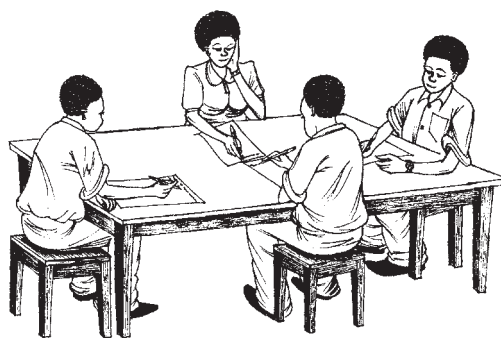
across information effectively in that setting.

However, the planner of the course, assuming that he or she wants to run another course sometime in the future, wants to learn about which sessions were the most useful for the participants, which trainers or facilitators worked best with the

material, what improvements could be made to the design or the content of the course. The course planner will use different instruments to measure the impact: probably a set of questionnaires that enable participants to score or rate different sessions through comparison.

A donor or sponsor of participants is more interested in the outcome of the course: did the participants learn anything? Have they been able to apply it in their work or their living situation? Was this the most cost effective way to improve practice or bring about change? Can the improvements or change be sustained over time? To measure these outcomes, the donor or sponsor needs to have had some information about the practice or situation before the course, to be able to compare it to what happened as a result.

Different questions need to be asked in any monitoring and evaluation activities depending on whose perspective is being considered and what the objectives are. No single set of indicators will work in all situations for both monitoring and evaluation.



Monitoring

When making a plan to monitor your communication intervention you need to decide:

- what you want to monitor, considering that it should be an ongoing programme activity and so should not take up too much staff time
- how you will monitor.

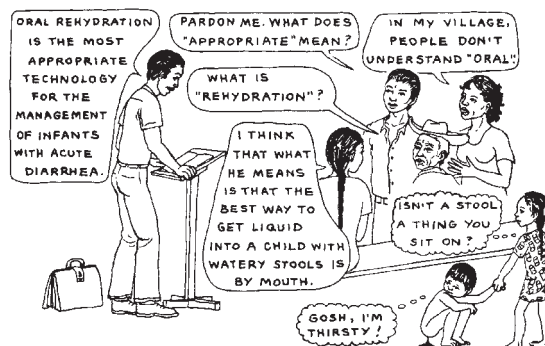
A monitoring plan can include:

- checking for *timeliness* of the activities: are there delays in implementing workplans? and if so why?
- reviewing costs in relation to the initial budget – do activities cost more than planned? How can budget deficits be resolved?
- *supervising personnel* – are staff carrying out their assigned duties?
- *assessing quality* – are staff using skills learned in the intended way? Are they practicing different attitudes?
- *assessing cooperation and participation* of others: are community members taking part? Are district health teams involved? Are NGOs collaborating? Have relevant authorities given permission for the intervention?
- *assessing audience reaction*: are the intended audiences using the materials, listening to the radio programme, watching the videos, coming to the discussions? What is their immediate reaction?



Depending on the stage of the intervention, specific monitoring questions can be formulated. For example:

- has rapid appraisal been done to analyse the problem further? Have all the methods which were planned been used? Has a report of the appraisal been written and has a workshop been held to define possible solutions?
- have appropriate messages and intervention methods been selected? Has the target audience been involved in defining the messages? Have the messages been checked for medical accuracy and for cultural relevance?
- have the intervention methods and materials been pretested? Have the results of the pretest been documented? Has pretesting led to revisions?
- have the interventions been implemented according to plan?



Methods can include:

- record keeping, and regular reviews of records by a task manager
- making reports on important events, such as training workshops and seminars
- field or supervisory visits
- regular meetings with people responsible for the implementation, to reflect on and review progress
- ongoing audience sampling
- reviewing expenditures compared to budgets
- comparing actual dates of completion of activities with planned dates.

Good monitoring will ensure that you have good information for your evaluation.

Evaluation

Evaluation is a way of looking at specific programmes or projects, in order to assess progress and effectiveness, consider costs and efficiency, show where changes are needed, and help to plan more effectively in the future. It should be primarily a

learning tool; however, it has often been used only as an accountability tool.

Evaluation needs to serve those involved in the programme as well as those who are financing it.

Evaluation is rarely carried out in a systematic manner. For example, only a few of the projects approached for a WHO global survey of public education on rational use of medicines could



produce evaluation reports. As a result very little is known about the impact of rational drug use interventions directed towards consumers – their coverage, their relative costs, their sustainability, and perhaps most importantly, the degree to which a programme successfully implemented in one country may be replicated elsewhere (Fresle and Wolfheim, 1997).

What should you evaluate?

The time and effort you put into evaluation needs to relate to the aims and size of the project, the reasons for conducting a particular evaluation and the supporting resources you can access. How do you decide whether to evaluate the:

- product (the material, the radio or TV programme, the training course)
- process (who was involved, what happened, how did it work, what problems emerged, what worked well, what needs to be done differently next time?)
- outcome or impact (what changed over time? what is different as a result of the intervention? did anything unexpected happen?)
- or all three?

Evaluation of the product is really a quality assessment process and much of this should be done as one small part of process evaluation. There should be some standards that your organization uses to define an acceptable quality level for the work that you are doing that you can measure against.

Process evaluation is central to learning about how to do things effectively. It is particularly important for practitioners to see what makes a difference in how they do things and understand why an intervention succeeds or fails. If an intervention was not implemented well, an effect in terms of influencing behaviour is not expected. It is important to find out where in the process the communication activity failed, so that improvement can be made.

Outcome evaluation measures whether the planned activities were actually completed. Impact (sometimes called effect) evaluation is critical for determining whether the intervention chosen, no matter how well done it was, actually achieved what it set out to do. When defining your evaluation questions you should primarily review the communication objectives. What did the intervention aim to achieve? At the end of an intervention you can measure the effects, outcomes or impact of a programme against its objectives.

Evaluation can either be done internally – a self-evaluation process involving those responsible for implementing the programme and those benefiting from it – or externally – having an individual or team from outside the programme reviewing it. Or it can be a combination of both, with some programme staff and an external evaluator, which is often the most appropriate as it allows for internal learning as well as introducing analytical perspectives from someone who has not been directly involved. In all cases, participatory processes can be used to generate a wide range of views as to what happened as a result of the programme.

Evaluation does not have to be a complex and highly time-consuming undertaking. The field of evaluation is often mystified unnecessarily, and it is important to be clear about the purposes of any particular evaluation. Who is it primarily for and what would you (the participants) like it to achieve? These issues will influ-



An outcome indicator could be – how many nurses are practicing new skills, and how many stick with the old ones?

BOX 86. THINKING ABOUT WHY AND HOW TO UNDERTAKE EVALUATION

1. Why are you conducting an evaluation? What exactly do you want to assess? What do you want to learn from the evaluation?
2. Who is it for? Is it for an external stakeholder? Is it for internal learning and development purposes? Or both?
3. What kinds of information do you need to collect? For whom? From whom?
4. What are the best indicators of progress for each aspect that you wish to consider?
5. Who should be involved in the evaluation and in what capacity?
6. Who will take responsibility for leading the process? Does your organisation have the appropriate skills and expertise in-house? Where else might you seek expert assistance?
7. Do you need an outside, experienced professional to facilitate the process?
8. What records and information do you already have? How can regular and existing monitoring procedures feed into the process?
9. What methods will best serve your information needs?
10. Do you need to develop tools, such as questionnaires or checklists for focus group discussions, to collect particular information?
11. How will you ensure that any information collected is used to improve the intervention?
12. How will you ensure that any process findings are used to improve working relationships and practices?
13. What can you learn from this experience about existing monitoring and evaluation procedures and processes?
14. How will you ensure that you learn from the evaluation process itself?

Source: Adapted from Healthlink Worldwide (2003). Quest manual: your guide to developing effective health communications. London: Healthlink Worldwide (available at www.healthlink.org.uk/resources/quest.html (accessed Nov 2004))

ence how you conduct the evaluation and what you get out of it. Box 86 provides a set of questions that can help you to clarify the purpose of the evaluation and some initial decisions you have to think about.

Evaluation methodology

It can be difficult to document changes in knowledge, behaviour or health status. It is certainly much more difficult to prove that the changes are caused by your intervention, and not by another factor. In selecting an evaluation design you need to consider how best you can prove the effects of your intervention.

In many fields, experimental impact studies are used to compare change that has occurred in relation to an intervention. The usual way to prove change is to compare changes in your intervention communities with changes in control communities. The controls should be similar to the intervention communities in terms of economic status, ethnicity, education, disease and medicines provision profile, and age. There are two evaluation methodologies which involve controls:

- a randomized control design: you study a population over time, assigning randomly who is exposed to the intervention and who is not
- a quasi-experimental design: you specifically select an intervention group, and identify a comparable control group.

If you cannot include controls in your study design, because of lack of resources, or for other reasons, such as the difficulty of identifying a control population when using a mass media intervention, you can evaluate by using a:

- time-series design: you collect information on your outcome measure and on factors which influence it at least three times: before the intervention, and twice after the intervention (for example, one month and six months after it). More frequent data collection both before and after the intervention improves the accuracy of such a method
- pre-post design: you collect data only twice, before and after the intervention.

