HEALTH PROMOTION COMMUNICATION PROCESSES:

A case study of ZIHP-Comm. and UNAIDS ICT/ESA

By

Morden Mumanga Mayembe

Submitted in partial fulfilment of the requirements for the degree of Master of Communication for Development offered by the Department of Mass Communication, University of Zambia

DECLARATION

I declare that this Practical Attachment Report has not been submitted for a degree in this University or any other university.

Full Name: MORDEN MUMANGA MAYEMBE

Signature: .....

Date: 22.04.2003

Supervisor: BLAY S.C. NKUNIKA

Signature: .....

Date: 22/04/03

ABSTRACT

This eight-chapter report explores the communication processes that are employed by health promotion organisations. It is a case study of the Zambia Integrated Health Programme, communication component (ZIHP-Comm.) and the Joint United Nations Programme on HIV/AIDS Inter-country Team for Eastern and Southern Africa (UNAIDS ICT/ESA).

This report is a result of a four-month attachment at ZIHP-Comm. in Lusaka and a two-month attachment at UNAIDS ICT/ESA in Pretoria, Republic of South Africa. It is a partial fulfilment of the requirements for the degree of Master of Communication for Development (MCD) offered by the Department of Mass Communication at the University of Zambia. The information contained in this report culminated from participant observation and individual in-depth interviews. Various books and documents were also reviewed, for relevant information, to add value to the report.

The report opens with a background chapter which is aimed at giving guidance to communication practitioners with regards to potential areas of intervention. The second chapter contains the methodology used during the attachment and the literature review. Chapter three gives the conceptual framework of health communication. It contains rich information that may assist communication practitioners and scholars to know what works and what does not work in health communication.

The fourth chapter talks about this writer's personal experiences during the attachment, while the fifth chapter discusses the problems and challenges faced by the two institutions to which this writer was attached. Chapter five is particularly important to communication practitioners and scholars as it highlights most of the problems associated with health promotion in the specified areas. Chapter six discusses the input of this writer during the attachment while chapter seven discusses the findings during the attachment. The final chapter draws some conclusions and recommendations on the findings.

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ABBREVIATIONS/ACRONYMS

AED	Academy for Education Development
AIDS	Acquired Immune deficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
BCC	Behaviour change communication
CBOH	Central Board of Health
CSO	Central Statistics Office
ECOSOC	Economic and Social Council
GRZ	Government of Republic of Zambia
HIV	Human Immuno-deficiency Virus
ICRW	International Centre for Research on Women
IEC	Information, Education and Communication
ILO	International Labour Organisation
JHU/CCP	Johns Hopkins University Centre for Communication Programmes
LCMS	Living Conditions and Monitoring Survey
MCD	Master of Communication for Development
MOFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
MTCT	Mother-to-child transmission of HIV
NGO	Non-governmental organisation
NHC	Neighbourhood Health Committee
ORS	Oral Re-hydration Salts
PATH	Programme for Appropriate Technology in Health
PC	Population Council
PCS	Population Communication Services
SBC	Steps to behaviour change
SIDA	Swedish International Development Agency
STD	Sexually transmitted disease
TRN	Technical Resource Network

TTS	Telling-the-story
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAIDS ICT/ESA	UNAIDS Inter-country Team for eastern and Southern Africa
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Education and Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
WHO	World Health Organisation
WILDAF	Women in Law and Development in Africa
YAO	Young Activists Organisation
ZCCP	Zambia Centre for Communication Programmes
ZDHS	Zambia Demographic and Health Survey
ZIHP	Zambia Integrated Health Programme
ZIHP-Comm.	ZIHP, communication component

CHAPTER 1
BACKGROUND

.1 The Country

Zambia is situated in the southern part of Africa. It covers an area of 752, 612 square kilometres. The country is landlocked and surrounded by eight neighbouring countries namely: the Democratic Republic of Congo and Tanzania in the north; Malawi and Mozambique in the east; Zimbabwe and Botswana in the south; Namibia in the southwest and Angola in the west.

The country is divided into nine provinces for administrative purposes. The provinces are named Central, Copperbelt, Eastern, Luapula, Lusaka, Northern, North-western, Southern and Western. The provinces are further divided into 72 districts. Each province has a provincial headquarters.

The year 2000 population and housing census put the Zambian population at about 10.3 million. The population grew from 4.1 million in 1963 to 5.7 million in 1980 at an annual rate of 3.2 percent. By 1990, the country's population was enumerated at 7.4 million.

Zambia has a mixed economy consisting of a modern and urban-oriented sector confined to the line of rail, and a rural agriculture sector.

To date, copper mining is the country's main economic activity. During the decade following the attainment of political independence, it accounted for 95 percent of export earnings and contributed 45 percent of government revenue. This situation did not however last long. It was sharply changed by the drastic decline in world copper prices in the late 1974 and 1975. The prices for copper rose in 1978 but only to drop sharply between 1981 and 1982.

The combined effects of the fall in copper prices, a rise in oil prices, the slow pace of industrialisation and a heavy dependence on imports put the country's economy under

serious pressure, which has seriously and adversely affected the provision of social services including health. Health is a serious concern in Zambia.

1.2 The Health Situation

Zambia has been facing numerous health problems. People have been dying in large numbers from various diseases most of which are preventable. On the other hand, reproductive health concerns have continued to bring down the quality of life for the majority of the Zambia population.

Several diseases and reproductive health problems that have had a go at the Zambian population can be prevented through effective communication, especially public education.

The Ministry of Health identifies eleven areas that need attention for the country to attain good health. These are (MOH, 1991):

1. Timing births
2. Safe motherhood
3. Breastfeeding
4. Child growth
5. Immunisation
6. Cholera
7. Diarrhoea
8. Coughs and colds
9. Hygiene
10. Malaria
11. AIDS

1.2.1 Timing Births

Timing births is a major health concern requiring effective communication interventions. Communication practitioners must, among other things, let people know that birth spacing is one of the most powerful ways of improving the health of women and children.

The Ministry of Healthy in Zambia has established that births that are too many or too close or to women who are too old or too young are responsible for approximately one third of all infant deaths in Zambia.

The 1996 Zambia Demographic and Health Survey (ZDHS) estimated that under-five mortality for the period 1992 – 1996 was 197 per 1, 000 births, meaning that almost one in five children born in Zambia died before reaching the fifth birthday. Half of the deaths under age five occur in the first year of life; the infant mortality rate is 109 deaths per 1, 000 births and the child mortality rate is 98 per 1, 000 children reaching one year of age(CSO, MOH and Macro International Inc., 1997).

> *Infant mortality is the probability of dying before the first birthday while child mortality refers to the probability of dying between the first and fifth birthday* (CSO, MOH and Macro International Inc., 1997:93)

According to the ZDHS report, child survival has deteriorated since the mid 1980s. Under-five mortality has increased from 174 deaths per 1, 000 births in the period 10-14 years before the survey (approximately 1982-86) to 197 for the period 0-4 years before the survey, an increase of 13 percent.

The age at which a woman gets pregnant has health implications that people need to know about. It has been scientifically established that becoming pregnant before the age of 18 years or after the age of 35 years increases the health problems for both mother and child.

The Ministry of health estimates that every year over 20, 000 women die from problems linked to pregnancy and childbirth, leaving behind thousands of motherless children.

According to the 1996 Living Conditions and Monitoring Survey (LCMS) data, 13% (approximately 550, 000) of Zambian children were orphans. Single orphans (86% of orphan children) outnumbered double orphans. 64% of orphan children had a deceased father, 22% had a deceased mother and 14% were double orphans (CSO, 1997).

Available data demonstrates that 56% of orphan children and 49% of non-orphan children are stunted. The Situation Analysis of Orphans and Vulnerable Children in Zambia 1999 Joint USAID/UNICEF/SIDA Study Fund Project finds it tempting to link the stunting of orphan children with lack of proper care by the foster care givers and the withholding of food from orphan children (Joint USAID/UNICEF/SIDA Study Fund Project, 1999).

