

Acknowledgements

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List of abbreviations

AIDS	Acquired immunodeficiency syndrome
BCC	Behaviour change communication
CBO	Community-based organization
FWCW	Fourth World Conference on Women, Beijing, 1995
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development, Cairo, 1994
IEC	Information, Education and Communication
NGO	Nongovernmental organization
STI	Sexually transmitted infection
TSS	Technical Support System
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Preface

In January 1997, the World Health Organization's Department of Reproductive Health and Research (RHR) commissioned a retrospective qualitative study of 25 years of experience in information, education and communication (IEC) as it had been applied to public health initiatives globally. The purpose of this study, which relied on a literature search, a field survey, and in-depth interviews, was to examine lessons learned from two decades of experience in applying IEC interventions in support of public health in order to improve the integration of reproductive health services. While the focus of the study was on ways in which IEC can support reproductive health strategies, the discourse surrounding this effort pointed to a number of generic issues of interest or concern to all health education, communication, and promotion practitioners. An analysis and synthesis of "lessons learned" as perceived by IEC programme managers, field implementers, donors, and evaluators revealed significant dichotomies and differences of opinion that have emerged in the field of IEC in recent years and helped to identify several areas for future operations research.

In 1998, author Elayne Clift published "IEC Interventions for Health: A 20 Year Retrospective on Dichotomies and Directions", in the *Journal of Health Communications* (Vol. 3, pp. 367-375). The article articulates those divergent opinions, cites major areas for further research, and highlights a strategic approach to partnerships aimed at improving the delivery of health and communication programmes.

This Occasional Paper, also authored by Ms. Clift, attempts to articulate the lessons learned, reflecting a retrospective view of what we know about planning, implementing, monitoring and evaluating IEC interventions. Also presented are special considerations which must be taken into account when applying IEC to reproductive health initiatives. The paper is intended for public health professionals who are conversant with, but not expert in, the IEC field. It compiles some common features in IEC components that have been evaluated and deemed successful.

Introduction

This paper was commissioned by the Department of Reproductive Health and Research at the World Health Organization to examine lessons learned from more than two decades of experience in applying information, education and communication (IEC)^a interventions in support of public health. It represents an attempt to gather and synthesize experiences in IEC for public health, and to succinctly analyse and share these experiences so that IEC can be effectively integrated into, and support, improved reproductive health programmes and service delivery. This effort is intended to serve as an orientation, or a ‘tour d’horizon’, to future IEC work as educators, practitioners, policy-makers and communication specialists in all aspects of public health strive to build upon past experience in enabling people to effect more healthful behaviours.

The document is primarily intended for individuals working in public health generally, and in reproductive health specifically, who are conversant with – but not expert in – the principles and practices of IEC. It is a retrospective rather than a prospective work. The paper is qualitative in nature and attempts to articulate lessons learned throughout the years. It is not the purpose of this document to critique the projects from which it has drawn lessons or to report evaluation findings, although wherever available, documented evidence of effectiveness has been included (in many cases, impact is anecdotal). For a more refined view of projects cited, readers may find it necessary to consult original sources as listed in Appendix 3: Information sources. Further, it is not possible in a document such as this to offer definitive IEC choices, best practices, or recipes for programming in individual situations. Each strategy must be designed and implemented based upon its own IEC objectives, the intended audience, cultural, social and political characteristics, and any facilitators or barriers that may exist in a given situation.

In order to undertake this work, a literature search was conducted. In-depth individual interviews as well as “round table discussions” were held with key informants (i.e., designers, implementers, evaluators and managers of IEC projects in health). It was also considered very important to garner the opinions and experience of people working directly in the field. To that end, a questionnaire was sent to numerous field contacts by WHO as well as by other agencies or organizations interviewed.

This document outlines a set of “lessons learned”. These lessons reflect a retrospective view of what we know now about planning, implementing, monitoring and evaluating IEC interventions. They focus on generic practical steps and on what has “worked”. This section is followed by a presentation of special considerations which must be taken into account when applying IEC to reproductive health initiatives.

At the onset, it is necessary to state several caveats with regard to the contents of this document. First, this paper brings together the results of an in-depth search for the most recent and the most relevant material and opinions. It is not, however, exhaustive.

^a While the words “information”, “education” and “communication” all have individual meanings, grouped together as IEC they become an accepted term in the field of health communication. Please consult glossary.

Constraints in time and other resources, and the extraordinary amount of information related to this task make it impossible to claim absolute coverage of all pertinent issues.

Similarly, this is not necessarily a consensus document. A wide range of views and experiences exist with regard to IEC work. While this paper attempts to capture the main nuances of professional discourse in an even and fair way, it cannot claim to be all-inclusive. In the end, parameters for discussion had to be established and within those parameters, as rich and full a picture as is possible has been laid out within the limitations of time and space. Thus, for example, projects “showcased” as models have been chosen for their innovation, their illustrative nature, their longevity, and so forth; no judgement is implied. Lessons learned are included because of their generic or thematic nature; it is not possible completely to dissect every project or every component of the methodology in order to extract lessons.

Further, this paper assumes a basic knowledge of the form and function of IEC interventions and of the disciplines which inform its practice. It is simply not possible to discuss all of the relevant theories and schools of thought which have contributed to the ever-evolving discipline of health promotion and communication.

It should also be underscored that attempts to apply the experience and lessons of vertical public health programmes using IEC to integrated reproductive health can be extremely challenging. Reproductive health is composed of many complex behaviours. The ways in which these behaviours interface in terms of individual actions, which can be largely influenced by culture and values, and in terms of IEC objectives, strategies and messages, must be carefully considered. At every step of the continuum (i.e., planning, implementation, monitoring and evaluation), there are numerous variables and issues to be considered.

Indeed, this concern is largely the reason that this paper has been undertaken. Until we assess lessons from the field and the questions they raise, we will not know what is transferable from vertical programmes to integrated reproductive health programmes.

The majority of this paper relies heavily on, and in some instances draws directly from, the work of others. All people, materials and organizations consulted are listed either in the Acknowledgements or in Appendix 3: Information sources. There is no intent to claim as original or proprietary the contributions of others, which may have been paraphrased or repeated from documents in the public domain.

Finally, this document is intended as a catalyst for further discussion and exploration. It is important to realize that it is necessarily limited in scope and that it intentionally raises more questions than it answers. It is believed that looking back is helpful insofar as it enables one to look ahead, and that in the dynamic world of public health and IEC, change is inevitable.

What is Information, Education and Communication?

Information, education and communication initiatives are grounded in the concepts of prevention and primary health care. Largely concerned with individual behaviour change or reinforcement, and/or changes in social or community norms, public health education and communication seek to empower people vis-à-vis their health actions, and to garner social and political support for those actions.

IEC can be defined as an approach which attempts to change or reinforce a set of behaviours in a “target audience” regarding a specific problem in a predefined period of time. It is multidisciplinary and client-centred in its approach, drawing from the fields of diffusion theory, social marketing, behaviour analysis, anthropology, and instructive design. IEC strategies involve planning, implementation, monitoring and evaluation. When carefully carried out, health communication strategies help to foster positive health practices individually and institutionally, and can contribute to sustainable change toward healthy behaviour.

IEC Lessons Learned

The following set of lessons learned represents a synthesis of documentation from numerous IEC projects over the past 25 years and also reflects the opinions of those interviewed or surveyed for this paper. These lessons constitute a compilation of some common features of programmes that have been deemed successful. They are not exhaustive, but speak to the issues which arise most frequently as IEC interventions are being planned, implemented, monitored, or evaluated, and which are seen as most critical. These lessons are intentionally presented in succinct fashion so that they may serve as a “check list” or ready reference.

Lessons Learned - General^b

- The most important lesson learned in **IEC** is that it **works**. It creates awareness, increases knowledge, changes attitudes and moves people to change or continue their behaviour or to adopt an innovation.
- Very rarely does a person make a decision alone. To make a lasting change in one individual, the **key influentials** must be identified and encouraged to support these changes.
- Mass media helps to create an agenda for public debate. It reaches many people and is not that expensive. However, to be effective, **mass media must be supported by interpersonal and group communication**.
- Communication channels should ensure availability of **feedback** mechanisms. This is important for reinforcement and for clarifying questions and issues.

^b Much of this section has been drawn from: *Nutrition communication project. Final report*. Washington, DC, The Academy for Educational Development, 1996.