These are weaker designs that may not give clear results. Even if they do, your results may be questioned because of the method used.

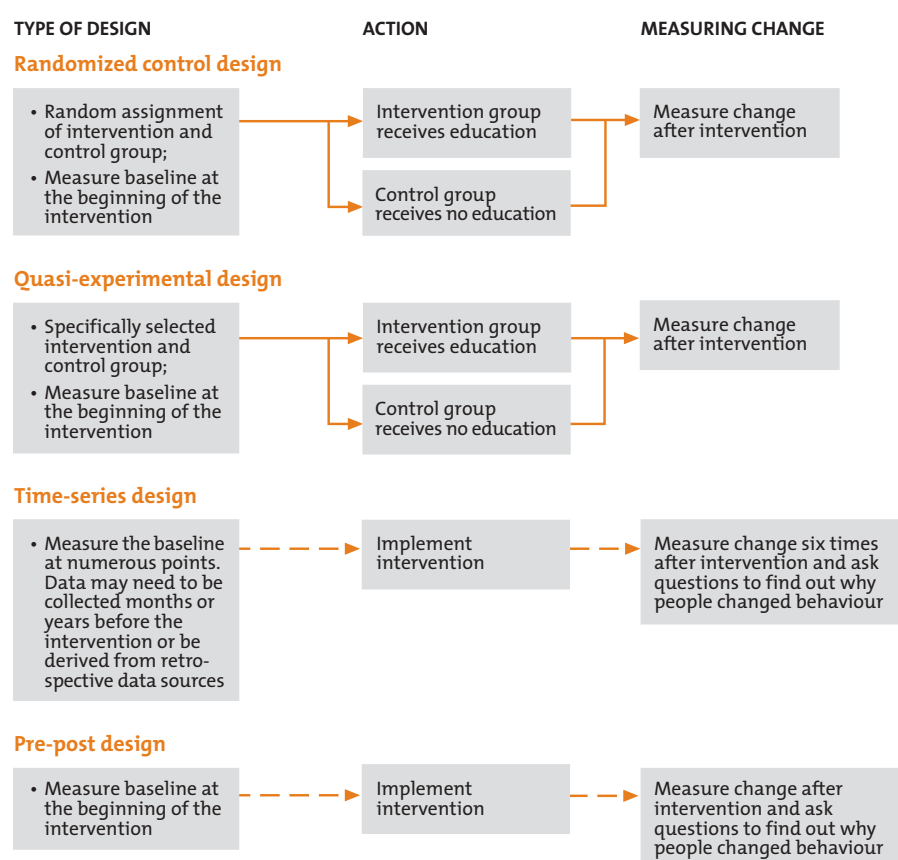
Figure 8 summarizes these four study designs. In all study designs it is crucial that you measure change using **key outcome measures**. You need to:

- review the intervention's communication objectives
- identify in advance what behaviours are likely to be influenced



For example – how many mothers used ORS before the intervention, how many used it after (define how long after) the intervention?

Figure 8. Four evaluation designs



Source: WHO (2004). *How to investigate the use of medicines by consumers*. Geneva, World Health Organization.

because of the intervention; and what changes in knowledge and attitudes you expect

- limit the number of outcome measures: don't try to measure all possible changes
- measure more than one dimension. Decide whether you want to measure changes in attitudes, and/or changes in knowledge and/or changes in drug use behaviour
- choose outcome measures that can be clearly defined and reliably measured.

Randomized control design

In a randomized trial one group receives the intervention, while another group acts as a control. Random assignment is a statistical technique that can help you to ensure that the intervention group and the control group are equivalent. If the group that received the educational programme achieves a better performance than the control group, you can do a statistical test, which will provide strong scientific evidence for the success of your communication activities. Box 87 describes a case study from Indonesia that is an example of a randomized control study.

Randomization is rare in studies that evaluate communication activities. One researcher reviewed 67 scientific articles that describe health education programmes in developing countries. He found that only four of these studies had used a randomized design (Loevinsohn, 1990). Partly this is due to lack of resources but it is also related to the way in which communication activities take place under field conditions. Johns Hopkins University's Center for Communication Programs

BOX 87. SELF-LEARNING FOR SELF-MEDICATION IN INDONESIA

An Indonesian case-study used a randomized control design to evaluate a problem-based self-learning process in which people were taught how to extract information from package inserts of over-the-counter (OTC) medicines.

The aim of the intervention was to empower mothers to seek and critically assess information about the drugs they commonly use. Two different intervention methods were compared. The first method was to organize a large seminar on the appropriate use of OTC medicines. The second method was to organize small group (6–8 people per group) discussions, facilitated by a tutor. An activity guide, worksheets and reusable set of OTC drugs were used in the small group sessions. The specific objectives of both interventions were to help participants understand the package inserts, help them understand that several brand names have the same or similar active ingredients, and help them assess the quality of the drug information given.

The researcher recruited 112 mothers of low to moderate levels of education, and randomly assigned them to three groups. The first group received the intensive training in small groups. The second group attended the large seminar, and the third group served as control. The study aimed to measure changes in knowledge by means of a questionnaire, which was administered pre- and post-intervention; and changes in actual use of OTC medicines in a one-month period after the intervention.

The study found that the score of knowledge was significantly higher, and the number of brand name products consumed in the previous month significantly lower, in the intervention group that followed the small group discussions. The researchers conclude that the problem-based self-learning approach is not only effective, but also all the mothers reported that they found the method enjoyable.

See: Suryawati S (2003). WHO Essential Drugs Monitor 32:22-23.

– with more than 25 years’ experience in managing and evaluating health communication programmes around the world – is clear that ‘experimental design is not feasible for many communication programs and certainly is not appropriate for large-scale communication projects’ (JHUCCP, 2003).

One problem when opting for a randomized control design is that usually the organization implementing the intervention wants to select the groups or communities in which they pilot the intervention. The selection of communities is based on programmatic considerations; for example, communities are selected where community health workers are active, or where there is active community participation.

The type of communication or managerial intervention that can be studied most easily using a randomized control design is one where it is possible to identify a particular technique that has been used on a selected group of people.

The example in Box 88 explains how a randomized control design helped to show that the managerial intervention of supervision was effective with health workers in Zimbabwe. However, what the study does not show is the impact of the larger initiative, including all the various communication, managerial and regulatory interactions that led to the development of standard treatment guidelines, a number of print materials to support the use of the guidelines, the training programme to introduce them and impact of face-to-face communication. Nor does the study show the effects of the advocacy that was done to encourage an enabling environment where the application of new learning from the training and supervision was more possible. Supervision, in this situation, was effective in improving medicine use. Would it have worked without all the other interventions?

This example demonstrates that although the randomized control design can be used to test a technique, it does not mean that simply applying that technique, without taking into account the context and influence of other factors, will have a positive effect. How the communication, managerial or regulatory intervention is done is probably as important as what was done. The randomized control design may answer the ‘what’ question, but it may not give enough information about the ‘how’. The use of more qualitative evaluation processes (see below) may help to fill in this part of the equation.



The effect of supervision on nurses’ skills can be measured.

Quasi-experimental design

If for operational reasons you cannot choose your intervention and control groups randomly, you can use a ‘quasi-experimental’ design. For this you specifically select a control group/community which is comparable in a number of key ways to the community/group where the intervention is conducted, as in the example of Peru in Box 89.

Time-series design

In some cases, a study design using controls is not possible. This is the case, for example, when you implement a mass media campaign. The whole population is reached by the intervention. Or you may lack resources to include a control group in your study. You can then evaluate your intervention using a time-series design (although it is preferable that this type of design also incorporates controls).

BOX 88. IMPACT ASSESSMENT OF SUPERVISION ON MEDICINES MANAGEMENT

A randomized controlled trial carried out in Zimbabwe, found that supervision is likely to improve health workers' performance with regard to the rational use of essential drugs, resulting in improved efficiency and effectiveness.

The study followed up earlier efforts to improve management of medicines through training of health workers. Although the training was found to lead to significant improvements in how health workers managed and used stocks of medicines, these achievements could not be sustained. An intervention was developed to test the impact and effectiveness of supervision by measuring actual behaviour change.

The study compared three different groups of district level peripheral health facilities: those that received supervision for either use of standard treatment guidelines (STG) or stock management: each facility acting as control for the other area of supervision; and a comparison group of facilities which received no supervision. Supervision comprised two visits about three months apart.

The evaluation measured performance using a range of indicators at baseline and six to eight months after the second supervisory visit. Nine different indicators were applied relating to medicines availability, use of stock cards and stock books, calculation of minimum stock and monthly ordering, for the 15 indicator items. Adherence to STGs with regard to medicine choice, dose and duration was assessed for four indicator diseases.



The results of the study showed that, following supervision, overall stock management improved significantly when compared to the control and comparison groups. Similar improvements were demonstrated for adherence to STG, although the effect was confounded by other interventions.

The study also showed that supervision has a positive effect on improving performance in other areas than those supervised. It demonstrated that pharmacy technicians with limited clinical skills can be trained to influence primary health care workers to positively improve prescription practices and have an impact on community use of medicines.

Source: Trap B, Todd CH, Moore H, Laing R (2001). The impact of supervision on stock management and adherence to treatment guidelines: a randomized controlled trial. *Health Policy and Planning* 16(3):273-280.