It has been found that every year many children die from problems such as malnutrition and diarrhoea diseases, as a result of unplanned pregnancies. The mothers are unable to look after their closely spaced children.

It has been proved that a woman is not physically ready to begin bearing children until she is about eighteen years of age. Thus for health reasons, a girl should not become pregnant before the age of eighteen years. To the contrary, ZDHS data show that half the women in Zambia marry before they reach age 18 and before they marry 70% of them have had sexual intercourse, which exposes them to pregnancy.

This is a major health concern because it has been proved that babies that are born to women younger than eighteen are more likely to be born too early and to weigh too little at birth. Such babies are at risk of dying in the first year of life. The risks to the mother's own health are also greater. And for women aged over 35 years, having pregnancies and giving birth can lead to maternal, child and family problems.

ccording to the Ministry of Health, the risk of death for young children is increased by out 50% if the space between births is less than two years (MOH, 1991). For the health f both mothers and children, parents should be advised to wait until their youngest child at least two years old before having another baby.

nother fact that has been established is that children born too close together do not sually develop as well, physically or mentally, as children born at least two years apart. ne of the greatest threats to the health and growth of a child under the age of two is the irth of a new baby. Breastfeeding stops too suddenly, and the mother has less time to repare the special foods a young child needs. Also, she may not be able to give the older hild the care and attention he or she needs, especially during illness. As a result the child ften fails to grow and to develop properly.

lthough it may seem trivial, physical contact between a mother and a child is a major ecessity for normal growth of a child. Regular physical contact between a mother and er child should never be discontinued abruptly. A new baby forces the mother to uddenly stop the contact with the older child. This can contribute to poor growth of the lder child, mentally, physically and socially.

is important to note that scientifically a mother's body needs two years to recover fully rom pregnancy and childbirth. Health problems for the mother increase if the next baby ollows too closely upon the last. Realistically, the mother needs time to get her strength nd energy back before she becomes pregnant again.

f a woman becomes pregnant before she is fully recovered from bearing a previous hild, there is a higher chance that her new baby will be born too early and too light in veight. Low birth weight babies are less likely to grow well, more likely to fall ill, and our times more likely to die in the first year of life than babies of normal weight (MOH, 991).

t has further been proved that having more than four children increases the health problems of pregnancy and childbirth. After a woman has had four children, further pregnancies bring greater problems to the life and health of mother, child and all family members. If the previous births have not been spaced more than two years apart, a woman's body can easily become exhausted by repeated pregnancy, childbirth, breastfeeding and looking after small children. Further pregnancies usually mean that the mother's own health begins to suffer.

After four pregnancies, there is an increased risk of serious health problems such as anaemia ('thin blood') and haemorrhage (heavy loss of blood). The risk of giving birth to babies with disabilities, or with low birth-weight, also increases after four pregnancies and after the mother reaches the age of 35.

Communication is needed to encourage couples to limit the size of their families. A small family is easy to look after, socially and economically. Except in exceptional cases, children from small families get better medical attention, improved nutrition and better education. Such children may grow into mature, secure, and confident individuals.

Spacing births at least two years apart, and avoiding pregnancies before the age of 18 and after the age of 35, can help to ensure that each baby is born healthy and strong.

In all this, family planning promoted through effective communication can play a critical role. Family planning gives couples the choice of when to begin having children, how far apart to have them and when to stop. Most health services can provide several methods of safe, effective family planning. No one method is suitable for, or acceptable to, every individual. Couples should be encouraged to seek advice about the most suitable means of family planning from the nearest trained health worker or family planning clinic. Family planning is not for women alone. Both husband and wife should seek a method with which they are most comfortable.

The 1996 ZDHS report seems to suggest that family planning is not universally acceptable in Zambia, especially where use of contraception is concerned. According to the report, there are reasons for rejecting contraception by married women who are not using any contraceptive method and do not intend to use them in future. For instance, 32 percent of all women said they did not intend to use because they wanted children. Men cite similar reasons for non-use as women, namely that they want more children (38 percent), or that menopause obviates the need for contraception (29 percent). Contrary to the popular belief, only 9 percent of men say that the reason they do not intend to use family planning is that they are opposed to it.

In terms of what is obtaining in family planning communications, the ZDHS reports that 15 percent of women said that they heard a family planning message on both radio and television, while 59 percent had not heard a message on either radio or television.

According to the ZDHS report, in general, messages broadcast on radio are more commonly heard than those on television. 39 percent of women heard a message about family planning on radio, compared to only 18 percent who heard a message on the television. The report also says that exposure to mass media is limited in rural areas; for example, 30 percent of women in urban areas have heard about family planning on both radio and television, compared to 4 percent of women in rural areas.

The report adds that in the more urbanised provinces in the country – Central, Copperbelt and Lusaka – women are much more likely to have access to mass media through radio and television than women in other provinces. However, in all provinces, the role of radio as a medium for disseminating information is significant. Women with higher education are much more likely to have heard family planning message on radio and television than those with less education.

Men who were interviewed showed a pattern similar to women: family planning messages in the mass media are heard less commonly by male teenagers, by men in rural areas, and by less educated men.

To assess the level of popular support for family planning messages on radio or television, ZDHS respondents were asked whether they considered it acceptable to air family planning messages on radio or television.

87 percent of women and 82 percent of men reported that such messages were acceptable to them. Women in the oldest age group (45-49 years) were the least likely to find media messages on family planning acceptable. Acceptability was highest among women with higher education (95 percent) and lowest among women with no education (78 percent). The same was true for men (94 percent and 79 percent respectively).

Women were asked whether they had received a message about family planning from print media in the few months prior to the survey. More than one-third of them received family planning messages from the print media. Posters were the most likely source for women to receive such messages (29 percent), followed by newspapers or magazines (17 percent) and leaflets or brochures (11 percent). The proportion of women who received messages through print media increased with age up to the 30's and declined among older women. Half of urban women interviewed saw a message in print, compared to less than one-quarter of their rural counterparts. The report adds that women in Eastern province and women with no education were the least likely to receive any family planning messages in print media.

Timing of births, as an aspect of health, has a lot of communication issues. It is one area where strategic communication is required.

1.2.2 Safe Motherhood

Related to timing of births and family planning, safe motherhood is another major health concern in Zambia, where it is reported that 10, 000 mothers deliver each year and 200 of these mothers die as a result of problems related to bearing children (MOH, 1991).

A Study of factors associated with maternal mortality in Zambia conducted in 1998 revealed that 18 percent of women in the reproductive age group of 12 – 50 were dying from maternal related complications (MOH, UNFPA, CSO & UNZA, 1998).

Going to the nearest health worker for regular check-ups can drastically reduce the risks of childbirth during pregnancy. It is important that a trained person should assist at every birth. There is a problem, however, because currently only 40% of births in Zambia take place in health institutions (MOH, 1991).

Many of the dangers of pregnancy and childbirth can be avoided if the mother-to-be goes to a health centre as soon as she believes she is pregnant. A health worker is trained to help women to have safe births and healthy babies. A trained birth attendant will know, for example, what to do if the baby is being born in a wrong position and what to do if too much blood is being lost.

To reduce the dangers of pregnancy and childbirth, public education is needed for all families to know the warning signs. For example, if the mother-to-be is less than 18, it is a warning sign of a risky pregnancy. The same applies if there is an interval of less than two years since the last birth.

Effective communication is needed to make people understand that spacing pregnancies at least two years apart, and avoiding pregnancies below the age of 18 or above the age of 35, drastically reduces the dangers of childbearing. One of the most effective ways of reducing the dangers of pregnancy and childbirth for both mother and child is to plan the timing of births. The risks of child-bearing are greater when the mother to be is under 18 or over 35, or has had four or more previous pregnancies, or when there is a gap of less than two years since the last birth.