- **Personal testimonies** of affected people are far more compelling than any other form of communication. Fear arousal is seldom effective.
- When a communication programme is designed and carried out by **expert practitioners**, it is more likely to achieve success.
- A mass communication programme dealing with sensitive issues **socially validates** open discussion of these issues, thus making them part of the everyday agenda.
- In order for a communication campaign to be successful, the relevant **social services infrastructure** should be prepared to satisfy the increased demand for services created by the campaign.
- An important element in a health communication campaign is an adequate **blend of entertainment and social messages**.
- A continuing **barrier** to the success of IEC interventions is **limited resources and unrealistic expectations**.
- **Resources** need to be devoted to producing salient materials in sufficient quantity, to establishing a workable distribution and reordering system, and to showing service providers how to use materials. Also needed are basics: signs showing the way to services, what services are available and what they cost, days and hours of service delivery, and how one can access services.

Planning a Strategy

- IEC succeeds when it is planned with a **comprehensive strategy**. This means having clearly articulated objectives, keeping the client at the centre of what is being designed, conducting appropriate research, undertaking audience segmentation, carefully crafting and testing messages, knowing and using appropriate channel choices, and planning for monitoring and feedback.
- Particularly in the case of reproductive health initiatives, it is important to know and **incorporate community traditions** (e.g., disposal of placenta, respecting preferred birth position), and to “follow the community at its own rhythm”. Communities will test you and credibility takes time.
- Much can be achieved through a comprehensive IEC intervention which emphasizes **long-term capacity building** at the grassroots level. In this respect, the community is vital; it is not simply a message channel or a passive recipient of services or information.
- **IEC issues overlap with related issues** of service delivery, quality of services, community participation, and so on. There must be a true dialogue around a wide range of issues relevant to public health during the planning stage.

- Changing behaviour is not an easy or quick task. An ideal campaign is **sustained over time** to foster changes in social and behavioural norms.
- It is important to remember that **everything cannot be changed at once**. Also, it is important to focus on what is relevant or not relevant, and consider not only information but also the “knowledge-behaviour gap”.
- IEC interventions are more cost-effective when there are clear **links with health care service delivery programmes** rather than when they are conceived as stand-alone IEC projects. From a communication perspective, this makes vital the quality of client-provider contact. Provider behaviours require monitoring, reinforcement, and updating. The lack of a supportive environment from the health care provider is also a factor that can hinder individual behaviour change.
- **People learn new behaviours best:** when they are learning something they feel is useful, when they can put into practice what they are learning, and when they receive feedback and are rewarded for doing well. Modelling is often the best way to teach complex behaviours.
- Programmes that seek to teach new behaviours work best when they **define through research** what the health problem really is, who it affects, how those people understand and respond to the problem, what obstacles they are likely to encounter, and how the audience can be influenced to change. A particular behaviour can be part of a complex set of behaviours with differing responses to each component along a continuum of change.
- Sound programmes also use **audience segmentation** (i.e., the grouping of audiences by demographic, social, and psychographic variables), marketing techniques, behaviour analysis, and anthropological research to **create messages that are salient, action-oriented and attractive**. They test those messages, integrate communication channels, monitor and evaluate regularly, and commit to the long haul.
- Getting information on which to base an IEC strategy doesn't need to be time-consuming, costly and complicated. A short list of highly specific questions can keep formative research focused on **essential issues**, i.e., identifying concrete and realistic behavioural targets for the different audiences, ways to reach each audience, and appropriate messages for each audience.
- The **type of information needed will drive the research methods** to be used. Most programmes require a mix of ethnographic, market, observational, attitudinal, consumption and epidemiological research. Hybrid approaches (qualitative and quantitative) are often best and are not necessarily more costly or time-consuming.
- More effective campaigns **combine mass media with community, small group, and individual activities**, and are supported by an existing community structure.

- Campaigns for preventive behaviour are more effective if they **emphasize positive behaviour change** rather than the negative consequences of current behaviour. Fear arousal as a campaign strategy needs to be used with caution. It is rarely successful as a long-term campaign strategy.
- In **message design**, be aware that people seldom like to be told what to do.
- The **timing of a campaign** helps to determine its effectiveness. For example, in diarrhoeal disease campaigns, seasonality is an important consideration since diarrhoeal disease often occurs in the rainy season.
- If more than one set of messages is being delivered via an **umbrella campaign** (e.g., several issues are being covered under one unifying theme), phasing of messages might be important to avoid information overload.

Implementing a Strategy

- **Support of community leaders**, public opinion leaders and decision-makers can lead to stronger results. The use of such identifiable and **credible sources** of information can enhance the success of an IEC initiative.
- Actively **involving the target audience** in the design, implementation and monitoring of a project is critical. Listen to local language, custom, and experience. Negotiate the relevance of an intervention with the audience. Make sure the intervention addresses reality “on the ground”.
- **Establish linkages** and relationships with, and actively involve, traditional healers, local nongovernmental organizations (NGOs) and local support groups, and recognize the important role each plays. Share information with them.
- The **interaction between health care providers (at all levels) and clients** is important for successful IEC interventions. This is where one stage of decision-making takes place. Provider behaviour is critical and the need for behaviour and attitude change among health workers has been established. (Physician resistance to change, as well as punitive actions by all other levels of health worker, is well documented.) Training in interpersonal communication and counselling skills is absolutely critical to successful programming.
- **Multimedia campaigns** are most effective when mass media and popular traditional channels are used in combination with person-to-person interactions. There is less power in stand-alone multimedia campaigns than in campaigns that link the power of media and the power of individual persuasion with service delivery.
- A media campaign should use diverse broadcast and distribution channels, combining television, radio, print and traditional media, in order to maximize penetration and impact. More attention needs to be focused on the **mix of**

channels used in a given situation. Achieving “reach and frequency” in communications takes careful research and planning.

- **Decisions about media** channels and frequency and intensity of broadcast or distribution should be closely **tied to** initial and ongoing **research** with the target population.
- Take advantage of **local holidays and festivals** to disseminate messages or for inaugural events.
- IEC interventions cost money to implement and to sustain over time. There is an imbalance between expectations about what IEC can do and the **resources allocated** to carry out those interventions. It is important to realize that change within five per cent of a designated population represents good progress. Remember, even Coca-Cola never stops promoting its product.
- **Logos and symbols** offer a way to create unity between a wide range of communication messages, allowing the target audience to build up interpretations and meaning over time. However, certain symbols are recognized at only certain levels of the population. Assure that you have adequately tested a symbol or logo and are aware of the audience’s understanding or interpretation of the same prior to launching.
- **The use of logos and symbols in advocacy campaigns** has also been successful. The red ribbon has come to symbolize the international struggle around HIV/AIDS, but this meaning has only developed through continued association with other HIV/AIDS messages. The White Ribbon Alliance for Safe Motherhood raises awareness about the need to make pregnancy and childbirth safer for all women and infants.
- A campaign should reach relevant **segments of the target population** with meaningful messages; materials should have broad appeal and, at the same time, some materials should be tailored to meet specific subsets (e.g., by gender, age, race, economic status). It is important to direct messages at specific behaviours and when defining behaviours to think about action/target/context/time (e.g., “Always use condoms correctly when having vaginal sex with your main partner.”) A media campaign should be **ongoing and responsive** to shifts in the market and the audience in order to prolong and sustain its impact.
- Media campaigns need to **reflect an entire programme’s behavioural objectives** through appropriate message cycles to targeted audiences. Such messages should support existing desired behaviours, promote new behaviours as necessary, and alter unhealthy behaviours. Conditions must be in place to support whatever behaviours are being promoted. For example, birth spacing messages might reinforce dialogue between partners, encourage clinic visits for contraception, and address community social norms that advocate large families. It is then

incumbent upon reproductive health facilities to have trained practitioners and counsellors on hand to facilitate these behaviours.