When not using a control group you collect information on your outcome measure at least six times before and six times after the intervention. This method is descriptive and does not provide strong scientific evidence on the effectiveness of your intervention. When you have no control groups, it is especially important to look carefully at what changes have occurred, in part by increasing the number of data points, to examine trends and provide possible alternative explanations for observed changes in outcome measures. For this you need to develop a conceptual framework which lists the factors affecting your outcome measurement. By means of multivariate analysis (ask a statistician for advice) you can determine which factors (including your intervention) are correlated with the changes observed. You can also assess the effect of interventions qualitatively by interviewing the target audience on why they changed their behaviour – was it because of the interventions or were there other reasons?

The examples from Kenya (boxes 90 and 91) give the results of two intervention studies using time-series designs.

Pre-post design

The pre-post design shares many of the same limitations as the time-series and is the least scientifically valid of the various experimental designs although it is

BOX 89. AN INTERVENTION TRIAL TO DECREASE THE INAPPROPRIATE USE OF DRUGS FOR CHILDHOOD DIARRHOEA IN PERU

In Peru a study evaluated an intervention aimed at empowering carers of children to treat children with diarrhoea more appropriately. The intervention's objectives were to discourage the use of antidiarrhoeals and promote oral rehydration therapy (ORT) in childhood diarrhoea cases.

The interventions were developed based on results of formative research on people's treatment of diarrhoea. This research revealed that people want a quick cure for diarrhoea. Although they were aware of the need for ORT, they did not know that most diarrhoea cases do not need drugs.

The intervention aimed to: reinforce the fluid replacement strategies already practised by people in



the communities; to increase awareness of the normal duration of a watery diarrhoea episode; and to increase awareness of the possibly hazardous effects of drugs. A 15-minute "motivational" video was developed to provide information in an entertaining and persuasive way, to change widespread and deep-rooted habits, and to increase participation through subsequent talks. The video included a Mrs Druguser, who expressed the beliefs and perceptions that previously prevailed in the community, and challenged all the appropriate treatment messages that she received. The video was used to generate debate during community meetings, which it was found to do in a positive way.

The messages given in the video were reinforced by radio and printed materials. Thus the evaluation was designed to measure the effect of a mix of health education methods. It did not provide evidence on the relative contribution of each of the methods used.

The effects of the intervention were measured by conducting a pre- and post-intervention survey of actual treatment practices in diarrhoea cases in the intervention community and in a control community. The selection of the control community was based on a number of criteria relevant to the study:

- similar diarrhoea prevalence
- similar socio-economic and ethnic characteristics
- availability of national health service and of NGOs.

Data on the process of the intervention were collected during the implementation phase, the effect measurement was done in a three-month period immediately after the intervention phase. Change in health-seeking behaviour was measured by a household survey in families with pre-school children on the actual treatment of diarrhoea episodes in a 15 day recall-period. Changes in knowledge and attitudes were measured by means of a structured questionnaire.

Knowledge levels increased significantly in the intervention communities. Results of the household survey revealed that the overall use of medicines in childhood diarrhoea cases dropped from 43% to 32% in the intervention community and from 49% to 42% in the control community. The percentage of episodes in which carers reported giving larger amounts of liquids every day of the episode increased significantly, from 51% to 59% in the intervention community; the control community showed a slight increase, but this was not significant.

See Paredes P et al. (1997). An intervention trial to decrease the unnecessary use of drugs during childhood diarrhea. Paper presented at the International Conference on Improving Use of Medicines, Chiang-Mai, Thailand, 1997. <http://mednet3.who.int/icium>



BOX 90. CHANGING HOME TREATMENT OF CHILDHOOD FEVERS BY TRAINING KENYAN SHOPKEEPERS

This intervention, aimed to improve the treatment of childhood fevers, took place in a malaria endemic area in Kenya. Research showed that the majority of early treatments of childhood fevers are self-medicated with shop-bought, brand name drugs. These treatments are usually incorrect or sub-optimal.

The aim of the intervention was to train shopkeepers who sell drugs in Kenyan communities in giving advice on the type and quantity of drugs to buy for childhood fevers, and on how to use them. The ultimate objective was to improve the use of antipyretic and antimalarial drugs in childhood fevers.

Shopkeepers were trained at a series of three workshops, each lasting three days. The methods used encouraged active participation, practical training and skill development. Shopkeepers were provided with dosage charts for chloroquine and aspirin/paracetamol-based drugs, and sets of rubber stamps depicting the correct way of using chloroquine in children of different ages.

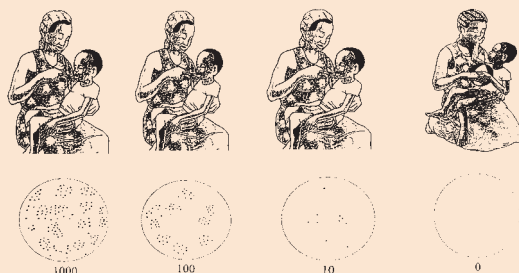
The impact of the training programme was evaluated in two rounds of observational studies and home interviews during peak malaria seasons.

Before the training workshops 32% of antimalarial sales included an adequate dose of antimalarials. After the workshops this percentage increased to 83% three months after the intervention and then to 90% seven months post-intervention. Before the training, advice was only given in 2% of antimalarial sales. This increased to 94% and 98% in the two subsequent observation rounds post-intervention. The home interviews revealed that only 4% of childhood fevers treated with chloroquine were given an adequate dose of chloroquine before the training. This increased to 65% three months after the intervention and 75% seven months later. Appropriate dispensing and safe use of aspirin also increased after the intervention. The researchers evaluated the process and found major changes in the way the shopkeepers sold their drugs and that the community viewed the changes positively.

Marsh VM et al. (1999). Changing home treatment of childhood fevers by training shopkeepers in rural Kenya. *Tropical Medicine and International Health*, 4(5):383-389.



Chloroquine for 3 days kills malaria fever



Shopkeepers were also trained to understand the reason **why** a child needs to take a full course of antimalarials, by linking treatment to parasite clearance.

commonly used in development situations. A pre-post evaluation is better than nothing but be very clear about the limitations of what it will tell you. If it is to be of any value you will need much more than numerical data to have any real idea of your intervention's success or lack of impact. You will need to include detailed qualitative investigation related to awareness and knowledge of the message, and underlying reasons for behavioural change.

Problems in proving effects of interventions

It may be difficult to decide on whether change observed in outcome measures is caused by the intervention and/or to determine the real strength of the impact. This is due to a number of methodological problems:

- The communication messages targeted at the intervention communities 'contaminate' the control groups. For example, people who live in the intervention community may

BOX 91. INTEGRATING RESEARCH AND EVALUATION IN KENYA

The Youth Variety Show (YVS) in Kenya, a radio call-in for young people on the subject of sexual behaviour, was guided by intensive formative and evaluative research. This included: a national baseline survey of youth and parents (6,300 interviews); focus group discussions with more than 350 adolescents and parents in 5 districts; in-depth interviews among leaders; a review of legislation and policy environment; content analysis of newspaper coverage of youth issues; and, once the programme started, content analysis of letters from young people. During the radio broadcast, a panel of young people and a separate panel of parents listening to the show carried out monitoring. Their critiques were used to improve the content of the next programme.

The intervention aimed to increase adolescent knowledge on sexual health matters, and encourage adolescents to go to reproductive health clinics for their sexual health needs.

Evaluation was done by including some relevant questions in a follow-up household survey conducted by a commercial market research firm among adults and adolescents to assess audience exposure to the YVS.

Results showed that 38% of respondents listened to YVS but of 15–24 year olds 55% listened. Surveys at representative clinics showed that increasing numbers of adolescents attending the clinics had listened to YVS and, along with friends, YVS was the most important source of referral. Content analysis of letters and radio listener panel studies corroborated this.

Source: Hubley (personal database).

be related to those living in the control community and spread the key intervention messages.

- Or a local radio station may decide to do a programme on the innovative community intervention, thus spreading key messages to the control groups. In that case you may observe changes in knowledge and behaviour in both control and intervention communities.
- *The intervention changes over time.* Under field conditions problems often occur in the implementation of interventions, and the key messages change over time. For example, in an evaluation of a programme on the appropriate treatment of malaria, the treatment guidelines issued by the ministry of health may change during the intervention. If that is the case, your outcome measures will have to change. This makes it difficult to measure the changes, as the outcome measures which you used in the baseline are no longer appropriate.
- *The communication programme includes a mix of methods,* and it is very difficult to measure the effects of each separately as they are actually designed to reinforce each other.
- *Other agencies start implementing interventions in the research areas.* Evaluators do not own the communities they work in. Unexpectedly, other actors can decide to conduct interventions in the community. These interventions may increase or diminish the impact of your intervention. If an intervention starts in your control communities, they may influence the case-control comparison that you intend to make.



The mother hears about ORS on the radio...



And the next day she discusses her new learning with friends in the next district

When trying to assess effects of your intervention, you should be realistic about what changes to look for in your evaluation. Changes in knowledge and understanding might take place soon after the education input. However, changes in behaviour and health usually take longer to achieve. The Kenyan case shows that over time the effect of the intervention increased. It is a good idea to carry out a short-term evaluation fairly soon after the activity and a follow-up afterwards to look for long-term changes, as was done in the case-study.