Avoiding births by having an abortion can be very dangerous. Illegal abortions carried out by untrained persons kill between 100, 000 and 200, 000 women every year (MOH, 1991).

On the basis of the study of factors associated with maternal mortality findings, several recommendations were made. Prominent among them was the reducing of the number of pregnancies (MOH, UNFPA, CSO & UNZA, 1998). On this recommendation, it was proposed that safe motherhood programmes and interventions must include the promotion of family and community support for delayed marriage and child bearing, for timely and planned pregnancies and for improved girl's and women's general health, nutrition and education.

The recommendation went on to emphasise that it was important that girls were kept longer in school as a strategy to increase age at first marriage or pregnancy. Ensuring that girls are given at least secondary education would contribute to both increased age at marriage and improved socio-economic status.

It was suggested that awareness must be raised of the need for women to reach emergency care without delay if complications arose during delivery. According to the report, particularly important is that programmes aimed at reducing maternal mortality must be sensitive to the socio-cultural environment surrounding most women especially in the remote rural areas of Zambia. There is need to address traditional beliefs and practices associated with maternal mortality through development of information, education and communication (IEC) materials.

1.2.3 Breastfeeding

While a majority of women continue to deliver normally and successfully, the health of the newly born child is another health concern altogether. Many infants do not live to grow. As a partial solution to this problem, breastfeeding must be promoted. According to the Ministry of Health (MOH, 1991), babies fed on breast milk have fewer illnesses and less malnutrition than babies who are fed on other foods. Bottle-feeding is discouraged, unless the mother is unable to breast-feed. It is a serious threat to the lives and health of children.

All mothers need a lot of encouragement to breastfeed from fathers, health workers, relatives and friends, women's groups, the mass media, trade unions and employers.

Breast-milk alone is the best possible food and drink for a baby until the age of four or five months. Babies should start to breastfeed as soon as possible after birth. Bottle-feeding can lead to serious illness and death. Breast-milk substitutes should only be used if the mother is unable to breastfeed or if the mother dies.

For good health, breastfeeding should continue well into the second year of a child's life and for longer if possible. Children should be weaned from the breast gradually. This allows the child time to increase the intake of other foods to replace the breast-milk.

The ZDHS results indicate that breastfeeding is almost universally practised in Zambia. The 1996 ZDHS report says that almost all Zambian children (98 percent) are breastfed for some period of time. More than half (58 percent) of the children are put to the breast within an hour of birth and 91 percent within the first day. The report says that this is an improvement since 1992 when only 40 percent and 87 percent of the children were put to the breast within one hour and one day respectively.

The report adds that breast milk is safe, convenient, and contains all the nutrients needed by children in the first six months of life. In addition, it provides immunity to disease through the mother's antibodies. Thus, we learn that breastfeeding has the ability to fight malnutrition and infection.

1.2.4 Child Growth

Malnutrition and infection are factors found to hold back the physical and mental development of hundreds of children. Parents of children between birth and three years should be encouraged to have their children weighed regularly. If the children do not gain enough weight then extra care is needed.

Public education is needed to teach people, mothers especially, that by the age of four or five months, the child needs other foods in addition to breast milk. A child three years of age needs other food five or six times a day. He or she needs a small amount of extra fat, oil or sugar added to the family's ordinary food. All children need foods rich in vitamin A. Hundreds of children go blind because they do not have enough vitamin A in their bodies. Vitamin A may also protect children against other illnesses such as diarrhoea.

It is important to note that after an illness, a child needs extra meals to catch up on the growth lost during the illness. In times of illness, and especially if the illness is diarrhoea or measles, the appetite falls and less of the food that is eaten is absorbed into the body. If this happens several times a year, the child's growth will be held back.

In terms of the childhood nutritional status, the ZDHS found out that overall, 42 percent of Zambian children under age five are classified as stunted (low height-for-age) and 18 percent as severely stunted. Another finding was that four percent of children under five in Zambia are wasted (low weight-for-height). The report says comparison with the 1992 ZDHS shows little change in these measures over time.

There is therefore need for more public education on child growth. Nutrition must be emphasised in all education campaigns aimed at promoting child growth.

1.2.5 Immunisation

One other major ingredient of childhood health is immunisation. Immunisation should be observed during the process of bringing up a child. The expanded Programme on Immunisation, launched as the National Immunisation campaign, is now called Universal Child Immunisation in Zambia to reflect the ultimate goal of immunisation of all children worldwide by 1990 (MOH, 1991).

According to the Ministry of Health, without immunisation, an average of three out of every hundred children born would die from measles. Another two would die from whooping cough. One more would die from tetanus and others from tuberculosis. And out of every two hundred children, one would be disabled by polio (MOH, 1991).

Children can be protected against these diseases by vaccines. But even when the service is available many of the infants who need it are not brought for the full course of immunisations mainly because most people do not have the information. It is essential that all parents know why, when, where, and how many times their infants should be immunised. If the immunisation services are not provided in their community, parents should ask for them through their health centre. This could be facilitated by effective communication.

The 1996 ZDHS report says that vaccination coverage against the most common childhood illnesses has increased recently. The proportion of children age 12 - 23 months who are considered to be fully immunised had increased from 67 percent in 1992 to 78 percent in 1996. Only 2 percent of children 12-23 months have not received any vaccinations.

Communication is needed to highlight that immunisation protects children against several dangerous diseases such as tuberculosis, diphtheria, whooping cough, tetanus, polio and measles. A child who is not immunised is more likely to become undernourished, to become disabled, and to die.

1.2.6 Cholera

Cholera also continues to be a threat to health in Zambia. Public education is needed to save lives from cholera. Cholera is highly infectious but also preventable when people take precautions. People should know that only one member of the family should nurse a person with cholera. No visitors should enter the house in which the patient is staying.

Vaccinating against cholera is ineffective against the spread of cholera. The available vaccines are unable to prevent cholera infection. It is also difficult, even with enormous efforts, to detect and isolate all infected persons, most of whom have no signs of illness.

Taking precautions such boiling drinking water and warming or heating food before eating it can effectively prevent cholera. Another person should not use any utensils, that is, spoons, plates, cups and pots that are used by a cholera patient.

People should also know that what kills the patient is rapid loss of body fluids and salts leading to dehydration. Quick replacement of lost water is the key to recovery. At home immediately a child or adult has frequent loose watery stools, those nearby should prevent dehydration by giving plenty of fluids, like breast-milk for children, fruit juices and especially Oral Rehydration Salts (ORS).

Effective communication is needed to let people know the precautions to undertake in the event of a cholera outbreak.

1.2.7 Diarrhoea

Diarrhoea diseases account for a high percentage of childhood morbidity and mortality in Zambia. Diarrhoea is also a major cause of child malnutrition. Zambia's experiences with major cholera outbreaks make diarrhoea disease control and prevention a high priority.

Diarrhoea can kill children by draining too much liquid from the body. So it is essential to give a child with diarrhoea plenty of liquids to drink. When a breastfed child has diarrhoea, it is important to continue breastfeeding. A child with diarrhoea needs food and a child recovering from diarrhoea needs an extra meal everyday for at least a week.

Trained help is needed if diarrhoea is more serious than usual. The Ministry of Health recommends that medicines should not be used (MOH, 1991). A child must not be given tablets or other medicines for diarrhoea unless a trained health worker has prescribed

these. According to the Ministry of Health, most medicines for diarrhoea are either useless or harmful. The diarrhoea will usually cure itself in a few days. The real danger is usually not the diarrhoea but the loss of fluids from the person's body.

Diarrhoea can be prevented by breastfeeding (in children), by immunising all children against measles, by using latrines, by keeping food and water clean, and by washing hands before touching food. Germs from faeces, entering the mouth, cause diarrhoea. These germs can be spread in water, in food, and by dirt under fingernails. To prevent diarrhoea, the germs must be stopped from entering the person's mouth. This needs public education so that people have adequate information on diarrhoea.