- Sometimes it is important to **anticipate trouble** and to develop a crisis communication plan if the intervention is considered controversial. It may be important to determine in advance who will act as spokesperson for the programme and s/he should be prepared. Centralizing information for dissemination to the public may help to avoid problems. It is important to communicate with all key audiences and to maintain good relationships with them. Know who the possible opponents are and, in so far as possible, build trusting relationships. Remember that people respond best to facts. Listen first, then act. Be prepared to make short-term sacrifices for long-term gains.
- **Facile pretesting can yield poor information.** Many erroneous conclusions have been attributed to superficial testing for such things as comprehension. Observations of materials in use and trial periods can help to detect problems. Go beyond simple focus group discussions. Use different approaches to collect information, and remember that moving from data to messages is difficult.
- **Simple, inexpensive print materials can be useful** and more cost-effective than more expensive and elaborate products, i.e. counselling 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 which only require visual literacy.
- IEC **materials** are more widely distributed when their **distribution system** is combined with relevant health commodities (e.g., distribution of contraceptive commodities simultaneously with posters for family planning).
- **Distribution** of print materials may occur more effectively if contracted out to the private sector. The failure to plan for, implement and maintain distribution systems is often a major failing of IEC efforts. Stories of materials, video cassette players, and other materials and equipment “sitting around gathering dust in warehouses” abound.

Monitoring and Evaluating a Strategy

- Monitoring has been neglected as a tool for understanding operational dynamics and for detecting what works or doesn't. **Inexpensive methods for monitoring** can be used and should be explored (e.g., observation).

- **Documentation** of programme inputs and implementation experiences is important for understanding successes and failures. Methods for doing this should be institutionalized as part of management information systems.
- **Evaluation of IEC efforts is a complex task** and should be considered from the very beginning, when projects are being planned and not just after they are underway or completed. Involving specialists in research design and evaluation early on can ensure that process and impact evaluations are valid and reliable.
- There is a need for extreme **specificity in questions** asked in an evaluation, especially in countries where multiple interventions have been carried out. Carefully constructed questions are very important. In designing questions, messages must be carefully analysed so that primary messages (e.g., “breast is best”) are distinguished from secondary messages (e.g., promotion of weaning practices).
- The **research and evaluation team should** be given an opportunity to fully **understand the project**. The stronger the understanding between programme staff and researchers, the better the product.
- **Evaluation should be considered a learning tool** by programme staff and should be embraced as a resource for programme redesign.
- An **evaluation framework should be responsive** to programme needs, and should feed information and data back to programme staff to allow for corrections and adjustments to programme components during implementation. Evaluation should not impede implementation. As one evaluation expert put it, “We will rarely have evidence that is incontrovertible; nonetheless, we still need to act sensibly on the best evidence we have.”
- Recognizing that **research and evaluation designs may have limitations** and factoring in those limitations when assessing the effectiveness of programme strategies can contribute to more successful outcomes.

Training

- Provided with relevant training, **non-IEC professionals** can coordinate the development of good quality IEC materials and approaches. In order for training to be relevant, it must take into account the role and job description of the persons being trained. People should not be trained just for the sake of training. All training designs should be seriously deliberated and individualized in order to meet the needs of the programme and of those being trained.
- People need **training in materials use and distribution** as well as materials development.
- **Phased training**, focusing first on skill building and then on skill transfer, is a successful model. It allows trainees to practice their new techniques (e.g.,

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counselling) before actually becoming trainers of others in the same skill area. This enhances overall programme sustainability. A **competency-based approach** to training is most effective at building skills.

- Training should be **curriculum-based** and apply the **principles of adult education**.
- Like other programme components, **training should be evaluated**, and those who are being trained should be involved in developing the curriculum.
- Even when trained, people have difficulty discussing personal matters (such as sex) with others. IEC training needs to address this problem, and to provide **specific techniques for opening dialogue** and moving it forward. It must also address the need for health care workers to come to grips with their own behavioural and cultural biases. (For example, can a midwife act against female genital mutilation in a believable way if it has been done to her and she has allowed it to be done to her daughters?)
- There is a pressing need for training in IEC techniques that effectively **motivate people to express their genuine desires** relating to reproductive health. Similarly, training design needs to take into account the desires of trainees and/or providers as well.
- It is most effective if the number of **levels of trainers** is **kept to a minimum**. That is, instead of having different trainers for each level (i.e., province, county, township, village), have perhaps two levels of trainers responsible for all training activities. The fewer the number of levels, the less opportunity for important content to be lost during training of trainers workshops.
- Ensure that **appropriate training materials** are **available** for community level workers. This includes budget considerations to assure funding so that adequate materials reach all levels, not just those at the higher levels.
- **Include leaders and managers** in the programme or establish a parallel programme for them to ensure they understand the importance of interpersonal communication work and will support it in future.
- A **client-centred approach** to training can have dramatic results in terms of service delivery. A consumer perspective requires that health workers understand the client's circumstances, that they seek solutions to problems in collaboration with the client, and that they are systematic about follow-up.
- **Well-designed and tested training modules can serve as reference points** for national and local training programmes. In designing materials for widespread use or for local adaptation, three strategies can help assure relevance and widespread use: involving a wide range of potential user organizations in identifying needs and issues;

involving them in pretesting the materials in their respective programmes; and involving them in the translation and publication of materials.

- Incorporate interpersonal communication principles and skill training in **regular, pre- and in-service training programmes**.
- Include in any training curricula, sessions on how to conduct **audience research** and how to use the results to adapt training materials for use at different levels.
- Include as many posters, models, and other **teaching aids** as possible in training programmes to supplement curricula and training materials.
- Schedule **follow-up** or **refresher training**.
- Be sure that clearly articulated job descriptions with realistic expectations are reviewed regularly and that supervision is ongoing.

Lessons Learned in IEC Specific to Reproductive Health

Peer education, support groups, counselling and interpersonal communication

Peer education, support groups, counselling and interpersonal communication are important components of a reproductive health programme. Peer education allows for dissemination of information and discussion about specific topics by members of a person's own age or social group. It often provides the most comfortable atmosphere for dialogue around sensitive issues. In peer education situations, the lead peer educator has been trained not only in interpersonal skills but also in the content area upon which the education focuses.

Support groups provide mutual assistance among members who share a common situation or problem. Such groups often provide a special form of social support that may be lacking in other networks. Support groups are recognized to have particular benefits for women, including improved psychological well-being, increased community participation, and greater message comprehension.

Counselling is a client-centred interactive communication process in which one person (usually trained) helps others make free, informed decisions about their personal behaviour. It provides support in decision-making and action. Counselling can occur individually or in groups. It may involve professionals or peers, the latter being especially important in the reproductive health arena. Counselling can focus on long-term change, or on crisis intervention (as in situations of post-abortion or sexual violence). It involves a set of specific skills, including active listening, non-judgmental attitudes, probing skills, problem solving ability, and behaviour modelling.

Interpersonal communication is a broad term for person-to-person interaction and mutual understanding. It implies trust, support and, frequently, negotiation, and it is an extremely important part of any communication strategy.

Peer education, support groups, counselling and interpersonal communication have proven to be extremely important as communication mechanisms on reproductive health-related topics and among certain specific audiences (e.g., teens, military). For example, one study of 21 projects worldwide that used a peer education strategy found that peer educators had moved from simply raising awareness to supporting actual behaviour change¹. Ninety-five per cent of peer educators in that study reported that they had changed their own behaviour since becoming a peer educator.

The ideal peer educator (and counsellor) is respected, charismatic and literate. He or she has good communication skills and an interest in self-enhancement. Peer educators are often chosen by the members of a target audience because they are viewed as leaders and role models. Peer educators may work with individuals or groups in a variety of settings and may use teaching aids such as videos or drama.

Peer education and counselling projects face numerous challenges. Among these challenges are time constraints, limited resources, transportation problems, client denial, and occasional harassment or intimidation. Also, peer educators and counsellors require more advanced training the longer they remain engaged in programmes. They should be professionally supported as legitimate members of the team by health care providers. In reproductive health programmes, the challenges are even more specific. The issues of counselling in reproductive health are increasingly complex. This reality raises questions about the training and supervision of those providing counselling, as well as about message content and the integration of messages (i.e., family planning with sexually transmitted infections, including HIV/AIDS). It will take sound scrutiny of past experience to address concerns about how to design salient sexual health education programmes, messages and curricula. Developing appropriate linkages, umbrella themes, and indicators of best practices are among the priorities of IEC planners working in the area of reproductive health and counselling, peer support and other forms of interpersonal communication.

It should be noted that consistent with this concern, significant attention has been paid over the past 15 years to counselling as a necessary part of education programmes and as a major communication strategy, although a relatively small body of research has been carried out in this area to date^c.