Confounding factors need to be considered in your design

When drawing conclusions on effects of interventions it is important to consider other factors that may be responsible for the changes observed. They are known as **confounding factors**. Box 92 provides an example that explains some of the issues to consider.

It is important to think about possible confounding factors before you conduct the intervention, so that you collect information on these variables in your base-

BOX 92. CONFOUNDING FACTORS

Let's assume that evaluators are looking at the effects of intensive training on the use of pre-packaged oral rehydration solution (ORS), by comparing ORS use in community A with use in a control community, B. Evaluation results reveal that ORS is often unavailable in the government health centre that services community B (where intensive education on the preparation of ORS did not occur); while in community A, the health workers of the NGO primary health programme ensure a regular supply of ORS to the community. In the analysis of the drug use patterns, the evaluators find that people in community A use ORS more often in the treatment of pre-school diarrhoea than people in community B after the intervention. Is this the result of the intensive health education or is it related to changes in availability of ORS? A more qualitative evaluation of the intervention process in community A can help in assessing its effects.



The evaluators, realizing that ORS availability is a confounding factor, should collect data on ORS availability before, during and after the intervention in both communities.



The evaluators can further compare ORS use in the families of women who attended the health education sessions



....with those who did not attend.

If there is a difference in use of ORS between these groups, then clearly the health education intervention makes a difference. Also the evaluators can use qualitative information collected among women who attend the health education sessions. If the messages given are understood by them, and if they themselves indicate that the training in ORS use has encouraged them to use ORS more often in childhood diarrhoea, then we can suggest that the health education played an important role. If the results of the study further indicate that women in community B have less knowledge on the use of ORS, then this conclusion is strengthened.

line study. If you fail to do so, it may be very difficult to assess the effects of your intervention.

Participatory and qualitative methodologies

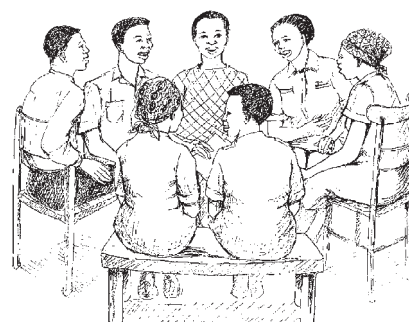
Evaluations are often done by outside experts, as they are considered to be objective and have the necessary expertise to assess the effect of an intervention. An argument for conducting the evaluation in a participatory manner is that local staff and beneficiaries of programmes are more likely to increase their commitment to the programme's success if they are involved in the evaluation process. Moreover, they have significant knowledge about programme implementation, relevant views on the strengths and weaknesses of the interventions, and insights on the contextual factors that affect the interventions. By involving local staff and beneficiaries in the evaluation process the evaluation is, therefore, likely to be more appropriate and the results more valid and likely to be used. However, in developing the plan for the evaluation phase, the evaluators should realize that not all aspects can be conducted in a participatory fashion. It is best to involve the local actors in evaluating interventions that they themselves are actively involved in. For example, mothers can be asked to participate in the evaluation of health education sessions that they regularly attend; and community health workers can be asked to participate in the evaluation of the training that they receive.

Participatory monitoring and evaluation (PM&E) is similar to conventional approaches to measuring changes resulting from specific interventions. The difference is in a participatory approach, a wider sphere of stakeholders who are directly or indirectly involved in a programme are involved in selecting the indicators to measure changes, in collecting information, and in evaluating findings.

External expertise may be used, but it is usually in a facilitative role, rather than as the researcher 'doing' the evaluation. The processes used help to build stakeholders' capacity for analysis and problem solving and usually favour collective methods of knowledge generation. PM&E is particularly useful for strengthening learning.

As with pre-testing (see Chapter 10) which is not only a way to test material but also a way of stimulating dialogue around the issues contained in the material, PM&E is also a way of opening up additional dialogue and can serve as part of the overall communication intervention. One of the arguments being made for the use of PM&E approaches to assess communication work is the degree to which good communication processes demand participation. Alfonso Gumucio-Dragon (2001) makes the point that 'we have finally moved towards people-centred development and towards a people-centred communication model. It is time to move towards people-centred evaluation methods... The bottom line is that the evaluation process should also integrate dialogue as an essential tool.'

There are many different forms of PM&E. They often mix qualitative and quantitative methodologies and can use both qualitative and quantitative indicators. Box 93 lists the core steps in developing PM&E that have emerged from considerable practice.



BOX 93. CORE STEPS IN DEVELOPING PARTICIPATORY MONITORING AND EVALUATION

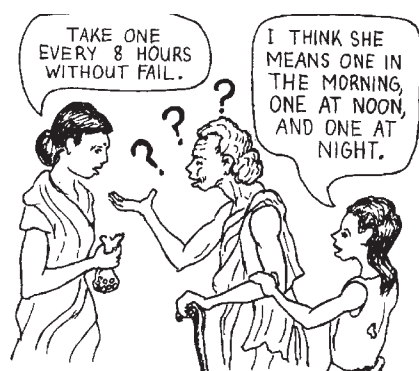
1. Identify who should, and wants to, be involved.
2. Clarify participants' expectations of the process (what are the information needs), and in what way each person or group wants to contribute).
3. Define the priorities for monitoring and evaluating (on which goals/objectives/activities to focus).
4. Identify indicators that will provide the information needed.
5. Agree on the methods, responsibilities and timing of information collection.
6. Collect the information.
7. Adapt the data collection methodology, as needed.
8. Analyse the information.
9. Agree on how the findings are to be used and by whom.
10. Clarify if the PM&E process needs to be sustained, and if so, how. Adjust the methodology accordingly.

Source: Estrella M (2000). *Learning from change: issues and experiences in participatory monitoring and evaluation*. London, Intermediate Technology Publications.

Two specific approaches that are growing in use are Outcome Mapping and Most Significant Change.

Outcome Mapping

Outcome Mapping focuses on changes in the behaviour, relationships, activities or actions of people, groups and organizations with which a programme works directly. Developed by the International Development Research Centre (IDRC) in Canada, it shifts away from assessing the impact of a programme. This significantly alters the way a programme understands its goals, and assesses its performance



One outcome could be – health workers' change to use of more direct instructions, and checking for understanding

and results. This is not to say that the achievement of impact is not important. It simply acknowledges that impact in complex situations, such as communication interventions, is likely to be the result of a series of complex interactions between a number of actors and activities. Attributing impact to any one of those is difficult to prove. Rather, Outcome Mapping seeks to improve performance, rather than prove impact.

Outcome Mapping moves away from the notion that monitoring and evaluation are done to a programme and instead actively engages people involved in the programme in the design of a monitoring and evaluation framework and evaluation plan and promotes self-assessment.

Outcome Mapping has three stages:

- Intentional design – which helps establish consensus about what changes are hoped for and what strategies will be used to get to them
- Outcome and performance monitoring – which provides a framework for the ongoing monitoring of the activities and the progress of those most affected by the programme (boundary partners) towards the achievement of outcomes

- Evaluation planning – which helps to identify the priorities to look at and the way of carrying out a final evaluation.

Outcome Mapping introduces monitoring and evaluation at the planning stage of a programme. It also unites process and outcome evaluation by collecting information about the programme's success in implementing its strategies and the results being achieved by its boundary partners. This approach argues that separating process and outcome evaluation is misleading, because it implies that an organization achieves outcomes as a direct result of implementing a programme.

Most Significant Change

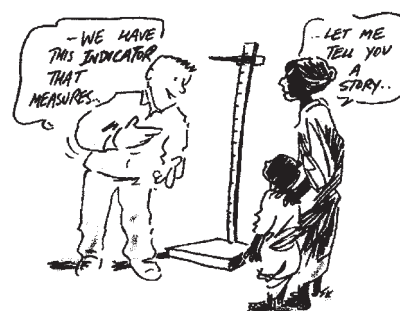
The Most Significant Change (MSC) technique has been used by nongovernmental organizations (NGOs) and governments in Africa, Asia, Latin America, Europe and Australasia. MSC is a systematic methodology based on telling stories about events people think were important – there is no need to explain what an indicator is or learn special professional skills. So everyone can participate and the technique can be used in different cultural contexts. Project stakeholders are involved both in deciding the sorts of change to be recorded and in analysing the data. MSC occurs throughout the programme cycle and provides information to help monitor and manage a programme.

MSC is particularly suited to monitoring a programme where the focus is on learning rather than just accountability. MSC provides data on impact and outcomes that can be used to evaluate the performance of the programme as a whole. MSC can identify unexpected changes to deliver a rich picture of what is happening even when there are complex and diverse outcomes.

MSC has three important stages:

- Establishing domains of change – identifying the broad areas of interest to be looked at such as 'changes in people's lives', 'changes in levels of participation'
- Collecting and reviewing stories of change – based on answers to a simple question: what do you think was the most significant change that took place in people's lives over the past six months and why do think that was significant?, followed by an ongoing review process where different groups of participants in the programme reach agreement on what are the most significant of the stories and why
- Secondary analysis of the stories and the process – to monitor what is happening and allow for the emergence of other findings, including the identification of contradictory stories and perspectives and to track other changes that may be occurring as part of the process.