1.2.8 Coughs and Colds

Coughs and Colds are also a major health problem that the Ministry of Health wishes to tackle.

According to the Ministry of Health (MOH, 1991), coughs and colds can become pneumonia, which kills globally approximately 2 to 3 million children each year (not counting the 1 million pneumonia deaths which are a result of measles and diphtheria and which can be prevented by immunisation).

In Zambia coughs and colds are a major prevailing complaint at health institutions, while pneumonia is among the top five causes of death in hospitals (MOH, 1991).

All parents should know what to do about coughs and colds and when it is essential to get trained medical help. All health workers should have access to the low cost drugs that can prevent pneumonia deaths.

If a child with a cough is breathing much rapidly than normal, then the child is at risk. It is essential to get the child to a clinic quickly. A child with a cough or cold should be helped to eat and to drink plenty of liquids and should be kept warm but not hot.

Coughs and colds are a normal process of growing up. They get better on their own and normal children survive them well.

More than half of all illnesses and deaths among young children are caused by germs that get into the child's mouth via food and water.

In communities without latrines, without safe drinking water, and without safe refuse disposal, it is very difficult for families to prevent the spread of germs. It is therefore also vital for the government to support communities by providing – as a minimum – the materials and technical advice needed to construct latrines and improve drinking water supplies.

To demand such services, communities need to know the facts about how illness is spread and communicators have a responsibility to educate the people on such issues.

1.2.9 Hygiene

Both community and personal hygiene is very important to health. Most diseases that keep having a go at the population in Zambia can be prevented with proper hygiene. There is need for communicators to consistently educate the people on hygienic tendencies

1.2.10 Malaria

In addition to all these health concerns, Malaria continues to be an unbearable threat to health.

In Zambia, where malaria is common, all families and communities should have access to today's information on preventing and treating the disease. Communication can help to

prevent the tragedy of 100 million malaria cases each year, causing hundreds of thousands of child deaths and many more cases of child malnutrition.

Communicators should be aware that the effective prevention of malaria depends upon community action and government support. Effective communication strategies are needed to prevent malaria related deaths.

1.2.11 HIV/AIDS

The Acquired Immune Deficiency Syndrome, or AIDS, is a relatively new global problem. Every nation is threatened by it, and as many as 5 to 10 million people, as of 1991, were already infected with the AIDS virus (HIV) worldwide (MOH, 1991). It kills by damaging the body's defences against diseases. So far, there is no known cure. But good medical treatment and advice can make people with AIDS feel better and help them to live longer.

Increasing numbers of babies are being born with the AIDS virus and many millions will be orphaned by it.

In the absence of a proven medical cure, the only effective weapon against the spread of AIDS is public education that would empower people to take preventive measures. Every health communication practitioner should assist people to know how to avoid getting and spreading the AIDS virus.

AIDS is an incurable disease that can be passed on by sexual intercourse, infected blood, and by infected mothers to their unborn children. Persons infected with the AIDS virus may feel and look healthy for several years before they develop the disease AIDS. They can, however, transmit the infection to others.

The key is to encourage people to practice safe sex. Safe sex means being sure that neither partner is infected, remaining mutually faithful, and using a condom if in doubt. Any injection or cut with an unsterilized needle, syringe and/or razor blades is dangerous.

Public education is needed that women with the AIDS virus should avoid becoming pregnant. These have about 40% chance of giving birth to a baby who will also have the AIDS virus. This is what is known as mother –to – child transmission (MTCT). Most babies with the virus will die before they are three years old.

Mother-to-child transmission is the primary route of HIV infection in children under 15 years of age (Population Council & ICRW, 2001). Since the beginning of the HIV epidemic, more than 5 million children worldwide have been infected with HIV.

Effective communication is needed to persuade all parents to tell their children how to avoid getting AIDS. Children who are growing up today need to be warned about AIDS. Parents must learn to talk with their children about sex and about AIDS even if it is difficult.

Results of the 1996 ZDHS indicated that knowledge of AIDS among adults was almost universal. A question to assess knowledge of ways to avoid AIDS yielded very revealing results, which communication practitioners ought to take into consideration. Less than 10 percent of the respondents believed that AIDS was unavoidable. The majority of women and men cited faithfulness with one partner (49 percent for both women and men) and condom use (38 percent of women and 49 percent of men) as ways of avoiding AIDS.

Over 80 percent of women and men knew that a healthy-looking person could have the virus. Between 10 to 19 percent of women and 4 to 11 percent of men in all age categories were ignorant of the risk of HIV transmission from healthy-looking people. Although this is a small number compared to those who knew, it is potentially consequential in AIDS control measures. Even a small percentage of the population who

do not adopt behavioural change measures because of ignorance can remain a vector for infecting the larger population.

More than 90 percent of respondents realised that AIDS is incurable and over 80 percent knew that it can be transmitted from mother to newborn baby. A higher percentage of women than men were aware of the latter means of transmission. Over two-thirds of the respondents said they knew someone who either had AIDS or had died of AIDS.

Respondents were asked questions to assess their perception of the risk of contracting AIDS. Men were more confident than women about avoiding AIDS (57 percent of men reporting no risk at all, compared to 45 percent of women). 37 percent of married women said they were not at risk of acquiring AIDS, whilst 12 percent perceived themselves to be at great risk. Rural men and those who live in Northern Province were most likely to say that they had no chance of getting AIDS. In addition, unmarried respondents and men who had sex only with their wives tended to say that their chances of getting AIDS were limited.

In the survey, older and better-educated persons cited having one sexual partner as a means of avoiding AIDS, while younger men cited condoms. This finding, especially about young men, is very cardinal in promoting behaviour change. It implies that, where safer sex is concerned, young men are more likely to adopt condom use than abstinence.

ZDHS respondents were asked whether they had changed their behaviour in any way to avoid acquiring AIDS virus. 20 percent of women and six percent of men said they had not changed their behaviour. Both women (57 percent) and men (48 percent) indicated that they had restricted themselves to one partner. Roughly 10 percent of both women and men said they decided to maintain their virginity to avoid AIDS, while the same proportion said they stopped having sex altogether to reduce their risk.

10 percent of women and men said that they asked their spouses to be faithful. One in every five men said they started using condoms, compared to two percent of women.

Age, residence, and level of education showed little effect on behavioural change. Marital status proved, however, to be an important factor. Restricting themselves to one sexual partner was the most often cited preventive measure among married persons, while among the unmarried, 40 percent of women and 22 percent of men said they would retain their virginity.

There is generally plenty of work needed to be done in the promotion of health. There are a number of challenges that communication practitioners must meet and overcome in the promotion of health. Effective communication strategies are definitely essential in the promotion of health.

1.3 Programmatic Response to Health Problems

From the background given above, there are clear indications that Zambia has a lot of health problems to deal with. This is the main reason why there are numerous health programmes in the country. One notable programme is the Zambia Integrated Health Programme (ZIHP).

ZIHP was developed by the United States Agency for International Development (USAID), in partnership with the Government of the Republic of Zambia (GRZ), to address the main health problems of the people of Zambia and to continue the process of health reform.

The implementation schedule for this programme was during the period of 1999 – 2002, with possible extension. During its life span, ZIHP was to focus on the following areas:

(i) Communication/behaviour change;
(ii) Community partnerships;
(iii) Improved health worker performance;
(iv) NGO strengthening;
(v) Private sector partnerships; and
(vi) Systems support.

ZIHP implementation was to follow an integrated approach with special attention to the following technical areas:

(i) HIV/AIDS;
(ii) Malaria;
(iii) Integrated reproductive health; and
(iv) Child health and nutrition.

ZIHP efforts were to focus on the following groups:

(i) Adolescents;
(ii) Women caring for children;
(iii) Pregnant women;
(iv) Men; and
(v) People requiring selective curative services.