Gender considerations

Women's concerns

One of the lessons learned across all sectors of development is the importance of incorporating a gender perspective in programme planning and policy-making. This lesson is also profoundly important in the spheres of reproductive health and IEC. Listening to women, including them in planning, implementation and decision-making, and validating the reality of their daily lives are all facets of a successful intervention

^c For more on this topic, readers may wish to see *Family planning counseling: a curriculum prototype* (1995) and *Family planning counseling: the international experience* (1993), both produced by EngenderHealth, New York.

aimed at healthy behaviour. Women have both short-term, practical needs (e.g., food, shelter, safety) and long-term, strategic needs (e.g., economic viability, reproductive freedom, enhanced status). In all aspects of their lives, women's needs and priorities must be met with sensitivity and without presumption. Whether in the realm of human rights and freedom from violence or in activities of daily living, women's empowerment is paramount.

Almost without exception, those programmes that actively listen to women by eliciting their opinions and preferences come closer to achieving their health promotion objectives². Inviting the voices of women, incorporating their experiences, and understanding their roles as economic producers, household caretakers, and community members can measurably enhance the success of holistic reproductive health programmes.

Issues of human sexuality, family planning and child spacing, conception, abortion, childbirth practices, obstetric events, and so on are sensitive, private matters. Women need to feel that their attitudes, values, experiences and beliefs are respected. They need to know that they can trust the information they get, and that they can act upon it without fear of repercussions. Reproductive health messages need to address women as women, not just as caretakers, and they need to speak to women as adult members of the family and community, not as if they were children. Programmes should be designed to appeal to women (and be accessible to them) and information should not be overwhelming, simplistic, or condescending. Reproductive health must be seen within the context of the life cycle, and also in the context of every aspect of women's lives. Such gender issues as power relationships between women and men, women's roles and status, their access to and control of resources, and sex preferences in children need to be included in the mindset and the dialogue surrounding IEC interventions.

Women can sometimes be seen as a "hard to reach" audience. This label can be pejorative and can eclipse good reasons, from a woman's perspective, why certain behaviours are not adopted³. Time allocation and competing demands, fatigue/illness/depression, health worker behaviour, or communication and power struggles within the marriage dyad can all be contributing factors to a woman's choice not to act. These realities need to be seriously considered when mounting an IEC initiative which demands even more of a woman's time, energy and resourcefulness.

Gatekeepers and influentials are particularly important in reaching women. Husbands, religious leaders, female family members, elders, and traditional birth attendants all play a part in women's access to information and in their decision-making with respect to their own reproductive health. Women, those who care about them, and those who depend on them must understand the importance of prevention, maternity care, and the full range of other reproductive health services that contribute to women's wellness.

Public health IEC programmes can contribute in many ways to increasing knowledge, changing attitudes, and enabling action and mutuality – important goals for women's well-being. Advocacy initiatives can increase awareness of women's health problems among policy-makers and can help foster a physical and social environment conducive

to good reproductive health. Public education can promote appropriate action in the home and community, and can discourage unsafe practices that harm women's health (e.g., delays in seeking care during pregnancy, and female genital mutilation)⁴.

Finally, it must be underscored that in order to adequately incorporate women's (or any other audience's) perspectives on reproductive health issues, it is necessary to begin with well-designed qualitative research. Such research can narrow the gap between women and reproductive health programmes which are intended to meet their needs. All too often, formative research asks only standard knowledge, attitudes and practices questions and fails to adequately investigate barriers, and motivating or facilitating factors for women. Such research fails to let women speak for themselves. And, too often, results are not applied effectively to developing IEC interventions. Using women's specific realities and felt needs as an entry point for reproductive health programmes requires a thorough understanding of what women themselves think those needs are. Sensitivity to using women's own health concepts and language in the design of messages, materials and activities increases women's ability to understand and benefit from them. Providing women with exactly the information they require, precisely when they need it, is easier when women have participated to the greatest extent possible⁵.

Men as partners

Reproductive health programmes have increasingly understood that men's support and participation are essential to the ultimate success of any reproductive health initiative. Men need to be addressed in three specific roles: as individuals/partners, as community leaders, and as government leaders⁶. Thus, the term "men as partners" seems more appropriate than "male involvement" or "male responsibility" when discussing the importance of including men in reproductive health initiatives.

It is important to learn what men want and need in terms of reproductive health. Increasing the participation of men in reproductive health programmes begins with understanding their point of view and their perceived needs as distinct from women's. One key to increasing men's participation is to develop messages, based on segmentation and qualitative research, that are relevant to men's concerns.

Men must also be positioned as caring partners, not as irresponsible adversaries. Power differentials notwithstanding, men's potentially positive role in family planning and reproductive health must be capitalized upon. The macho stereotyping of men is counterproductive and may limit men's ability to access information. At the same time, men's potential for exerting a negative influence on women's decision-making must be checked; it is well known that many women feel they must use contraception without discussing it with their partners or in the presence of a counsellor because of fear of reprisal. Idealism in these matters must not override reality. Accordingly, men should be encouraged and oriented in talking to their partners and in making joint decisions with them. Messages need to appeal to men's sense of responsibility and involvement in family matters. Couples' communication is crucial.

In an interesting perspective on “ensuring male responsibility in reproductive health”, Errol Alexis of the Margaret Sanger Center International makes the case that men know very little about their own sexuality and that they do not communicate about sexuality in their relationships. Their lack of information is overshadowed by their strong belief in sexual myths. Alexis believes that the lack of greater success in promoting reproductive health is directly related to male resistance and to the fact that men make decisions about sex based on “power, trust and pleasure”. Programmes need to examine male power and privilege as well as male trust or mistrust around such issues as contraception. Finally, programmes need to address male pleasure in relation to his and his partner's sexuality. Men tend to see involvement in family planning and reproductive health as restricting their pleasure. Programmes and messages need to be designed, therefore, to address these issues.

Male peer educators, promoters, and providers should be trained in issues of male sexuality including sexual myths and facts, family communications, and domestic violence and sexual abuse. Acting as role models, they can provide information in a culturally sensitive manner using existing communication channels. The success or failure of such male-oriented programmes should be measured not in terms of the number of condoms sold or vasectomies performed, but rather by a combination of levels of communication, attitudes toward sexual and reproductive health, attitudes towards family size, knowledge and use of contraceptives, levels of knowledge about sex and sexuality, and acceptance of family planning⁷.

Service sites for men should be publicized and promoted; promoting men's access to information and services has been overlooked in the past. Further, a focus on women only serves as a barrier for men who may be interested in knowing more about condoms or vasectomy. Such male-oriented sites could also improve men's perception of contraceptive methods. Studies around the world have shown that men want more information about contraception. Without accurate information, men (like women) are susceptible to rumours and misinformation and thus fail to become active partners in family planning and reproductive health. In programmes where men's fears and concerns have been addressed, men's attitudes have improved and their contraceptive use has increased⁶. Men should also be given facts about women's family planning methods.

Working with opinion leaders to increase men's social support and using multiple communication channels to create a synergistic effect are also important in reaching men of all ages.

Youth as an audience^d

Reproductive health projects for youth can be controversial. Parents, policy-makers, religious groups and other influentials often fear that by openly discussing sexuality and family planning and by providing services, such projects foster premarital sex and

^d Much of this section has been drawn from: Israel R, Nagano R. *Promotion of adolescent reproductive health: lessons learned from social marketing and communications projects*. Newton, MA, Educational Development Center, for USAID, 1998.

encourage promiscuity⁸. In order to build support for a youth project, it is important from the beginning to identify and work with both high-level supporters and opponents of youth programmes. Early on, programme managers must inform policy-makers and community leaders as well as potential collaborators about the extent of the adolescent sexuality issues to be addressed. Leaders and gatekeepers should be invited to participate in designing the project or should serve on a project advisory committee. This kind of action gives programme planners an opportunity to assess what materials and services are acceptable and to defuse any potential opposition. Indeed, sceptics can be converted into vocal champions of an effort they have helped to develop.

Because of the sensitivity of reproductive health issues for youth, planners should begin work on a small scale and expand efforts slowly. A pilot project may help to make people comfortable with larger initiatives. It may also be wise to begin with less controversial topics and then systematically build upon them, adding more sensitive issues as work progresses.