MSC is particularly useful for identifying changes that are important to different audiences or groups. For example, in a particular community, for people living with HIV, a significant change might be increased access to antiretroviral drugs; for sex workers, it might be increased access to condoms and more ease at being able to negotiate safe sex; for health workers, it might a decrease in sexually transmitted infections, lower levels of opportunistic infections, or having more time available to provide advice. MSC cannot prove that a particular intervention brought about



those changes, but it may be able to indicate that the intervention made a contribution to the changes. In reality, that is probably what any single intervention can do in the complexity of social change and development.

What information collection methods will you use?

Whatever monitoring and evaluation process you choose, there are some standard methods to collect information about what is happening. The methods you choose will depend on your evaluation question and design. Start with the easiest. The following methods are useful:

- **Review of project documents:** records of monitoring activities can be very helpful. These documents include workplans, minutes of meetings, workshop reports, notes from discussion with intended audiences in pre-testing activities, interview guides, training and other printed materials.
- **Semi-structured interviews with staff** and those responsible for managing and conducting the intervention. These interviews give you an insider's view of the intervention process.
- **Semi-structured interviews and focus group discussions** with representatives of the intended audiences. These can provide considerable qualitative information about how people see the effect of the intervention upon their lives.
- **Short quantitative surveys** on awareness of the information campaign. Such a survey can give quantitative data on the same questions used in the semi-structured interviews (see above).
- **Focused weekly illness recalls** to measure changes in drug use patterns. In interventions oriented towards the appropriate treatment of illnesses, quantitative data on drug use patterns by means of focused illness recall can be collected. This involves a short questionnaire to be administered to all people in the target audience who suffered the illness that is the focus of the intervention, in the previous week. An example is the survey done in the case-study from Peru (note that that survey used a 15 day recall period which is relatively long. It is better to use a one week recall period).
- **Structured observations** can be used to evaluate the conduct of interventions. Observers can check if key messages are covered in training sessions, if the target audience listened attentively, and how many participants attended. Structured observations can also be used to evaluate changes in behaviour, as was done in the shopkeeper intervention discussed above.
- **Role play, drama and storytelling** can be used to highlight the human response to an intervention and to draw out sensitive issues.



Developing key outcome measures or indicators

One of the most challenging steps in an evaluation is the development of key outcome measures or indicators. These need to be directly related to your communication objectives. You need to do this in the planning stage of your intervention, as that is when you will collect baseline data. Try to limit the number of measures to those which show key aspects of your intervention. They should measure effects which are achievable, and collecting data to measure them should be feasible.

Examples are given in the case studies above. For the Peruvian evaluation a key outcome measure was:

- the percentage of childhood diarrhoea cases treated with antidiarrhoeal medicines

This was a key measure, as the intervention aimed at reducing the use of medicines in the treatment of diarrhoea.

In the shopkeeper intervention in Kenya, key measures were:

- the percentage of total antimalarial sales which included an adequate dose of antimalarial drugs, and
- the percentage of childhood fever cases treated with chloroquine in which a full dose of chloroquine was given.

These measures are directly related to the key communication objectives of the interventions.

When describing the key outcome measures in your evaluation plan, you should describe for each:

- its purpose: why you are measuring this, in relation to the intervention's communication objectives
- the method that will be used to collect data for it
- the way in which the indicator is calculated (see Box 94 for an example).

BOX 94. SAMPLE DESCRIPTION OF AN OUTCOME MEASURE

The percentage of total antimalarial sales which included an adequate dose of antimalarial drugs

Purpose: One of the main aims of the shopkeeper intervention is to teach shopkeepers to inform clients of the need for an adequate dose of antimalarial drugs. This measure calculated to what extent the client actually buys such a full dose.

Data-collection method: Data are collected by means of observation in the shops, three months and seven months post-intervention. Observation is done in all the 23 shops with shopkeepers who received training. In each shop 10 drug purchases are observed. The observation forms included information on the type of medicine sold, the patient's age and the dosage of the medicine given.

Calculation: A percentage is calculated by dividing the total number of purchases in which an adequate dose of antimalarial was given by the total number of antimalarial transactions.

Summary guidelines

Evaluation is an integral part of any communication plan. It is important to begin planning the evaluation from the beginning of your project. The following guidelines can ensure that you include evaluation components in your programme in an appropriate way:

- decide at the beginning of a programme how you are going to evaluate it
- make an evaluation plan
- prepare a set of realistic, achievable and measurable outcome measures which relate directly to your objectives
- evaluate both the process of the intervention and its effects
- look for changes in the short-term as well as long-term
- encourage participation of target groups in all stages of your evaluation
- share your successes and failures with others.

An evaluation plan should have the following elements:

1. A statement of objectives
2. Evaluation questions (process and effect)
3. Key outcome measures
4. Methodology (use of controls or not; how to prevent 'contamination', possible confounding variables)
5. Data-collection methods
6. Plan for data processing and analysis
7. Plan for dissemination and use of results
8. Discussion of known limitations to the evaluation strategy.



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INRUD/WHO Promoting Rational Drug Use Course. Decision-Making for Rational Drug Use Interventions module. http://dcc2.bumc.bu.edu/prdu/HTML_DOCS_TOC.htm

MandE News <http://www.mande.co.uk>

12

Conclusions

This manual has highlighted a number of possible interventions that can be used to improve the use of medicines by consumers. Two broad strategic areas have been identified:

- communication strategies
- strategies to create enabling environments, including managerial and regulatory strategies.

Much of this manual has looked at ways to use communication processes effectively, and to do so after careful participatory research that involves and interacts with the communities, groups of patients or consumers. This manual complements and follows on from a companion manual – *How to investigate the use of medicines by consumers*, (WHO, 2004) which describes in detail how to prepare for and undertake such research together with community members.



Research-based strategies...



...selection of effective channels...



...and use of methods to involve audiences, which can make them act – can result in success.

Successful health communication programmes involve more than the production of messages and materials. They use research-based strategies to shape the products and processes and determine the channels that best connect with the intended audiences (US Department of Health and Human Services, 2002). They also engage and involve those audiences in ways that will encourage them to act – to change a practice, to advocate with others for changes in policy, or to take

BOX 95. CHARACTERISTICS OF EFFECTIVE HEALTH COMMUNICATION

- Promotes realistic and feasible action within the constraints faced by the family, community and cultural contexts
- Builds on ideas, concepts, knowledge and practice that people already have
- Repeats and reinforces over time, using different methods or channels
- Adapts and makes use of existing, locally preferred channels of communication, including song, drama and storytelling
- Entertains, attracts people's attention, affects people's emotions
- Uses clear simple language with local expressions and emphasizes the short-term benefits of any suggested actions or suggested changes
- Provides opportunities for dialogue and discussion to enable interaction, involvement, participation and feedback on learning, understanding and implementation
- Uses demonstrations to show the benefits of adopting practices
- Involves beneficiaries in the design and implementation of the process and content of the communication programme.

Adapted from: Hubley J, 2004

part in community conversations and dialogues that will lead to broader social change. Box 95 highlights some of the key characteristics of effective health communication.

Successful and effective health communication programmes also consider what else needs to change to enable the communication to work. In dealing with the rational use of medicines, this is likely to include a number of managerial and regulatory interventions that serve to create and support an enabling environment where change becomes possible.

Participation and empowerment

Over the past 50 years, health communication processes have evolved. Each of these progressions has involved a shift away from messages disseminated by experts to largely passive audiences towards greater involvement and participation of people in identifying, analysing and adopting the information that is most suited to their own circumstances and their own realities.

This manual has positioned its approach very strongly on a participatory approach to communication, one that works with and seeks to empower those most affected by the health problems they face. This is particularly relevant for community-level communication programmes.

However, in doing so, the manual also makes the clear point that there is no single model or approach that is the solution to all health communication challenges.

Different techniques are appropriate in different contexts to deal with different priorities



and problems. Selection of the appropriate approach from a 'menu' or 'tool-kit' of possibilities, based on an understanding of both the realities of the situation and the most appropriate change theory to apply, is increasingly the way to develop effective communication interventions.

The manual has also acknowledged that even though efforts might be being made to improve medicine use at community level, it is likely that this has to be supported on a number of other levels to achieve real change. The main levels of influence that have been identified as affecting consumer medicine use are:

- family/household level
- community level
- health service institution level
- national level
- international level.

Supporting the process of change



Bringing about change in the way medicines are used at community level starts with understanding how change happens for individuals and communities, and especially the important role emotions play in the process of behaviour change.

The reasons people decide to change (or not to change) are almost always linked to their emotions. Information or knowledge about the advantage of the change, although a necessary component,



is not sufficient to lead to the adoption of changed behaviour. You cannot change someone else's behaviour. People have to take the decision themselves to change, and may do so if they are treated with respect, given appropriate information by a credible person, and they have emotional reasons as well as rational ones. If you want to support the change of a particular behaviour, you will need to influence the factors that shape it. These may include knowledge, skills, attitudes, beliefs, values and empowerment.

Choosing what to do

The choice of an intervention will depend on the type of drug use problem and the reasons why it exists. If communication approaches are going to be used, the choice of communication method will depend on what you are trying to achieve, the characteristics of your audience, and the resources and constraints you have.