ZIHP was to continue to socially market and expand the availability of the following products:

(i) Maximum – male condoms;
(ii) Lovers PLUS – male condoms;
(iii) Care – female condoms;
(iv) SafePlan – oral contraceptives;
(v) Prolact – foaming tablets;
(vi) PowerNET/POWERCHEM – insecticide treated bednets and retreated kits; and
(vii) Clorin – home chlorination solution.

1.4 Global Response to HIV/AIDS

Of all the health problems, HIV/AIDS is such a big problem that it has necessitated the formation of global programmes. One such programme, and perhaps the biggest, is the Joint United Nations Programme on HIV/AIDS (UNAIDS).

From 1996, the World Health Organisation (WHO) had the lead responsibility on AIDS in the United Nations (UN), helping countries to set up much-needed national AIDS programmes. But by the mid-1990s, it became clear that the relentless spread of HIV, and the epidemic's devastating impact on all aspects of human life and on social and economic development, were creating an emergency that would require a greatly expanded United Nations effort. It was also realised that no single United Nations organisation could provide the co-ordinated level of assistance needed to address the many factors driving the HIV epidemic, or help countries deal with the impact of HIV/AIDS on households, communities and local economies. Greater co-ordination would be needed to maximise the impact of UN efforts.

The need for a joint programme was outlined by a resolution of the World Health Assembly in 1993. The establishment of such a programme was further endorsed by resolutions of both the United Nations Economic and Social Council (ECOSOC) and UNICEF, UNDP, UNFPA, UNESCO, WHO, and the World Bank – were joined in April 1999 by UNDCP and in October 2001 by ILO. This gave birth to UNAIDS.

By bringing together the efforts and resources of eight UN system organisations, UNAIDS' aim is to help mount and support an expanded response – one that engages the efforts of many sectors and partners from government and civil society.

UNAIDS is guided by a Programme Co-ordinating Board with representatives of 22 governments from all geographic regions, the UNAIDS co-sponsors, and five representatives of non-governmental organisations (NGOs), including associations of people living with HIV/AIDS. UNICEF, UNDP, UNFPA, UNDCP, UNESCO, ILO,

WHO, the World Bank and the UNAIDS Secretariat also meet separately as the Committee of Co-sponsoring Organisations.

As the main advocate for global action on HIV/AIDS, UNAIDS leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic.

The goal of UNAIDS is to catalyse, strengthen and orchestrate the unique expertise, resources, and networks of influence that each of these organisations offers. Working together through UNAIDS, the Co-sponsors expand their outreach through strategic alliances with other UN agencies, national governments, corporations, media, religious organisations, community-based groups, regional and country networks of people living with HIV/AIDS, and other non-governmental organisations.

UNAIDS operates at global, regional and country level. A study of communication processes employed by UNAIDS thus gives a broader perspective. On the other hand, the study of communication processes employed by ZIHP gives a more focused approach to country level communication.

During the six months practical attachment, the writer had experience of working with these two programmes.

CHAPTER TWO
METHODOLOGY AND LITERATURE REVIEW

This chapter describes:

(i) How the attachment was conceived;
(ii) Where the student was attached and why;
(iii) What problem the student was addressing;
(iv) What research question the student was answering;
(v) The methodology used for the attachment;
(vi) The justification of the attachment; and
(vii) The literature that formed the conceptual framework of the attachment.

2.1 How the Attachment was Conceived

Communication for Development, as a Master's degree programme at the University of Zambia (UNZA) is packaged in a way that makes it easy to understand that communication is a systematic process.

After having gone through the theory phase of the programme, this student wanted to find out if social change organisations were practising systematic communication. This student developed the desire to investigate what communication processes were being employed by organisations involved in social change. The idea behind this thinking was to learn how the theory taught in communication for development could be translated into practical communication processes in social change organisations. This desire prompted the student to design a practical attachment proposal, which was to enable him to work in an organisation that was involved in social change.

2.2 Where the Student was Attached and Why

There are many organisations involved in social change communication in Zambia. Some have a bias towards human rights, others women's rights, others reproductive health, and others health in general

This student had a wide range of choices both in terms of subjects and in terms of organisations. His choice was guided by personal bias. The student had a bias towards health and thus chose an organisation that was promoting health.

The student was attached to the Zambia Integrated Health Programme, communication component (ZIHP-Comm.). The interest in being attached to ZIHP-Comm was generated by the organisation's vast involvement in health communication.

The attachment started as a case study of ZIHP-Comm. This went on for a period of four months. It was during this period that the student had contact with several organisations that were running communication programmes and had interest in the skills taught in the MCD programme. The organisations were at different levels, including community, regional and international levels.

Some of these organisations gave this student short-term contracts to add MCD skills to their programmes. Among these organisations was the United Nations Population Fund (UNFPA), which engaged the student to conduct a communication needs assessment in the North-western province of Zambia. The other one was Women in Law and Development in Africa (WILDAF), which engaged the student to develop a communication strategy, to reduce violence against women during the 2001 tripartite elections. Other organisations requested for the student's curriculum vitae so that he could be included on their contact list of communication consultants. One such organisation was the London-based AIDS Alliance.

UNAIDS ICT/ESA invited this student to work with them in Pretoria, South Africa for a period of two months. The student was specifically invited to give advice on various communication issues that UNAIDS was dealing with. The invitation was discussed with the student's supervisor, who assessed the invitation and found it to be in line with the student's original idea of being attached to a health promotion organisation. Thus, the student had an extra two months of practical attachment.

2.3 What Problem the Student was Addressing

There is usually a notable departure between theory and practice. When one considers communication steps that are taught in academic programmes, such as the Master of Communication for Development (MCD), it is not unusual to find that there is a major departure between theory and practice. In other words, people can easily mention the steps or procedure involved in effective communication but fail to put it in practice. This student considers the main problem as being the inability to operationalise communication theories or models. It was for this reason that the student posed a practical attachment question "to what extent do communicators in health promotion organisations follow social change communication steps or procedure?" Even of much more significance, the student wanted to find out how these organisations operationalise the steps.

2.4 The Methodology Used for the Attachment

The practical attachment exercise used participant observation methodology, which enabled the student to observe and participate in the activities that where taking place at ZIHP and later at UNAIDS ICT/ESA.

The student was attached to ZIHP-Comm. for a period of four months. During that period, the student observed the communication process that ZIHP-Comm. was employing, as a health promotion organisation.

The student first conducted an enquiry into communication products that ZIHP-Comm. had produced a year before his attachment. This was to enable the student to learn what steps had been followed in developing those products.

The student conducted an inventory of the materials that had been produced a year before his attachment. All the sections under ZIHP-Comm. were asked to prepare a list of materials that they had produced in the specified period. So many materials had been produced that, as a result, officers who produced them could not even remember all of them. The materials ranged from audio-visual to print. There were several videos on health and numerous brochures and leaflets. The media section had also written insurmountable health articles that had already been published.

A questionnaire was designed to gather details pertaining to, among other things, the following:

(i) How the idea to produce the material was conceived;
(ii) Who participated in message development;
(iii) What criteria was used to select who to participate; and
(iv) What specific steps were taken from idea-conception to material finalisation and distribution.

Regarding sampling, a combination of procedures was used. A list of all the materials, which were made available, was compiled. The materials on the list were given numbers then randomly selected from the table of random numbers. For the officers, a purposive sample was selected. This was based on the officer being directly involved in the communication process employed by ZIHP-Comm. in promoting health.

At the UNAIDS ICT/ESA, there was no preliminary research undertaken. The student went straight into participant observation. The reason why this happened was that UNAIDS ICT/ESA was not in the attachment proposal. The attachment at UNAIDS ICT/ESA was treated as continuation of the attachment at ZIHP-Comm.

2.5 The Justification for the Attachment

Most communication efforts undertaken by various organisations, purporting to induce social change are done without paying attention to the essential steps involved in communication for social change. The reasons are quite varied. Sometimes the officers involved fail to operationalise the steps even when they know them in theory. This often results in the failure of many programmes.