Research and evaluation should drive the development of youth programmes. It is very important to conduct appropriate audience analysis and pretesting of materials so that messages do not seem to “preach”. To reach youth directly, projects must speak to the audience in credible and trustworthy ways. It is also important to involve youth themselves from the outset, as designers, implementers, and as spokespersons.

It should be recognized early on that young people want accurate information about sex. If they do not get it, they may accept hearsay and rumour which will then have to be countered. Also, information must be linked to services. Sexually active youth need support, counselling, and services for family planning as well as prevention and treatment of sexually transmitted infections (STIs). Where youth do not have access to legal, safe, affordable, convenient and confidential reproductive health services, projects may need to advocate for changes in national policy or they may need to establish alternative sources of care.

Youth projects must address both males and females and double standards of sexual behaviour must be considered. Programmes must work with parents and other influentials, often a daunting task in the face of resistance and poor information and skills on the part of adults. Mass media can foster family communication and can make discussions around sensitive topics easier. Schools are another partner for youth. Administrators and teachers must be brought into the dialogue on health and sexuality.

Community activities often offer a way to reach young people. Entertainment or sports events can be action-oriented. Also, by using various communication media, youth projects can reach different audiences with complementary messages. Pop culture and print materials are a powerful combination. Finally, engaging positive role models for youth are key. In this regard, caution must be exercised in using celebrities. The spokesperson's own lifestyle should illustrate wholesome attitudes and behaviour such as that being promoted by a campaign. Also, role models need not be real people. Fictional characters in TV drama or radio soap opera can be just as powerful figures as real life people.

Changing adolescent behaviour requires intensive, long-term programme efforts that incorporate a mix of media along with interpersonal communication and counselling. Guidance and facilitation help to keep youth focused on critical issues.

Negotiation/Life skills

Development of life skills is an important concept in promoting healthy behaviour generally, and specifically with respect to reproductive health. Negotiation will be required which involves risk-taking and a set of acquired skills that even the most sophisticated may find intimidating at times. Negotiation-focused messages need to be developed that deal specifically with negotiation issues as they relate to reproductive health matters for all audience segments. For example, what is negotiation and how do you carry it out successfully? How do you deal with opposition and resistance? How do you achieve a win-win situation? How can you avoid locking into an entrenched position so that negotiation or compromise is impossible? Assertiveness and decision-making skills will also be important, accompanied by methods that help to develop positive self-esteem. Experience has shown that practising negotiation skills with “scripts” tends to yield positive outcomes. Such questions and skills are critical if women, youth, and other vulnerable populations are going to be enabled to “own” power, and to act on their own behalf.

Religious Institutions

As was underscored at the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women (FWCW) in Beijing, some religious institutions have a vested interest in issues relating broadly to gender equality, and specifically to the area of women’s reproductive lives. In particular some religious fundamentalist groups perceive an erosion of their teachings and beliefs if women are granted what others deem to be their basic human and reproductive rights. This is obviously an area of potential conflict that must be considered carefully by public health educators and advocates as they pursue “health for all”. Many communication programmes have successfully broached this dilemma with sensitivity, and have been able to find common ground, delicate though it might be, with religious leaders in the communities where they work.

Building Partnerships for Integration through IEC

Integration can be considered with respect to IEC itself (e.g., the integration of messages and media mix), and it can be thought of in terms of integrating service providers, organizations and agencies, or others with a vested interest in reproductive health outcomes. A fundamental operations research question is whether or not it is viable and/or appropriate to integrate reproductive health services and/or IEC messages. But, assuming a consensus can be reached on what is meant by integration and how to achieve it, and assuming agreement in terms of its viability and usefulness, it becomes important to understand the relationship of IEC to integration vis-à-vis reproductive health. Most simply put, communication, and more broadly IEC, can be

the natural facilitator of programmatic integration because dialogue and cooperation are inherent in the discipline and its methodologies. In addition, IEC brings specific skills to bear on the challenge of achieving sound integration, whether organizationally or interpersonally. Whether one is trying to effect better coordination and collaboration between agencies, or attempting to inform clients about coordinated resources in the community, communication techniques and trained communication specialists can offer the bridge that is often necessary for understanding how the parts of a system (or campaign) form a whole.

In terms of organizational integration, which implies functional linkage rather than cooptation, it is important to build alliances with others working in the same community or delivering services to the same clients. By doing so, it is possible to maximize effort, expertise and resources while avoiding duplication of services and contradictions in information provided. However, developing partnerships is not easy, nor is it a static process that will progress without significant nurturing. It could therefore be helpful to envisage developing and maintaining partnerships as a fluid process along a continuum which ranges from mere co-existence, to communication, cooperation, coordination and, finally, to collaboration. During the process of achieving collaboration, conflicts inevitably arise. How these conflicts are resolved is critical, because the basis for moving forward rather than remaining static resides in that process. Alliances are formed when groups successfully negotiate beyond their differences to jointly accomplish a common purpose.

In a state of coexistence, organizations perform their tasks in isolation, even though they may be serving the same client or offering the same or similar services. There is no attempt to work together and, in some instances, competition between agencies or organizations may exist. Communication between organizations, as with people, includes more than just verbal exchanges. Partners draw conclusions from such indicators as body language, decisions made and behaviours exhibited. Most organizations are structured to preserve, expand and justify themselves. Once they can establish a minimum level of trust, learning to acknowledge conflict and to address such conflict through a variety of negotiation strategies, the threat to the development of partnerships decreases. In the cooperation phase, there is a willingness among organizations to work together to make programmes successful, even though each party maintains separate and autonomous programmes. Partners may plan activities and schedules jointly, even though each one retains its independence and autonomy. Examples include referrals between organizations, networking, cross-training or information sharing. In coordination, elements of the service delivery system are articulated in such a way as to provide for comprehensiveness, accessibility and compatibility among service elements. Partners agree upon strategies that modify existing services or activities to achieve greater efficiency and effectiveness, and although each agency remains independent, there may be mutually agreed upon goals and shared resources. Collaboration represents the most fully developed level of partnership, in which organizations establish a mutually agreed upon vision and mission. They share power, authority and resources. Collaboration requires long-term institutional commitment and participants must agree to relinquish organizational autonomy in order to accomplish the mutually agreed upon goals and objectives⁹.

Another model developed by NGO Networks for Health looks at a participation continuum based on levels of control. Where outside control is high, cooptation and tokenism occur; when there is collective action, people set their own agenda and mobilize in their own self interest.

In 1994, in Cairo, ICPD established a number of challenges for reproductive health service delivery in which partnerships and integrated approaches are implicit. Countries will have to determine on an individual basis how to operationalize the ICPD mandate. (In doing so, they will need to keep in mind clients' needs from the perspective of those clients.) Integration will have to occur at all levels, i.e., intellectually, as well as in relation to health interventions per se and to management practices. Potential partners will have to remember that while people are usually rhetorically committed to the ideal of integration, in reality calling for collaboration can make it more difficult to garner practitioner support because it often represents increased work loads or a sense of competition, especially if scarce resources are involved. The challenge lies in overcoming this perception.

Integration in message development raises other issues, including such things as the challenge of dealing with cognition and effect in message design, or the problems of overload and appropriate phasing. Strategies, messages, and IEC infrastructure must all be integrated for optimal outcome. But is it really possible, or even advisable, to integrate messages about safe motherhood, STIs, family planning, HIV/AIDS, violence against women, and so on? When does integration become cooptation? What should be the focal point for integration (e.g., behaviour change? management? messages?) Where does IEC actually fit in terms of the whole picture? Clearly, "integration" is a linchpin for a variety of issues to be addressed as IEC continues to mature as a methodology.

These are difficult considerations in the post ICPD and FWCW era, and in development generally, when reproductive and other health programmes are being called upon to do more and to expand services in the face of shrinking resources. Similarly, IEC strategies are challenged to be more comprehensive, more enabling, and more inclusive. This reality means that the issue of partnerships – how to identify appropriate partners and how to collaborate and negotiate with them more effectively – is critical. One of the most important, and to date underdeveloped, partnerships is the one that should exist between providers and clients. Many would claim that this is the true starting point for a successful IEC intervention. Beginning here, planners and implementers need to examine what power struggles exist, they need to grasp who are influencers or peers, and they should identify relevant management issues. Unless the client, frequently constrained by social norms, and the provider, often controlled by management, converge on a common goal, health objectives will most likely not be met.