Over the years, research has shown that:

- combining strategies – for example, communication with managerial – produce better results
- combining communication methods – face-to-face communication with mass media – produces better results
- the use of any *single* communication approach – print, radio, other mass media or only face-to-face communication – is rarely effective
- research, planning, pretesting, monitoring and evaluation are essential for effective interventions

- involving and interacting with the people the intervention is expected to benefit are essential and lead to more practical and effective interventions
- one-off communication interventions are not very effective and their impact is not sustainable.

Box 96 provides an example of the way a combination of approaches – participatory communication coupled with managerial interventions including improving access to essential medicines and supplies – improved neonatal mortality in Nepal. It also underlines the power of interactive group processes among health workers or consumers to bring about change. Members of the group absorb group norms and are motivated more than through passive learning (Laing, Hogerzeil and Ross-Degnan, 2001).



BOX 96. USING MULTIPLE STRATEGIES TO REDUCE NEONATAL AND MATERNAL MORTALITY IN NEPAL

Birth outcomes in rural Nepal among poor populations improved greatly through a low-cost, potentially sustainable and scalable, participatory intervention with women's groups. It made use of communication and managerial strategies at various levels to achieve a neonatal mortality rate of 26.2 per 1000 in the intervention groups compared to 36.9 per 1000 in control groups and the national average of 39 per 1000.

For every one of the 12 intervention clusters with a population of 7000, one local facilitator was recruited to work with women's groups. Every month, she convened nine meetings of groups. The intervention needed a facilitator rather than a teacher, with abilities and training in participatory communication techniques. She acted as a broker of information and a catalyst for change.

The first step of the intervention was to discuss issues around childbirth and care behaviours in the community, which allowed facilitators to develop participatory learning skills and generated information on pregnancy and childbirth, covering beliefs and practices in both complicated and uncomplicated pregnancies. Women sought more information about perinatal health which was provided through an interactive process involving the iterative design and playing of a picture card game that addressed prevention, treatment, and consultation for typical problems.

The form and content of discussions within the groups varied as did the levels of involvement and potential approaches to improve situations. Some typical strategies were community-generated funds for maternal or infant care, stretcher schemes, production and delivery of clean delivery kits, home visits by group members to newly pregnant mothers and awareness raising with a locally made film to create discussion.

Interventions were also made to improve the health services in both the intervention and control areas. Primary health care centres were equipped with locally made incubators, phototherapy units, warm cots and neonatal resuscitation equipment. Shortfalls in essential neonatal drugs were replaced once, and strategies for re-supply discussed with local health service managers. Training for all cadres of government health staff and community health volunteers and traditional birth attendants was organized. Community-based workers received a basic newborn care kit.

The study concluded that the approach of a participatory communication model supported by managerial strategies to enable changes to take place could benefit other health outcomes.

Manandhar, D. et al. 2004

The importance of interaction

A key message that emerges from the Nepal example is the role of the facilitator. She encourages community dialogue. For rational drug use, the facilitator of the dialogue could be a trainer, a drug dispenser, a health worker (formal or informal), or a community leader. **For good face-to-face communication, the attitude of the dialogue facilitator is as important as his or her knowledge.**

Face-to-face communication will only be effective long-term if developed through interaction with the community. The interaction must build on an understanding of and respect for what is important to people and why they do what they do, and use this as a bridge to explain new practices.

Similarly, framing information in a popular, entertaining format helps create an environment where people of all ages can carry on conversations about topics discussed in the performance. When the content of the folk media is well chosen and followed up with appropriate discussion after a performance, it can help to bring about change in *critical awareness* of the audience, around how people understand problems, the reasons for them, and can stimulate trying out new approaches as part of the solution to the problems. Facilitators who are skilled in participatory processes can make it possible to use folk media for empowerment and social transformation.

Whether at the level of theatre performances in a number of communities, or the scale of Soul City's multi-media approaches in South Africa, the common principle is that the content must be carefully chosen to reflect the important issues in a community. It involves enabling local people, through dialogue, to identify the issues that most concern them, finds ways to dramatize them and through that process to analyse what, for them, are the key messages.

Print materials are often seen as non-interactive. However, their development and use can be a highly interactive process. Indeed, without involving users in developing the materials, it is very difficult to ensure their relevance. The more collaboration there is in developing the materials, the greater the commitment to distributing and using them widely.

By themselves, print materials do not change behaviour. However, they are valuable tools to increase awareness and interest in a topic. When materials are used together with other methods, such as face-to-face communication, they can influence attitudes and behaviour. As part of an integrated communication strategy, they make a valuable contribution to changes in policy and practice.

The same is true for mass media which have the potential to reach large numbers of people quickly and at relatively low cost. However, they are often seen as distant and interaction with them is sometimes difficult.





Mass media on its own is good for raising awareness and interest in an issue, but rarely results in sustained change in social or individual behaviour. When combined with other communication methods, such as face-to-face interactions, the influence on both social and individual behaviour can be substantial.

No matter what communication method is used, there are six key questions (see Box 97) that you should be able to answer that will help you decide on your overall strategy once you have defined the problem and its causes with the people most affected.

BOX 97. SIX BASIC COMMUNICATION QUESTIONS

1. **WHY?** What is the **purpose** of the intervention? What is the need for it? What are you hoping to achieve?
2. **WHO?** Who is the **audience**? What do you know about the audience? What do they know about the topic?
3. **WHAT?** What is the **content** or the main idea that you want to communicate?
4. **WHERE?** What is the **setting** where the communication will take place? What materials or activities can support what you are trying to communicate? Is there anything that will work against your efforts to communicate ideas on rational drug use?
5. **WHEN?** What is the **timing** for your communication? Does it come before someone is about to start a new activity? Will it be during an event? Is it a reminder to be left with someone? Is it to introduce a topic, or to reinforce existing information, knowledge or learning? Are you trying to prevent something from happening, or trying to change an existing practice, policy or behaviour?
6. **HOW?** What **medium** is best to use? Print, face-to-face, audio-visual, theatre, radio or other mass media, electronic or a combination of some of them? What other strategies will reinforce or support what you are trying to achieve?

Developing an enabling environment

Mass media are also very good for raising an issue's profile so that it is talked about and in people's minds when they make decisions. This type of agenda-setting is particularly worthwhile if you are trying to influence policy-makers about the implementation of laws or controls on product marketing. This is part of the way in which enabling environments are created. An enabling environment is a characteristic of a society or a community that encourages change, supports development and seeks to support those that are innovators and proponents of change.

Allies are important in developing and sustaining any change process. Changing policy and practice in the use of medicines is not a task that any one institution or organization can do. It takes teamwork, collaboration and a sharing of skills, experience and information.

Journalists and media programme makers can be powerful partners in communicating about rational drug use. Knowing your media and the role it plays in the society

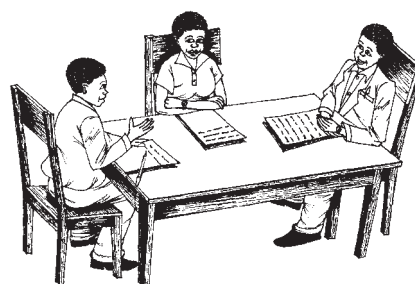


in which you are working can help you to use it effectively to improve the use of medicines.

Effective advocacy and networking can be important factors in determining the success and sustainability of interventions on rational drug use in communities. Collaborating with partners, working to gain and maintain political will, the timely and effective use of expertise, and exchanging experience and information are important in achieving success.

Advocacy is about building a convincing case and getting it across to people who are in a position to influence, formulate or implement policy and affect the decision-making process. In the health and pharmaceuticals field the role of consumer advocates is particularly important because powerful economic interests often conflict with the interests of patients and consumers.

Networking is most simply defined as communication and co-operation between groups and individuals sharing a commitment to a common goal, ideal or objective. Individuals share resources and ideas and make efforts to support, encourage and strengthen each other. It is essential for advocacy. Effective communication relies on feedback, interaction, the quality of the relationship, the level of trust, and the degree of willingness to explore options and share understanding. So does effective networking.



Managerial and regulatory strategies

The problems and possible solutions to rational drug use are complex. The strategies needed to deal with this are also complex and are likely to include managerial and regulatory strategies.

Managerial strategies help to **guide** choices. Managerial strategies for rational drug use usually involve:

- developing standard treatments, essential medicines lists and dispensing standards
- training, supervision and follow-up strategies to support human resources
- ensuring technical resources, such as laboratory, testing, and quality control systems, are in place and functioning well.

While most of these strategies are aimed at health workers or at changes within health care facilities, their ultimate objective is to ensure that consumers have access to the right medicines and the right information about drugs and are



Most strategies are aimed at changing health worker practices ...



... but the ultimate objective is to make sure patients have access to right drugs, information and support.

therefore more likely to use them wisely. Managerial strategies are demanding and ongoing, and require consistent efforts over a period of time.

Regulatory strategies tend to **enforce** choices. They need to ensure the efficacy, safety and quality of drugs and the quality of the information about drugs. This includes determining who is allowed to prescribe and dispense what drugs. This may involve protecting consumers from misleading promotion of medicines, from poor quality products or from drugs that are found to have higher levels of risk. Regulatory approaches may, however, have unintended consequences. In some countries, for example, when ineffective but popular and inexpensive antidiarrhoeal drugs were banned, people began to use more antibiotics – which were readily available and affordable.