The student perceived ZIHP-Comm. and UNAIDS to be ideal organisations for attachment to learn how communicators in health promotion organisations implement communication for social change. These two organisations have intense communication activities. There was no better way to observe and participate in the programme activities of these organisations apart from being attached to them.

2.6 The Literature that Formed the Conceptual Framework of the Attachment

Achieving social change calls for strategic communication. The required communication goes beyond an ad-hoc 'let's-print-a-poster' approach. Social change communication requires a tested systematic process that is goal-oriented, focused and responsive to feedback

Available literature, culminating from various studies, points to the fact that social change can only be achieved by communication programmes that are a result of systematic planning and implementation processes. Recent communication for social change works recommend systematic processes that can initiate change, accelerate changes already underway, or reinforce change that has already occurred.

Phyllis Tilson Piotrow, D. Lawrence Kincaid, Jose G. Rimon 11, and Ward Rinchart (1 997) have, through various lessons learned in family planning and reproductive health, devised a systematic process for developing strategic communication programmes required for social change. Their model is known as 'P-Process', where P can stand for

project or programme. In addition, Philip Kotler and Eduardo L. Roberto have propounded a systematic process of social marketing strategies for changing public behaviour. They have called their model 'Social marketing management process'.

This literature review has taken particular attention in giving the highlights of the two models. Other scholars, who may not have identified comprehensive communication processes for social change, have also been cited as they strengthen, weaken or comment on some aspects of the two models.

2.6.1 The P-Process

The P-Process, as propounded by Piotrow and colleagues (1997), consists of six steps that can be followed in sequence to develop and implement effective communication strategies, programmes or activities. These steps are:

(i) Analysis;
(ii) Strategic design;
(iii) Development, Pre-testing and revision, and production;
(iv) Management, implementation and monitoring;
(v) Impact evaluation; and
(vi) Planning for continuity.

2.6.1.1 Analysis

According to Piotrow and colleagues (Piotrow, et al., 1997), the success of any communication programme depends on accurate analysis and understanding of the problem to be solved; the people, policies, programmes, and organisations needed to solve it; and the communication resources that can be mobilised. This process can be undertaken through the application of various research sources and methods, which means that successful communication programmes are preceded by research.

In most population domains, the broad outlines of the problem have already been identified by high-level policy-makers. For example, the Ministry of Finance and National Planning (formerly known as Ministry of Finance and Economic Development), in the draft Revised National Population Policy, has broadly outlined problems such as rapid population growth, high maternal and infant mortality, and high HIV/AIDS infection rate (MOFED, 1996). Hence, agents of social change such as ZIHP, establish programme objectives that respond to these nationally defined problems. To this effect, problem identification is not really a concern for social change organisations. Their task as change agents, at analysis level, is to identify what is needed for communication to help achieve social change objectives. Consequently, initial communication analysis must focus on strategic information such as:

(i) Whose behaviour must change for the programme objectives to be achieved;

(ii) How different people perceive the problem, that is, how much they know about it;

(iii)What their present attitudes, intentions and practices are, regarding the problem at hand.

Other pertinent information pertains to what beliefs and barriers exist, which block change. Change agents ought to find out how society, culture, and religion influence the way people communicate about the subject of interest both privately and publicly. Besides, information pertaining to the secondary audiences that can influence or reinforce potential adopters to adopt the desired change must be obtained.

Analysis is not complete without finding out the national and local policies, politics and health care standards and guidelines concerning the issue of interest. Questions such as: who are the policy-makers and opinion leaders? What programmes and services exist? How good are they? And how can they be strengthened? Provide an excellent way forward.

Other strategic information is in the area of knowing the important organisations government, non-governmental, and private/commercial - that are already active in the issue of interest. It is also important to know which organisations can carryout a

communication programme, how public and private organisations work together, and what type of collaboration is needed. Such information reduces on duplication of efforts.

Initial analysis must also yield information pertaining to communication resources - what are the best communication channels to reach the primary audiences? Who controls access to these channels? What technical firm, advertising agencies, performers, producers, and distribution services are available? How knowledgeable are communication professionals about the issue of interest? All this information is vital for determining the direction of the programme.

In Kenya, for example, to design the youth-to-youth HIV prevention programme, an analysis was undertaken. Glen Williams, Lucy Ng'ang'a and Johm Ngugi (1999) have documented some findings on which guided the programme. The analysis revealed that the great majority of adults in Kenya acquired the virus through unprotected heterosexual intercourse, i.e. penetrative sex, without using a condom, between a man and a woman. The analysis indicated that even young people in Kenya were potentially at risk of contracting HIV through unprotected sexual intercourse. The analysis was able to point to communication barriers that would influence the implementation of youth programmes.

According to the analysis (Williams et al, 1999), most young people in Kenya become sexually active before marriage, many while still in their teens. The average age of first intercourse among Kenyans is 17, but many young people become sexually active much earlier. Rural adolescents are likely to begin sexually activity at an earlier age than their urban counterparts.

The analysis generally, as seen above, provides information that can guide programme design. It helps to identify where attention must be focussed. Analysis influences strategic design. A good analysis gives rise to a good strategic design.

2.6.1.2 Strategic Design

Piotrow and colleagues (1 997) emphasise that every communication programme or project, large or small, needs a strategic design. All future activities depend upon strategic design. According to these authors, the strategic design comprises four main activities:

(i) Setting objectives;

(ii) Positioning the issue, service, or product to be promoted;

(iii) Selecting the means of implementation;

(iv) Identifying partner organisations; and,

(v) Planning for documentation and evaluation.

(a) Setting objectives

A communication programme must have pre-set objectives that are specific, measurable, appropriate, realistic and time-bound (SMART).

(i) *Specific* - defining what is to be accomplished in terms of specific steps to behavioural change among specific, well defined audiences.

(ii) *Measurable* - quantifying the objectives by indicating a numerical or percentage change expected.

(iii) *Appropriate* - defining intended changes that are culturally and locally acceptable.

(iv) *Realistic* - avoiding objectives that are beyond the scope of available resources, contrary to relevant experience, or unrelated to communication efforts.

(v) *Time-bound* - identifying the period in which changes should be achieved.

According to Piotrow and colleagues (Piotrow, et al., 1997), the 1993 Family Planning and Health Project campaign in Ghana offers an example of SMART communication objectives.

The strategy was specific because it sought to increase the use of modern contraceptive methods among the primary audience of women whose ages ranged from 15 to 45 who

approved of and intended to use family planning, and who had social support to do so - about 32 percent of all Ghanaian women; it was measurable because it set four percentage points as the expected numerical increase in modern contraceptive use; it was appropriate because the local health staff participated actively in drawing up plans that were based on local conditions; it was realistic because the intended audience was women who were 'ready' and had already expressed their intention to limit or space pregnancies; and it was time-bound because the behaviour change was expected to take place in a 24-month period.

(b) Positioning

Piotrow and colleagues (1997) define positioning as presenting an issue, service, or product in such a way that it stands out from comparable or competing issues, services, or products and is appealing and persuasive. Positioning creates a distinctive and attractive image, a perpetual foothold in the minds of the intended audience. It provides a framework within which a consistent appeal can be developed and publicised.

Strategic positioning helps to ensure that all stakeholders and participants in the communication programmes understand what the central thrust of the strategy is in terms of message development.

(c) Selecting means of implementation

Once objectives, audiences, and positioning are established, the strategic design must provide a guide to what actions to take. The design must indicate the activities, channels, and scheduling that will be most likely to lead to the desired destination.

(d) Identifying implementing organisations

The major criteria for implementing organisations are competence, commitment, coverage, influence (clout or power), and continuity. A review of existing organisations shows which can carry out an effective communication programme and how different organisations can collaborate. A solid needs assessment reviews all the organisations that

can play a role in national communication programmes and identifies their strengths and weaknesses for future communication activities.