Further, the private/public sector partnership, promoted and scrutinized for many years, still requires examination in the continuing quest for a paradigm of partnership that actually works. As some say, we "talk the talk" of partnership, but in fact, we don't always invite others in. But genuine coordination, collaboration, and shared responsibility are required if partnerships are going to be viable. This requires strategic

communication at all levels and across all relevant sectors. To that end, communication specialists need to be brought into a project or programme from the beginning. They are vital to the strategic vision of an intervention and can contribute measurably towards the establishment of convergence models that are perhaps more efficient and effective than vertical models that parallel or compete with one another.

The question then becomes: how can IEC contribute to the overall goals of reproductive health integration and how can it support a sense of “ownership” among partners? How can it help to inform policy rather than to shore up, after the fact, policies that may not be entirely feasible? Life skills and negotiation are as relevant here as they are in interpersonal dyads. Similar risk-taking and skill-building is required, for just as individuals need to feel valued and included, so do organizations and their leadership. They too must learn to deal with opposition and resistance in order to achieve a win-win situation. Working toward compromise is crucial if mutual reproductive health goals are going to be met, whether from an organizational or an IEC perspective.

Conclusions

This paper has attempted to share instructive ideas and experiences in IEC interventions over the course of the past two and a half decades, for public health in general, and specifically for reproductive health programmes. In the course of exploring experiences and lessons learned about IEC interventions, there emerges a number of fundamental issues to be addressed by IEC specialists and other experts with whom they interact as the field moves forward. First, the communication strategy has become more important than the mere production of messages, posters, campaigns, or events, as health issues and behaviours are recognized as being ever more complex. Viable partnerships, in all their potential varieties, have been recognized as vital to successful and sustainable outcomes. Values, meaning, and cultural context have risen in the list of priorities and motivational factors that must be considered when strategies are being designed (whether aimed at individual behaviour change or at changing social norms), and this in turn has led to increased respect for genuine participatory approaches that go beyond the usual rhetorical commitment to “client-centred” campaigns. Quality of services, sound management, interpersonal communication and counselling, and capacity building are now recognized as crucial to the success of truly integrated IEC and preventive health care and health promotion efforts. Understanding the overall sociocultural and political environments into which IEC programmes must fit is now paramount.

Success can be achieved by working through private and public sectors, centralized and decentralized programmes, or hybrids, so long as they are operating with a coherent system that takes into account divergent perspectives and needs in its assumptions and its approaches. The role of advocacy is much better understood than in the past and the importance of social support in all of its guises is widely acknowledged. It is important to pursue long-term goals that recognize the need for resources, creativity, high levels of energy and commitment, and continued surveillance. It must also be recognized that the task is, as ever, an evolving one requiring focus, flexibility, and forward thinking that remains open to the nuances and new thinking within the discipline of IEC.

The goal then, in short, is to apply what has been learned to date, to remain open to new and ever-enlightening experiences, and to carry forward an expanding field with increasing sophistication and insight, and to raise critical questions for further consideration. What better time than now to begin this important task?

Appendix 1: Theoretical Perspectives **B** Understanding IEC in the Larger Context

For many public health professionals who are now used to the idea of prevention, it may be surprising to remember that the formal concept of health promotion is barely three decades old. It emerged in the mid-1970s with the publication, in Canada, of *A New Perspective on the Health of Canadians*, a document which first introduced into public policy the notion that death and disease could be attributed to four discrete elements: inadequacies in the provision of health care; lifestyle or behaviour factors; environmental pollution; and bio-physical characteristics. The Alma Alta Conference of 1978, in which the concept of primary health care came into focus, further elucidated a new framework in which lifestyles and the environment were highlighted against a backdrop of political will, social commitment, and appropriate technology. From Alma Alta forward, public health specialists began to think in terms of developing new social norms for health, empowering people toward personal growth and responsibility for their health actions, increased use of the media for health education, and building alliances and support systems which would enable individuals to make healthy choices. “Health for All by the Year 2000” became the global clarion call.

Prior to this time, the public health movement, which evolved as an outgrowth of industrialization and urbanization, had focused on the effects of poverty in the home and the work place (particularly sanitation) and had led to health education efforts which initially tended to be one-way, didactic, and victim blaming. As the discipline progressed, it called for delivering information about behaviours that would benefit the health of large numbers of people within a community, motivating those people to adopt healthy behaviours and/or to make use of existing services; it concerned itself with training populations around these behaviours, and with mobilizing community groups to create conditions conducive to supporting these behaviours. Health promotion grew out of a concern that more emphasis needed to be placed on developing and implementing supportive health policies. According to the World Health Organization, health promotion represents the sum of policies and actions which secure the conditions for healthy living and sustainable health development at the individual and collective levels.

Theories on behaviour change suggest that the adoption of healthy behaviours is a process in which individuals progress through various stages until the new behaviour is routinized. Behaviour models, based on a set of assumptions about the change process, emphasize features that are relevant to community-based health promotion. The challenge for IEC specialists and health educators is the creative use of these theories to promote healthy behaviour¹⁰. Among the most important of these theories are:

Health Belief Model - A psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals, particularly with respect to their perceived susceptibility, seriousness and severity of disease, benefits of service, and barriers to accessing health care.

Theory of Reasoned Action - This theory specifies that adoption of a behaviour is a function of intent, which is determined by a person’s attitude (beliefs and expected

values) towards performing the behaviour and by perceived social norms (importance and perception of others).

Social Learning Theory - A theory which states that one's behaviour and cognition together will affect future behaviour. In this model, behaviour, personal factors, and environmental influences all interact. An individual's ability to symbolize behaviour, to anticipate outcomes, to learn through observation, and to have confidence in performing the behaviour are all crucial¹.

Preceed-Proceed Model - A model which applies behaviour change theories such as those cited into a planning, implementation and evaluation process. Its main principle is that most enduring health behaviour change is voluntary and results from people actively participating in the change process.

Running like a delicate thread through all of the contributions these models offer is the concept of creativity. As a report by The British Council says, "Creativity taps into our cultural resources, our emotions, beliefs, values, and personal experience; it induces an emotional engagement with issues which can lead to a voluntary change of behaviour; it also engages our natural problem-solving faculties which enable us to find alternative solutions to the challenges of life"¹².

Appendix 2: Glossary of Terms

Advocacy - persuading others to support an issue of concern to an individual, group or community.

Anthropology - the study of the cultural context in which behaviours take place. Anthropological or ethnographic studies explain prevailing perceptions, beliefs and values.

Barrier - any financial, logistical, physical, emotional, or psychological impediment that constrains or prevents a person from acting.

Behaviour analysis - the rigorous focus on behaviour which helps to draw attention to environmental events that may be influencing individual behaviour patterns. By exploring antecedents and consequences, researchers can explore the rewards and punishments of a particular action in order to determine what might be more compatible with cultural norms.

Catalytic approach - an approach to social mobilization that relies on an event or an idea as a catalyst to mobilize multiple sectors, form alliances to address critical health issues, develop organizational capacity, and build a community of advocates with a shared vision.

Channel - a means of communication with an individual or target audience; includes mass media, print media, interpersonal contacts, and indigenous media.

Communication - the use of language as well as nonverbal signs to convey meaning between parties.

Communication campaign - a strategically planned series of related, carefully targeted activities delivered through multiple channels to a large audience and designed to achieve a specific cognitive or behavioural goal in a predefined period of time.

Communication objective - a target that specifies the intended audience, the type of change expected, when and where the communication activity is to take place and what criteria will be used to measure its success.

Communication strategy - a combination of methods, messages and approaches by which planners seek to achieve a communication objective.

Community - a group of people living in the same geographic area with some degree of common interests and an easy means of communication.

Community-based organization - a specialized organization usually formed with a specific set of objectives which is not affiliated with governments but with specific populations. CBOs are similar to nongovernmental organizations (NGOs).

Community participation - a process by which community members actively take part in the design and delivery of programmes and activities being conducted in the community's interest.

Counselling - a client-centred interactive communication process in which one person helps another to make free, informed decisions about their personal behaviour, providing support in decision-making and action.

Diffusion of innovation theory - a theoretical approach concerned with how innovations, or ideas perceived as new, are communicated through channels over time among the members of a social system. How do people create and share new information, what makes them adopt or change a behaviour, and how quickly are they willing to change?