In thinking about what strategy to use, it is important to remember that no single strategy is likely to work on its own. Various strategies and interventions have been used to promote better prescribing: education and communication including training and print-only materials; managerial interventions include standard treatment guidelines and selection of drugs; regulatory interventions include prescribing control by level of use and banning of unsafe and doubtful drugs.

Rules and regulations may exist, but they may have little impact if those they are meant to benefit are not aware of them, if people lack an environment that is supportive of change, and if supportive managerial strategies are not in place.

Plan, test, revise, review, reflect and learn

Whatever the choice of strategy, three essential processes help to lead to success:

- the **planning** process that can help to develop a successful and comprehensive intervention
- **pretesting** processes that help to ensure that materials and concepts with promise are carefully tested and validated
- **monitoring and evaluation** processes that can be used to improve learning about what interventions work best, how they can be improved, and how to assess the impact of different interventions.



A critical part of the planning process is to clarify what it is that you hope to achieve with your intervention. The greater the clarity you have about the objective of the intervention, the easier it is to formulate activities that are likely to achieve that objective and the easier it will be to measure whether you manage to achieve what you set out to do.

Pretesting is a vital and all-too-frequently overlooked part of any communication intervention. Experience shows that pretesting actually saves time and money. Projects that skip this step often end up with communication material that is not understood, does not appeal to the intended audience or does not match its views on the problem. That results in wasted resources and time and can have negative health impacts.

Pretesting also is part of a dialogue process with the intended audiences. It is a way of discussing key issues, confirming or questioning initial research about

the drug use problem, and collecting early views on the likelihood of the success of the planned intervention and ideas for changes.

Monitoring and evaluation are part of the normal project cycle. Monitoring relates to how well the activities are being implemented and evaluation assesses the degree to which the project objectives are being achieved. Monitoring and evaluation processes need to be planned and started at the beginning of a project, not handled as an add-on at the end.



Monitoring is a natural component of most communication processes. Effective communication relies on feedback. Monitoring is the main tool to check feedback. Monitoring is done during the implementation of the intervention to find out what has been achieved so far, to identify any constraints, and to make relevant changes. Monitoring relates to activities and uses routinely collected information. Monitoring is continuous.

Evaluation of communication interventions is more challenging. The usual research goal of establishing links between project activities and particular outcomes is particularly challenging when interventions use a number of actions, are aimed at different audiences, over different time periods, and where effects may not be evident for some time. There is no simple or single way of evaluating communication interventions. Using a number of different approaches, including participatory approaches, are more likely to provide the best information to be able to make adjustments to individual projects or programmes, and to provide policy-makers and programme managers with the best guidance on what type of interventions works best in different settings.

Evaluation is done to find out if change has taken place and if so whether it occurred as a result of the health communication programme. Evaluation relates to objectives and whether they have been met. It requires collection of additional data to that which is routinely collected. Evaluation is intermittent.

This manual has consistently stressed the need to monitor and evaluate whatever type of intervention you are trying. The main purpose of doing both of these activities, particularly in any communication programme, is to ensure that what you are trying to achieve with your communication is having the desired effect.

Towards rational use of medicines

Influencing human behaviour is a complex undertaking that requires careful groundwork and carries responsibility for doing the right thing to improve public health. To develop an intervention capable of delivering measurable changes requires working with communities to find the answers to eight basic questions:

1. What is current medicine use?
2. What are the problems related to current medicines use and what are the critical factors underlying these problems?
3. What practices put people most at risk and are a priority for an intervention?



4. What solutions are possible that will build on existing perceptions and understandings to motivate changes in individual and social behaviour?
5. Who needs to be addressed?
6. What channels of communication and what materials/approaches are likely to be most effective?
7. What other measures might be needed?
8. How will the intervention be monitored and evaluated?

Having found appropriate answers, the work then starts, with the people most affected, to put into practice an intervention that will encourage rational use of medicines in the community to help everyone attain the best possible level of health.

Annexes



ANNEX 1

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Useful links

Below are details of several major networks, e-mail discussion groups and organizations which are involved in promoting rational drug use or other aspects of health communication. You can ask them to tell you about people with expertise who might be of use to you. They can also help you to identify others working in your country or region to promote rational drug use. In this section we do not give the contact addresses of national networks or NGOs and organisations active in the area of essential drugs. However if you have problems identifying national or regional partners then you can either contact HAI or post an enquiry on E-drug asking for contact addresses.

Health Action International (HAI)

HAI is an international network of consumer organisations, health and development NGOs, other public interest organisations and health professionals from more than 70 countries. HAI's main focus is rational drug use and it works through research, campaigns, training and advocacy. HAI has four regional co-ordinating centres in Africa, Asia, Latin America and Europe. *HAI News* is published electronically four times a year. In addition there are other regional and national newsletters.

Contact addresses

HAI Africa

P.O. Box 66054 00800
Nairobi, Kenya
Tel: +254 20 386 0434-6
Fax: +254 20 386 0437
Email: info@haiafrica.org
Website: www.haiafrica.org

HAI Asia-Pacific

Level 2, 5 Frankfurt Place
Colombo 4, Sri Lanka
Tel: 00 94 11 2554 353
Fax: 00 94 11 2554 570
E-mail: hai@haiap.org
Website: www.haiap.org

HAI Europe Coordinating Office

Jacob van Lennepkade 334-T
1053 NJ Amsterdam
The Netherlands
Tel: 31 20 683 3684
Fax: 31 20 685 5002
E-mail: hai@hai.antenna.nl
Website: www.haiweb.org

AIS Coordinating Office**Asociación Acción Internacional para la Salud**

Apdo 41 – 128 Urb Javier Prado
Ca. Mario Florian Mz 3 Lote 22
San Borja, Lima 41, Perú
Tel/ Fax: 511 3461502
E-mail: ais@aislac.org
Website: www.aislac.org

Healthy Skepticism

Formerly the Medical Lobby for Appropriate Marketing (MaLAM), Healthy Skepticism defends health care from misleading and harmful marketing through advocacy, research and education. It aims to:

- (a) defend appropriate compassionate scientific medical care, health professionals and the public from marketing practices which may be detrimental to health;
- (b) engage in dialogue with bodies involved in health-related marketing;
- (c) provide a balance of information and practical opportunities for action, which assist health professionals to act for the benefit of the public;
- (d) encourage bodies involved in health-related marketing to provide reliable information to assist appropriate therapy;
- (e) support the development of marketing quality control systems and other methods which enable health-related marketing to become more trustworthy and helpful;
- (f) support appropriate compassionate scientific medical care;
- (g) provide a Medical Lobby for Appropriate Marketing where:

Appropriate Marketing refers to “health-related marketing with provision of appropriate information to assist health professionals to provide appropriate compassionate scientific medical care”.

Contact address

Healthy Skepticism
34 Methodist St
Willunga SA 5172
Australia
Fax: +61 8 8557 1040
www.healthyskepticism.org

The International Society of Drug Bulletins (ISDB)

ISDB is a global network of independent bulletins and journals on drugs and therapeutics, helping them to work together. These bulletins are produced in different countries, often by small groups. Drug bulletins face special problems that editors and publishers of other journals do not have, and therefore benefit from cooperation.

ISDB was founded in 1986, with the support of the WHO Regional Office for Europe. It aims to promote the international exchange of information of good quality on drugs and therapeutics, to encourage and to assist the development of professionally independent drug bulletins in all countries and facilitate cooperation among bulletins.

The main criteria for membership of ISDB are editorial and financial independence and the quality of the published articles.

Contact address

ISDB Coordinating Office
Dialogo sui Farmaci
Via Salvo D'Acquisto 7
I-37122 Verona, Italy
Tel: 39 045 8076068
Fax: 39 045 8011693
www.isdbweb.org/

Ecumenical Pharmaceutical Network (EPN)

EPN is an independent, apolitical, non-profit, Christian organization that works in a context of increasing poverty and need for health services. Its goal is to increase positive health outcomes through church-related pharmaceutical services and its purpose is to increase the capacity of church-related pharmaceutical activities to provide effective and efficient services.

EPN's ultimate beneficiaries are in line with the 'Health for All' ideal; however there is a specific emphasis on the poor and marginalized. The Network's intermediate beneficiaries are its members – church-related health services and their representatives.

The Network currently has three main programmes:

- development of an active network with increased impact
- maximizing access to essential medicines for church health services and their clients
- increasing the capacity of church leaders and church-related health services to respond to the massive challenge of HIV and AIDS treatment.

As part of their efforts to increase access to essential medicines, the Network members have developed a set of 25 factors (guidelines) and an implementation strategy that will expose the practitioner, the consumer and the institution to the critical issues of access. These guidelines include factors necessary for the institution to access the drugs and others to ensure access for the customer of the institution.

Other access activities include the strengthening of the church-related drug supply organizations so as to ensure appropriate selection, supply, distribution, use and management of the medicines and capacity building to address the human resource limitations.

Contact addresss

Ecumenical Pharmaceutical Network
P.O. Box 73860 – 00200
Nairobi Kenya. Tel. 254 (020) 4444832/
4445020 Fax: 254 20 4440306
Email: epn@wananchi.com
www.epnetwork.org/

International Network for the Rational Use of Drugs (INRUD)

INRUD was established in 1989 to design, test, and disseminate effective strategies to improve the way drugs are prescribed, dispensed, and used, with a particular emphasis on resource poor countries.