(e) Planning for documentation and evaluation

Plans for monitoring and evaluation, based on the project activities, should be included in the strategic design, workplans, and budgets. One of the greatest misconceptions about evaluation is that it is something that is done after a project is finished to find out whether the project was successful or not. Yet one of the first principles of evaluation is that, if evaluation is not planned at the start of the programme, it is too late to be informative or useful any time. Planning for evaluation is therefore an integral part of strategic design. In fact, in setting programme objectives and sub-objectives, planners should simultaneously be asking themselves how they hope to find out whether those objectives have been achieved.

2.6.1.3 Development, Pre-testing and Revision, and Production

Once the strategic design for a communication programme is established, work begins on developing specific messages and materials to support the strategy. Developing materials that can increase knowledge, change attitudes, and, especially, encourage new behaviour must combine art and science. It must be a creative process that applies imagination and talent, within the framework of agreed-upon strategic design.

Agents of social change should always be mindful that health messages compete for attention with professionally developed commercial marketing messages crafted by creative and skilful message makers with ample resources. For health messages to be noticed, remembered, understood, and acted on, they must compete in quality (if not quantity) with other messages.

Piotrow and colleagues (1997) have recorded that, to be effective, staff of the Population Communication services and their colleagues around the world have learned to play the game the way the competition plays it.

Family planning messages developed by the Population Communication Services are now developed according to many of the principles and techniques that successful commercial advertisers apply.

> The seven Cs of Effective Communication adopted from standard advertising practices, offer a convenient guide to the key attributes of effective communication (J.R. Williams, 1992 in Piotrow et al., 1997:91)

Important lessons learned in health communication include the fact that the same approaches that work in developing messages and materials for professional marketing and advertising must be applied to health communication. According to Piotrow and colleagues (1997), whether promoting consumer products or encouraging healthful behaviour, persuasive communication follows these seven basic rules:

(i) *Command attention.* This rule suggests that only messages that are noticed and remembered can be effective. An unnoticed message might as well not have been sent. Messages will not be noticed if they are dull or nondescript. Effective messages should be daring enough to attract attention and elicit comment while at the same time remaining sensitive to cultural context, social values, and political priorities. Slogans such as *Haki Yako* (It's Your Right) in Kenya or the two skipping children in the Philippine logo with slogan *Kung sila'y mahal n'yo, maplano* (If you love them, plan for them) meet that test. Sometimes it is the medium even more than the message that is the attention-getter.

(ii) *Cater to the heart and head.* Most people are moved at least as much by emotions as by reason. A message that arouses emotion is effective because people learn better when their emotions are aroused. Emotional appeals usually involve storytelling – reflecting, however briefly, the situation and feelings of an individual. Thus emotional messages are often best delivered in an entertainment format, as a song, a drama, or even a comic sequence. Appeals to reason at the same time add staying power to a message. After emotion has

cooled, the message still makes sense. For example, in an Egyptian television spot, the wise and caring "Doctora" (Kareema Mouhktar) loses her temper at the mother who wants to lie about her young daughter's age so that she can be married to a rich man. The Doctora's emotional outburst reinforces her sensible message against early marriage.

(iii) Clarify the message. Focus and freedom from clutter are crucial. A message should convey a single, important point. Ancillary information and multiple themes can detract the audience, and some people will miss the point. The technical information used by care providers confuses many audiences. Such detailed information, put in terms that are meaningful and understandable to clients, is best communicated in counselling or other interpersonal communication. Above all, the audience must understand what the message means. Hence the motto 'Focus Demands Sacrifice'. A single, clear, and comprehensive message is best. For example, in Ghana the simple message, "Trust your family planning advisor. She cares," proved more powerful on a billboard than attempts to depict the wide range of contraceptive methods.

(iv) Communicate a benefit. People need a strong motive to change their behaviour. The best motivator is the expectation of a personal benefit; people rarely buy a new product or take up a new practice unless they see some direct personal benefit in it. In the commercial field, advertisers know that consumers do not merely buy products; they buy expectations of benefits. As Charles Revson, a major cosmetics company magnet, put it, "In the factory, we make cosmetics; in the store, we sell hope" (Tobias in Piotrow et al., 1997). The benefits that family planning promises must reflect the positioning of the product, which in turn will reflect the values, expectations, and hopes of the intended audience. Depending on the audience's concerns (learned from the analysis of formative research), a message might promise such benefits as good health, beauty, sex appeal, financial security, or a happier marriage. The *Las Tromes* campaign in Peru, for example, suggested that contraceptive users could join the ranks of "with-it" young women (*tromes*) who enjoy modern life styles and supportive husbands. In Nepal, in contrast, attractive posters suggested that young men

and women who use family planning will be strong and healthy for the necessary work on their farms.

(v) Create trust. A message that people will act on of their own accord must come from sources that they trust. If the promise of a future benefit does not come from a credible source, people will not believe it. Many family planning messages are expressed by the character of a benevolent, trustworthy local nurse or a doctor, such as Egyptian television's "Doctora Kareema," to show that the message can be trusted. Also, sources can inspire trust if they are people similar to the intended audience or to what the audience aspires to be. To reinforce trust, messages often are phrased informally, the way one person speaks to another – that is, "you" in the familiar second-person singular, rather than "they". For example, the Bolivian *Salud Reproductiva* (Reproductive Health) campaign used as its tag line, "Reproductive health is in <u>your</u> hands." (Valente, Saba, et al., in Piotrow et al., 1997)

(vi) Call for action. After seeing or hearing a persuasive message, the audience should know exactly what to do. Once convinced that the promised benefit is worth pursuing, people need to know how to act on this belief – where to go, whom to call, what to buy. Directives should be clearly stated. Without a specific cue to action, people may hear, understand, and even approve of a message but still take no action. For example, in promoting sexual responsibility among young people in the Philippines, television spots showed the telephone numbers of the Dial-A-friend hotline. (Rimon, Treiman, et al. in Piotrow et al., 1997).

(vii) *Consistency counts* – repetition is essential. A message that is repeated many times, perhaps with variations but always with basic consistency, becomes familiar, and people come to recognise and understand it without having to stop to think. As it gains recognition, it also reaches wider and more diverse audiences. A good logo, slogan, or central message theme therefore should be used and reused until, like the dynamic white ribbon or red background in the Coca-Cola logo , or the American Express slogan 'Don't leave home without it,' people know what it stands for even without seeing the name of the

product. In family planning communication, the use of logos to identify service providers' posts, contraceptive distribution sources, information materials, and contraceptive products is an example of consistency and repetition to make the idea more familiar.

Communication professionals will record more success if they apply the seven Cs of Effective Communication. The idea has worked in commercial advertising.

For the success of health promotion, communication professionals need close supervision in developing appropriate health materials while health professionals need to provide input and to review materials for technical accuracy.

Piotrow and colleagues (1997) point out that message development is a collaborative and participatory process. Communication is a dialogue not a monologue. An effective way to design messages is to ask members of the audience to talk about the issue in their own words and then to design programme messages accordingly. The participation of representatives of intended audiences in pre-testing helps to ensure that the materials will speak effectively to actual audiences. Even the most careful preparation cannot guarantee that the intended audience will understand messages and materials or find them appropriate, relevant, and persuasive.

Pre-testing - that is, asking selected members of the intended audience what they think about the messages and materials - is an excellent way to ensure that the audience is involved and the best way to ensure that materials do indeed evoke the intended response. Pre-testing and revision take time and money but help to avoid even the greater costs of ineffective materials.

Pre-testing not only checks how well project managers, artists, and writers have interpreted audience analysis, but it also uncovers matters that researchers and officials may have overlooked. Even when pre-test participants generally like an overall concept, they usually can suggest significant changes that will make materials easier to understand

and more appealing. Piotrow and colleagues (1997) record that the Bolivian project managers were surprised to learn from pre-testing that indigenous men and women, although bilingual, differed in the languages they preferred for radio messages. Men, because they were accustomed to working in Spanish-speaking environments, preferred hearing family planning radio spots in Spanish. Messages in Spanish sounded more authoritative, the men said. Women, in contrast, preferred the indigenous languages which they heard at home. Messages in local languages sounded more personal. With this information, the managers revised their plans and aired spots on appropriate stations and at times to reach men and women separately, each in their preferred language.