Enter-educate - a strategy using entertainment to convey educational messages.

Folk media - any form of traditional entertainment (e.g., stories, songs, plays, puppet shows) which lends itself to integration with current social issues.

Formative research - a systematic investigation carried out during the planning and development phase of a campaign or programme to deepen one's understanding of the audience and the environment in which that audience functions.

Health communication - the crafting and delivery of messages and strategies, based on consumer research, to promote the health of individuals and communities. A public health communication strategy has three components: planning, intervention, monitoring and evaluation. Like health education, it attempts to change or reinforce a set of behaviours in a large-scale target audience regarding a specific problem in a predefined period of time.

Health education - a multidisciplinary practice concerned with designing, implementing and evaluating educational programmes that enable individuals, families, groups, organizations, and communities to play active roles in achieving, protecting and sustaining health. The process is comprised of a continuum of learning which enables people to voluntarily make decisions, modify behaviours, and change social conditions in ways that enhance health.

Health information - the content of what is communicated through various channels to be used for informing various populations about health issues, products and behaviours. All information related to health.

Health promotion - Health promotion represents a comprehensive social and political process; it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion action.

HIV/AIDS - the acronym used in most countries to refer to human immunodeficiency virus and acquired immunodeficiency syndrome.

Information campaign - a systematic, planned intervention that uses various communication channels to reach a “target audience” with specific messages.

Information, education and communication (IEC) - a package of planned interventions which combine informational, educational and motivational processes as a component of a national programme. IEC aims at achieving measurable behaviour and attitude changes or reinforcement within specific audiences based on a study of their needs and perceptions. IEC requires multidisciplinary skills and borrows techniques and methods from various disciplines.

Integrated campaign - a promotional campaign that combines elements of communication, education, information, advertising, mass and folk media, and community outreach to convey information and ideas to populations or individuals for the purpose of eliciting emotional and behavioural responses.

Media advocacy - the strategic use of mass media for advancing a social or public policy initiative.

Media strategy - a carefully tailored plan for using the media to accomplish a specific goal.

Norms - social or cultural sanctions defining the acceptability of behaviours within a given cultural context.

Outreach - contacting individuals in a target population through person-to-person channels.

Peer education - dissemination of information and discussion about specific topics by members of a person's own age group, occupation, or social group.

Positive deviance - a departure, difference, or deviation from the norm resulting in a positive outcome.

Reproductive health - a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Reproductive health addresses the reproductive processes, functions and system at all stages of life.

Segmentation - a division and study of the intended audience by primary, secondary and tertiary groups based upon specific criteria, such as by needs for products and services as well as by sociodemographic characteristics, in order to make IEC efforts more effective.

Sexual health - Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love.

Sexually transmitted infection (STI) – an infection or set of diseases that can be contracted due to certain unprotected sexual activity.

Social drama - an umbrella term to describe any theatre or mass media dramatization of a social issue or problem to probe controversy and mobilize community action.

Social marketing - the design, implementation and control of programmes aimed at increasing the acceptability of a social idea, practice, or product in one or more groups of target adopters. The process actively involves the target population who voluntarily exchange their time and attention for help in meeting their health needs as they perceive them. Social marketing borrows heavily from commercial marketing, especially in the use of the “4 P’s” of product, place, promotion, and price. It also adheres to the principle of segmented target audiences and use of multiple channels to disseminate messages. A client-centred approach, social marketing is concerned with the target market’s perceptions and preferences, which are determined by qualitative research.

Social mobilization - a broad-scale movement to engage large numbers of people in action for achieving a specific development goal through self-reliant effort, most effective when composed of a mix of advocacy, community participation, partnerships and capacity building activities that together create an enabling environment for sustained action and behaviour change.

Social norms - expectations about an individual's behaviour or beliefs that can be attributed to others who are emotionally important in the individual’s life.

Strategic mobilization - a process for managing individual and environmental change activities, accomplished by a lead agency and intermediaries, in a coordinated fashion; represents a fusion of social marketing and social mobilization, using the best each has to offer for communication efforts.

Sustainability - the adoption and maintenance over time of new behaviours.

Target audience - a group of individuals defined by specific demographic, geographic, or psychographic characteristics to whom a programme or campaign is directed.

Appendix 3: Information sources

Materials consulted

Ahmad JS. *A two-dimensional approach to audience analysis* (unpublished paper), 1990.

AIDSTECH Final Report. Vol. I. Arlington, VA, Family Health International, 1992.

Allison A. *Implementing Beijing's platform for action in Nepal: A focus on CEDPA's partner projects.* Paper presented at the Population Association of America, New Orleans, LA, May 1996.

Babalola S, Adebajo C. *Evaluation report of female circumcision eradication project in Nigeria.* Seattle, WA, Program for Appropriate Technology in Health (PATH), 1995.

Blair J. *Population Services International (PSI)/Project ACTION: impact on teen risk reduction.* Washington, DC, PSI, 1995.

Brooke P. *Communicating through story characters.* Lanham, MD, Institute for International Research and University Press of America, Inc., 1995.

Cerqueira MT, Coe G. *Communication, education and participation: A framework and guide to action* (unpublished paper). Washington, DC, Pan American Health Organization, 1996.

Chambers R, Guijt I. Participatory rural approach - five years later: Where are we now? *Forests, trees and people*, Newsletter No. 26/27, Uppsala Swedish University of Agricultural Sciences, 1995.

Clemmons L, Coulibaly Y. Turning the ordinary into the extraordinary: The green pendelu and maternal health in Mali. *High Impact PVO Child Survival Projects, Volume. 2.* Washington, DC, Gallaudet University, 1999.

Clift E. Folk arts present exciting new avenues for health communication. *Journal of American Medical Writers Association*, 1990, 5(1):12-13.

Clift E. Traditional media, new ideas. *Toward Freedom.* Online magazine (<http://www.towardfreedom.com/index.htm>), 1995.

Clift E, Freimuth V. Health communication: What is it and what can it do for you? *Journal of Health Education*, 1995, 26(2):68-74.

Cohen S. *Developing information, education and communication (IEC) strategies for population programmes. Technical paper No. 1.* New York, NY, United Nations Population Fund, 1993.

Cohen S. Mobilizing communities for participation and empowerment. In Eds: Servaes J, Jacobson TL, White SA. *Participatory communication for social change*. New Delhi, Sage, 1996.

Coleman PL, Meyer RC. *The enter-educate conference. Entertainment for social change*. Baltimore, MD, The Johns Hopkins Center for Communication Programs, 1990.

Communicating to improve health. What communications practice tells us about effective strategies: Two case studies. Occasional publication. Princeton, NJ, Robert Wood Johnson Foundation, 1998.

Communication and social change: A position paper and conference report. New York, NY, Rockefeller Foundation, 1999.

Descriptive analysis of AIDSCAP/Haiti BCC projects: Some lessons from the field. Arlington, VA, AIDSCAP, Family Health International, 1996.

Face to face: Training family planning counselors in China. Program for Appropriate Technology in Health, State Family Planning Commission, and United Nations Population Fund, 1995.

Fishbein M. The role of theory in HIV prevention. *AIDS Care*, 2000, 12(3):273-278.

Flanagan D, Williams C, Mahler H. *Peer education in projects supported by AIDSCAP: A study of 21 projects in Africa, Asia and Latin America*. Arlington, VA, AIDSCAP, Family Health International, 1996.

Gould H. *A creative route to rights: The role of arts and creative media in human rights*. Manchester, UK, The British Council, 1999.

Green CP. *Mother support groups: A review of experience in developing countries*. Published for the US Agency for International Development (USAID) by the Basic Support for Institutionalizing Child Survival (BASICS) Project, Arlington, VA, 1998.

Green J. Flirting with suicide. *The New York Times Magazine*, October 13, 1996.

Griffiths M, Moore M, Favin M. *Communicating safe motherhood: Using communication to improve maternal health in the developing world*. Paper prepared for workshop on "Guidelines for Safe Motherhood Programming", The World Bank and MotherCare, Washington, DC, 1991.

Hardee K, Yount KM. *From rhetoric to reality: Delivering reproductive health promises through integrated services*. Arlington, VA, Family Health International, 1995.

Hornik R. *Public health communication: Making sense of contradictory evidence* (unpublished paper), 1996.