The network now comprises 23 groups, 18 from Africa, Asia and Latin America, and other groups from the World Health Organization Medicines Departments, the Harvard Medical School Department of Ambulatory Care, the Karolinska Institutet in Sweden, the University of Newcastle in Australia, and a secretariat based in Management Sciences for Health in the United States.

A key responsibility for any health program or organization is ensuring that high-quality essential drugs are available, affordable, and used rationally. For both health systems and individuals, pharmaceuticals represent a major expenditure. Misuse of scarce resources, makes a difficult situation even worse. To improve this situation, it is crucial to improve the use of medicines. INRUD's mission is to identify the best ways of improving their use and to disseminate these findings.

Contact addresss

INRUD Coordinator
Dr John Chalker
4301 N. Fairfax Dr., Suite 400
Arlington, VA 22203, USA
Tel: 703-534-6575
Fax: 703-524-7898
E-mail: inrud@msh.org
www.inrud.org/

E-Drug

E-Drug is SATELLIFE's electronic conference on essential drugs. E-Drug is used by professionals in this field to obtain and discuss current information on essential drugs, including national policies and standard treatment guidelines. Members also use E-Drug to announce and learn of upcoming conferences or courses new publications, recent articles, and broader political (such as trade, patents, pricing) aspects of drug access. To view archives of previous discussion: www.healthnet.org/programs/edrug.html .

To subscribe to E-DRUG

Send an e-mail to majordomo@usa.healthnet.org

Leave the subject line blank and write "subscribe e-drug" in the text space.

For the French language E-Drug, write “subscribe e-med” and for the Spanish “subscribe e-farmacos”.

For more details of INDIA-DRUG and E-LEK (Russian) see: www.essentialdrugs.org/index.php

The Communication Initiative

A partnership involving more than 20 major international agencies involved in health and development communication. The website set up by this initiative is a valuable starting point for exploring health communication on the Internet and contains many valuable links to other sites.

Contact address

The Communication Initiative
5148 Polson Terrace
Victoria, British Columbia, Canada V8Y 2C4
Tel: 1-(250)-658-6372 Fax: 1-(250)-658-1728
<http://www.comminit.com>

Network for Rational Drug Use (Pakistan)

The Network for Rational Drug Use is part of the The Network for Consumer Protection, commonly known as “TheNetwork” – a national, public interest, not-for-profit organization.

The organization came into being in 1992 as “Association for Rational Use of Medication in Pakistan” in wake of a drug tragedy. For some years it did policy advocacy with a mission “to promote rational use of drugs and essential drug concept and in order to optimize the usefulness of drugs and help bring equity in their access”. Building on this experience, TheNetwork developed a vision to become a national consumer protection organization with a broad mandate and multi-pronged strategy.

Contact address

40-A, Ramzan Plaza, G-9 Markaz, P.O. Box 2563, Islamabad, Pakistan.
Phone: +92-51-2261085, Fax: +92-51-2262495
e-mail: contact@thenetwork.org.pk
www.thenetwork.org.pk

Journalists Against AIDS (Nigeria)

Media professionals, concerned about the impact of HIV in Nigeria, have linked together to support each other and to act as advocates in efforts to respond to the epidemic.

Contact address

Journalists Against AIDS (JAAIDS) Nigeria
44B Ijaye Road, Ogba, Lagos, Nigeria
Tel: 234-1-7731457
Web: www.nigeria-aids.org
Email: editor@nigeria-aids.org

ELECTRONIC DISCUSSION GROUPS

AFRO-NETS

African Networks for Health Research and Development

For exchange of information between networks active in health research for development in eastern and southern Africa. To subscribe contact: majordomo@usa.healthnet.org. Leave the subject line blank and write “subscribe afro-nets” in the text space.

EVIMED

Provides an electronic forum in Spanish for those wanting to discuss new ideas, research, education or practice of evidence-based health care.

To subscribe contact: RafaBravo@bitmailer.com

HIF-net at WHO

An e-mail discussion list for people who want to improve access to reliable information for health workers in developing and transitional countries. It involves people working together to improve access to reliable information for healthcare providers in developing and transitional countries. Send list messages to hif-net@dgroups.org. To join the list, send an email to hif-net@dgroups.org with name, organization, country, and brief description of professional interests. Archive at: www.dgroups.org/groups/HIF-net/

INDICES: International Network for Drug Information Centres

An electronic forum for discussion of issues related to drug information.

To subscribe contact: indices-join@healthnet.org.

IP-health

Very comprehensive and super-rapid discussions of intellectual property and health care issues, including pharmaceutical policies, particularly in relation to access to medicines, pricing, global campaigns. A digest option is available.

To subscribe contact: ip-health@lists.essential.org and to set the digest option go to: <http://lists.essential.org/mailman/listinfo/ip-health> <http://lists.essential.org/mailman/listinfo/pharm-policy>

No Free Lunch

Serves as a forum for the exchange of ideas and information on evidence based treatment in the belief that pharmaceutical promotion should not guide clinical practice. To subscribe contact: <http://www.pairlist.net/mailman/listinfo/nofreelunchserve>

SAFCO (SIDA en Afrique du Centre et de l'Ouest)

Network set up to encourage discussion (in French) and the electronic exchange of information on issues related to HIV or AIDS in francophone Africa. To subscribe contact: safco@hivnet.ch

ORGANIZATIONS

Child-to-Child Programme

This is a useful source of material on school health promotion in general. It also provides activity sheets on the use of medicines.

Contact address

Child-to-Child Programme
Institute of Education
20 Bedford Way
London WC1H 0AL
United Kingdom
Tel: +44 (0)207 6126648
Fax: +44(0)207 612 6645
www.child-to-child.org

Healthlink Worldwide

Healthlink Worldwide is a specialist communication and information organization that collaborates with over 50 partnerships across 30 countries to address the social, cultural and economic aspects of vulnerability to poor health. It works to increase the effective use and impact of communication, information and knowledge to address public health issues and support disadvantaged people to bring about positive change in their lives. It provides communication and information services to academic institutions, government institutions, international agencies, local and national civil society organizations. It strengthens the capacity of individuals and organizations to identify and voice their own health needs which enhances their participation, inclusion and decision making in local, national and international policy dialogues. It has a range of practical tools and processes that facilitate participatory communication approaches, sharing of knowledge and learning, and the documentation of good practice.

Contact address

Healthlink Worldwide
56-64 Leonard Street
London EC2A 4LT
United Kingdom
Tel: +44 20 7549 0240
Fax: +44 20 7549 0241
info@healthlink.org.uk
www.healthlink.org.uk

Johns Hopkins University Center for Communication Programs

The Johns Hopkins University Center for Communication Programs provides a range of practical manuals on planning communications, using inter-personal methods and folk media as well as case studies mainly from the field of family planning. It also provides the newsletter *Population Reports* free of charge. This includes details of communication programmes.

Contact address

Johns Hopkins Bloomberg School of Public Health
Center for Communication Programs
111 Market Place Suite 310
Baltimore MD 21202
USA
<http://www.jhuccp.org>

Médecins Sans Frontières

Access to Essential Medicines Campaign

Médecins Sans Frontières (MSF) is an international humanitarian aid organisation that provides emergency medical assistance to populations in danger in more than 80 countries. In countries where health structures are insufficient or non-existent, MSF collaborates with authorities such as Ministries of Health to provide assistance. MSF works in rehabilitation of hospitals and dispensaries, vaccination programmes and water and sanitation projects. MSF also works in remote health care centres and slum areas, and provides training of local personnel. All this is done with the objective of rebuilding health structures to acceptable levels.

As a medical humanitarian organization, it is fundamentally unacceptable to MSF that access to essential medicines is increasingly impossible, particularly for the most common global infectious diseases. Since 1999, MSF has been campaigning internationally to find long-term, sustainable solutions to this crisis. The Campaign is pushing to lower the prices of existing medicines, to bring abandoned drugs back into production, to stimulate research and development for diseases that primarily affect the poor, and to overcome other barriers to access.

<http://www.accessmed-msf.org/>

World Health Organization (WHO)

WHO's goal in medicines is to help save lives and improve health by ensuring the quality, efficacy, safety and rational use of medicines, including traditional medicines, and by promoting equitable and sustainable access to essential medicines, particularly for the poor and disadvantaged. Its vision is that people everywhere have access to the essential medicines they need; that the medicines are safe, effective, and of good quality; and that the medicines are prescribed and used rationally.

WHO's website on medicines <http://www.who.int/medicines/> provides access to a wide range of information.

The *Essential Drugs Monitor* contains regular features on national drug policies, current pharmaceutical issues, rational drug use, access, operational research, educational strategies and much more. Published by WHO once a year, it is available free of charge in **English, Arabic, Chinese, French, Russian and Spanish**. Aimed at policy-makers, prescribers, health educators, administrators and health development organizations, the *Monitor* has an international readership of over 300 000.

<http://mednet2.who.int/edmonitor/>

Other publications are available at: <http://www.who.int/medicines/publications/en/>

WHO's Department of Health Promotion provides materials on the health-promoting schools and healthy cities movement. <http://www.who.int/healthpromotion/en/>

WHO
20 avenue Appia
1211 Geneva 27
Switzerland

ANNEX 3

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