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UNI/LIA

June 1, 1984

Revelians Tuluhungwa
Chief
Project Support Communications
UNICEF
866 United Nations Plaza
New York, NY 10017

Dear Reve:

Work is finally proceding on the health communications paper. I have enclosed an outline which I consider very tentative. I expect it to grow and change throughout the next few months.

I would like to spend a day at UNICEF in late June or early July to speak to you and other persons about the paper and to look at some UNICEF reports and other documents.

I'll give you a call in a few weeks. Please let me know if you'll be traveling then.

Best wishes,

Mike

Michael Favin
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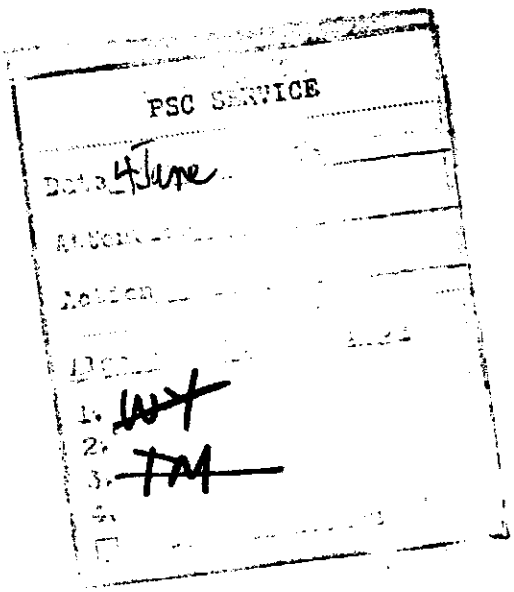

HEALTH COMMUNICATION PAPER

Preliminary Ideas, May 1984

Title: "Health education," "Social communication for health" and other titles have been suggested for this paper. We prefer "Health Communication," which avoids the didactic connotations of health education and the possible theoretical connotations of social communication for health. Health Communication is a title easily understood and acceptable by the generalist readers who are the main audience of the paper.

Scope: Health communication can encompass a number of aspects of education, communication, advocacy, and training. While this paper will not propose a strict definition, in general the following areas will be discussed: individual and family health education; community health education (including mass media, non-formal education, and community motivation); training of health educators and others in health education; and educating health staff to make health communication a two-way communication process in which they and the public jointly formulate appropriate program targets and ways of reaching them.

Approach: The paper will take an issues approach. Approximately four major sections will be subdivided into issues that will be the basis of discussion. Discussion will emphasize project experiences. Few if any universal answers to issues will be proposed; rather, the discussion will point out how different answers may be appropriate in different circumstances. Below is a very preliminary outline of sections and issues. Both the content and wording of many of the issues are likely to be modified over the next few months.

INTRODUCTION

A. What is health communication? How will this paper limit the meaning?
B. What are the basic purposes of health communication? [to inform (transmit knowledge); to motivate (change or create attitudes); to teach (skills); and to enable the public and health staff to learn from each other and work together to improve individual, family, and community health].

SECTION I: ROLE OF HEALTH COMMUNICATION IN PHC

A. Should health communication be oriented toward changing behavior, providing information, or capacitating and empowering the public? What kinds of behavior can appropriate health communication change -- definitely, possibly, almost never?
B. Can health communication be effective even when the community's demand for curative care and non-health services goes unmet?
C. Is a certain satisfaction of basic needs required before people will respond to health communication?

SECTION II: ORGANIZING HEALTH EDUCATION

A. How can a cohesive, coordinated health communication strategy be devised and maintained, so that resources will be used efficiently and effectively?
B. How should health communication be organized within the Ministry of Health?
C. How should health communication be coordinated with resources outside the

Ministry of Health, including those of the Ministry of Information (or office of information in the Ministry of Interior), advertisers, popular entertainers, and other communicators such as the keepers of village oral histories?

D. How should health communication be organized at the local, district, and national level?

E. What are the advantages of educational campaigns vs. ongoing health communication? What are the advantages of separate health communication projects vs. health communication components in ongoing projects?

F. How much does health communication cost, and how can planners balance investment in education with other investments?

G. How can health workers be motivated to educate rather than to spend all of their time giving curative care?

H. How much effort should be devoted to evaluating the effects of health communication on behavior?

SECTION III: HEALTH COMMUNICATION APPROACHES

A. What are the basic approaches? How should a program decide which to use? What are the costs of different approaches? How can fatalism be best overcome? Should the program staff determine health problems and propose actions, or should staff and community jointly decide on problems and solutions? Is person-to-person health communication required to achieve behavioral change, or can mass media alone achieve it? Basic approaches to health communication:

1. Marketing approach: aimed mainly at changing individual and family behavior; selected community members involved in details of behavioral recommendations and message selection, but program staff come in with strong general lines of action in mind; aims to make new behavior socially acceptable; aims more to get people to change behavior rather than for them to understand details and reasons why.

2. Community development or non-formal education approach: aimed mainly at fostering community behavioral change and problem-solving capabilities; through the medium of the promoter or organizer, program helps community members to identify problems and devise and carry out solutions; takes a long time to develop and is very dependent on an excellent, stable promoter; fits some communities and countries much better than others.

3. Behavioral modification approach: basically depends on rewards (e.g., saris or money for family planning operations, monetary and legal benefits for one-child families in China) and punishments (fines, disapprobation). Under what, if any, circumstances is social or legal coercion appropriate?

4. Traditional health education approach: health professionals, often using audiovisual aids, informing people how they should change their behavior; basically one-way communication.

5. School health education: trying to formulate health knowledge, attitudes, and practices among primary school children in the hope that they will both educate their parents and learn themselves; essentially a variation on traditional health education. Can educating school children lead to behavioral change throughout the community?

B. Who are the most effective educators, "one of the people" or respected health professionals?
C. What role should formal community leadership play in fostering behavioral change?
D. How does new behavior become socialized (routinized and accepted)?

SECTION IV: EDUCATIONAL METHODS AND MATERIALS

A. What are possible methods and materials? Where can communication take place? What methods and materials are most appropriate under varying circumstances of purpose, approach, strategy, target audience, resources, etc.? Where should health communication money be spent by topic and by medium? How can programs assure that methods and materials are consistent with program strategy, approach, purpose, etc. rather than letting educational technology skew real program objectives and logical approach? How can programs assure that messages are understandable, acceptable, feasible, simple, and consistent? How can programs assure that if people follow the suggested behavior, their health will actually improve?
B. How can messages and media be localized? What are the trade-offs between professional and local specificity?
C. What role should the community play in developing educational materials?
D. What is an appropriate role for traditional materials and methods, e.g., shadow puppets, storytelling?
E. What are some simple field-testing and evaluation techniques?

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Sent to Revelians Tuluhungwa, UNICEF NY with covering letter from Michael Favin.

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