Howard-Grabman L, Seoane G, Davenport CA. *The Warmi Project: A participatory approach to improve maternal and neonatal health. An implementer's manual.* Arlington, VA, MotherCare/John Snow Inc., (undated).

Joint Committee on Health Education Terminology. Report of the 1990 Joint Committee on Health Education Terminology. *Journal of Health Education*, 1991, 22(2):105-108.

Kiragu K et al. *Promoting family planning through the mass media in Nigeria. Campaigns using public service announcements and a national logo.* Field report No. 5. Baltimore, MD, The Johns Hopkins Center for Communication Programs, 1996.

Krieger L. *Behaviour change?* Paper prepared for The Society for Applied Anthropology, Annual Meeting, Baltimore, MD, March 1996.

Lynam PF, Dwyer JC, Bradley J. *Inreach: Reaching potential family planning clients within health institutions.* New York, NY, AVSC International (renamed EngenderHealth) Working Paper, No. 5, April 1994 .

Moore KM. *Communicating the mother-baby package: Guidelines for developing the communication component of national safe motherhood programmes* (unpublished). Geneva, World Health Organization, 1994.

Moore KM. *Safer motherhood 2000: Toward a framework for behavior change to reduce maternal death.* The Communication Initiative. Online at http://www.comminit.com/misc/safer_motherhood.html April 2000.

NGO Networks for Health. *Technical approach to behavior change programs* (unpublished draft). Westport, CT, Save the Children, Inc., 2000.

Nutrition communication project. Final report. Washington DC, Academy for Educational Development, 1996.

Parker W, Dalrymple L, Durden E. *Communicating beyond AIDS awareness: A manual for South Africa.* Commissioned by: The HIV/AIDS and STD Directorate of the Department of Health as part of the 1997/98 Beyond Awareness campaign, First Edition, Auckland Park, South Africa, 1998.

Partners against AIDS: Lessons learned. AIDSCOM. Washington DC, Academy for Educational Development, 1993.

Piotrow P et al. *Strategies for family planning promotion.* World Bank Technical Paper No. 223, Washington DC, The World Bank, 1994.

Proceedings of the consultative forum on community-centered approaches to behaviour and social change. Washington, DC, NGO Networks for Health, 2000.

Rau B. Ten steps for HIV/AIDS advocacy, *AIDScaptions*, 2(2):35-37, July 1995.

Reaching men worldwide: Lessons learned from family planning and communication projects, 1986-1996. Working Paper No. 3. Baltimore, MD, The Johns Hopkins Center for Communication Programs, 1997.

Reaching young people worldwide: Lessons learned from communication projects 1986-1995. Working Paper No. 2, Baltimore, MD, The Johns Hopkins Center for Communication Programs, 1995.

Rice M. *Developing health promotion and education initiatives in reproductive health: A framework for action planning* (unpublished). Geneva, World Health Organization.

Rimon JG et al. *Promoting sexual responsibility in the Philippines through music: An enter-educate approach.* Occasional Paper No. 3, Baltimore, MD, The Johns Hopkins Center for Communication Programs, 1994.

Shreedhar J. Living with STDs and AIDS: The Mother Saradadevi Social Service Society, India. In: *PLA Notes* 26:34-38, London, International Institute for Environment and Development, 1996,

Smith W, Helquist M, MacDonald G. Applied behavior change (ABC) framework (Appendix). In: *Controlling AIDS through health promotion.* Washington DC, Academy for Educational Development, 1993.

Smith WA et al. (Eds). *A world against AIDS: Communication for behavior change.* Washington DC, Academy for Educational Development, 1993.

Social marketing for adolescent sexual health. Results of operations research projects in Botswana, Cameroon, Guinea and South Africa. Washington, DC, Population Services International, 2000.

Soul City Evaluation Report. *Let the sky be the limit.* Soul City is a project of the Institute of Urban Primary Health Care (IUPHC), based at the Alexandra Clinic and University Health Centre, Bergvlei, South Africa, 1996.

The World Bank. *A new agenda for women's health and nutrition.* Washington DC, The World Bank, 1994.

The future of social marketing. Results of a Delphi study, conducted in preparation for the Future of Social Marketing Consensus Conference. Washington, DC, Porter Novelli International, 1996.

Thompson R, Bennet D. *Crisis communications lessons learned: Case study of Niger and the Philippines.* Occasional paper No. 20, Washington, DC, Social Marketing for Change project (SOMARC), 1996.

United Nations Children's Fund. *Healthy communication from practical field experience*, No. 1-8. New York, NY, UNICEF (undated)

United Nations Educational, Scientific and Cultural Organization (UNESCO). UN plans to promote internet to poor. *WebWorld News*. Online at http://www.unesco.org/webworld/news/000609_poor.shtml June 2000.

United Nations Population Fund (UNFPA). *Male involvement in reproductive health, including family planning and sexual health*. UNFPA Technical report No. 28, New York, NY, UNFPA, 1995.

United Nations Population Fund (UNFPA). *Professional meeting of TSS/CST advisors on population information, education and communication*. Technical report No. 20. New York, NY, UNFPA, 1994.

United Nations Population Fund (UNFPA). *Towards a more effective integration of IEC within the UNFPA country programme*. Technical report No. 22. New York, NY, UNFPA, 1995.

Verme CS, Wegner MN, Jerzowski T. The language of male involvement. What do you mean by that? *Populi*, 1996, 23(2):10-12.

Williams C. HIV/AIDS peer education: evolving with the epidemic. *AIDScaptions*, 3(3):12-15, 1996.

Winnard K. *Applying social marketing to maternal health projects: The MotherCare experience*. Washington, DC, Manoff Group, 1993.

World Health Organization (WHO). *Education and treatment in human sexuality: The training of health professionals. A report from a WHO meeting*. WHO Technical Report Series No. 572, 1975.

World Health Organization (WHO). *Effective approaches to AIDS prevention: Report of a meeting, Geneva, May 26-29*. WHO/GPA/IDS/93.1. Geneva, WHO, 1992.

World Health Organization (WHO). *Mother-baby package: Implementing safe motherhood in countries*. WHO/FHE/MSM/94.11. Geneva, WHO, 1994.

World Health Organization (WHO). *Ottawa charter for health promotion. First international conference on health promotion, Ottawa, 21 November 1986*. WHO/HPR/HEP/95.1. Geneva, WHO, 1996.

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References

- ¹ Flanagan D, Williams C, Mahler H. *Peer education in projects supported by AIDSCAP: A study of 21 projects in Africa, Asia and Latin America*. Arlington, VA, AIDSCAP, Family Health International, 1996.
- ² Moore KM. *Communicating the mother-baby package: Guidelines for developing the communication component of national safe motherhood programmes* (unpublished). Geneva, World Health Organization.
- ³ Clift E, Freimuth V. Health communication: What is it and what can it do for you? *Journal of Health Education*, 1995, 26(2):68-74.
- ⁴ The World Bank. *A new agenda for women's health and nutrition*. Washington DC, The World Bank, 1994.
- ⁵ Griffiths M, Moore M, Favin M. *Communicating safe motherhood: Using communication to improve maternal health in the developing world*. Paper prepared for workshop on "Guidelines for Safe Motherhood Programming", The World Bank and MotherCare, Washington, DC, 1991.
- ⁶ *Reaching men worldwide: Lessons learned from family planning and communication projects, 1986-1996*. Working Paper No. 3. Baltimore, MD, The Johns Hopkins Center for Communication Programs, 1997.
- ⁷ Clift E. Unpublished lecture notes.
- ⁸ Kiragu K et al. *Promoting family planning through the mass media in Nigeria. Campaigns using public service announcements and a national logo*. Field report No. 5. Baltimore, MD, The Johns Hopkins Center for Communication Programs, 1996.
- ⁹ Rice M. *Developing health promotion and education initiatives in reproductive health: A framework for action planning* (unpublished). Geneva, World Health Organization.
- ¹⁰ Cerqueira MT, Coe G. *Communication, education and participation: A framework and guide to action* (unpublished). Washington, DC, Pan American Health Organization, 1996.
- ¹¹ NGO Networks for Health. *Technical approach to behavior change programs* (unpublished). Westport, CT, Save the Children, Inc., 2000.
- ¹² Gould H. *A creative route to rights: The role of arts and creative media in human rights*. Manchester, UK, The British Council, 1999.