In addition, high quality materials must be produced in large volumes since this is cost effective. Moreover, high quality materials hold up over time and encourage use. Re-use extends the life of communication materials and serves resources.

2.6.1.4 Management, Implementation and Monitoring

This is where everything comes together. After all the analysis, design, material development, pre-testing, revision, and production, the public campaign begins. This is what the public will see and respond to. Even the most revealing research and a brilliant strategic design will not produce results unless they are well implemented.

Over-the-years experience has yielded various important lessons in the management, implementation and monitoring of health communication programmes. Piotrow and colleagues (1997) have identified the following:

(i) Identification of the lead agency and clear lines of responsibility

Identification of the lead agency and clear lines of responsibility for each phase of the programme enable everyone to focus on achieving communication objectives.

In Ghana, for example, the Health Education Unit in the Ministry of Health has been the lead agency, but it has developed many partnerships with other ministries and

organisations to work at the local level (Ghana MOH/HEU & JHU/PCS, 1992). In Bolivia, the IEC Technical Committee took initial leadership, and various agencies worked to develop materials until the Ministry of Health formally launched the programme and became the national leader (Valente, Saba, et al., in Piotrow et al., 1997).

(ii) Training can build a critical mass of communication experts

Training can build a critical mass of communication experts in each country who share the same conceptual framework, pursue the same strategic goals, and apply relevant technical skills.

To develop a critical mass of competent communication practitioners calls for training at all levels. A single workshop or a variety of long-term degree programmes is not enough. The best approach is a continuing series of highly participatory workshops followed by on-the-job experience implementing a programme in a number of countries, including Bangladesh, Bolivia, Egypt, Ghana, Indonesia, Nigeria, and Zimbabwe, a critical mass of health communication practitioners has been trained in the P-Process of project development.

(iii) Dissemination of materials is a separate activity, requiring a specific plan and budget.

Distribution is often a neglected task because it is not perceived as glamorous or challenging. When print or video materials designed to be used by various providers do not reach those providers, the effect is the same as taping a radio or television show and never broadcasting it.

(iv)Regular and accurate monitoring helps ensure that outputs are produced and distributed as planned.

In Brazil, for example, the monitoring system built into the AIDS-prevention project for street children in the city of Belo Horizonte collected data on the number of outreach sessions held, attendance at sessions, topics covered, and materials distributed. With this information the project managers could be sure that enough sessions were held in each area, could track attendance and the number of materials distributed, and could provide complementary data for impact evaluation. During the first three months of campaign implementation, monitoring showed that over 600 youth had participated in 55 sessions and that over 68 percent of the youth had attended several outreach sessions and other community activities (Payne Merritt & Raffaelli, in Piotrow et al., 1997).

Rapid feedback allows managers to fine-tune programme operations and improves the organisational climate.

Feedback about radio and television materials can sometimes combine monitoring of the broadcasts with assessment of the impact on intended audiences and can even generate suggestions for future activities. In Kenya, for example, radio programmes and print materials produced by the Provider and Client Project invited listeners and readers to write in for more information. More than 3, 000 letters poured in over nine months, providing information about the relative reach and impact of different media. Project staff analysed the letters by district, the gender of senders, the nature of information requested, and the programmes and articles that promoted the request. As a result, the on-going radio programmes could include the kind of information listeners asked for.

(vi)Too much information can clog a monitoring system

An overambitious sentinel site system designed to monitor the "I care" campaign in Ghana illustrates the pitfalls of collecting too much information. The initial plan was to collect data from household interviews and focus-group discussions conducted every three months at 25 sentinel sites and to analyse the data at the University of Ghana in Accra. Since it took months and sometimes years for busy researchers in Accra to analyse even a portion of these data, the results did not reach the local project managers in time. A project review recommended that future monitoring systems be far simpler and that on-site data collectors and regional managers be trained to analyse and interpret their own essential data promptly (Ghana MOH/HEU & JHU/PCS, in Piotrow et al., 1997)

(vii) When monitoring reveals unexpected problems or opportunities, a flexible and rapid response is necessary.

Good managers are quick to recognise and take advantage of any unexpected opportunities that show up during project monitoring. In Egypt, for example, managers of the *Minya* initiative discovered that after motivational meetings people did not want to set up a clinic appointment for a later date. They wanted information and supplies right away. As a result, two of the implementing organisations – the Ministry of Health and Population and the Ministry of Information/State Information Service – began conducting joint meetings in rural areas with a physician present to provide services at the end of the talk (JHU/PCS, in Piotrow et al., 1997).

The other important lessons identified by Piotrow and colleagues include the following:

- Activities at the community level depend on strong local support and decentralised initiatives.
- The funding for communication activities, materials, production, and technical assistance needs to be closely coordinated.

- All parties need to understand and follow established consultation and clearance requirements.
- A campaign launch is an opportunity for maximum public, press, and political attention.
- Compensation or appropriate recognition for the people who work on a communication programme improves morale and performance.

Whether the health communication programme is run in a hierarchical fashion by an agency or is a team effort, specific individuals or groups need to be responsible for specific activities. In addition, regular and accurate monitoring helps ensure that outputs are produced and distributed as planned. Monitoring must focus on outputs - processes and products. It must tell project managers whether activities are taking place as planned or whether there are significant deviations.

2.6.1.5 Process and Impact Evaluation

According to Piotrow and colleagues (1997), process evaluation determines whether strategies are working while impact evaluation determines whether the original project objectives were met - that is, whether the intended audience changed its knowledge, attitudes, or behaviour.

Evaluation is the systematic application of scientific procedures to assess the conceptualisation, design, implementation, impact, and cost effectiveness of social interventions. The purpose of evaluation is to measure the process and the impact of a programme against the objectives established in the strategic design in order to contribute to decision making. Impact refers to programme outcome. Decision-making means applying the findings of an evaluation to improve on-going or future programmes.

Piotrow and colleagues (1997) record that evaluations in Kenya, the Philippines, Tanzania, and Uganda show primarily how multimedia campaigns can be evaluated. In each case, the purpose of the evaluation was not only to determine whether the

programme achieved its pre-established objectives but also to learn what worked and what did not work within the programme so that future activities could be improved.

2.6.1.6 Planning for continuity

Communication, being an on-going and not a one time effort, continuity is necessary. Planning for continuity begins with a review of changing environments and an analysis of how on-going programmes can adapt to these changes. Planning for continuity is important to link past experience with present and future needs. This planning can help communication programmes scale up to meet the growing needs of ever growing populations. In the process, planning for continuity can enhance the overall quality and impact of health communication. Piotrow and colleagues (1997) outline numerous other reasons why continuity is important. They include:

(i) Repetition, which is per se a fundamental part of learning - few people remember one-time message;

(ii) Different audiences are best reached through a series of different materials, messages, and campaigns, phased in over time;

(iii) Different people move through the steps to behaviour change at different speeds, and therefore a single, one-time message will not influence an entire audience, even if everyone is exposed to it;

(iv) People's circumstances and needs change over the years – and thus their receptive to family planning messages changes;

(v) Over the years new people enter their reproductive years while others leave;

(vi) Continuity allows programmes to expand, scaling up from pilot projects to regional or national efforts;

(vii) Continuity creates opportunities for sustainability by permitting managers to seek additional support for programmes and events that have proved popular; and,

(viii) With continuity, programme managers can apply the lessons learned from the past to improve and expand future efforts.

Planning for continuity is therefore important to link past experience with present and future needs. This planning can help communication programmes scale up to meet the growing needs of ever-larger populations. In the process, planning for continuity can enhance the overall quality and impact of health communication.

Planning for programmes to continue, to scale up, to reflect changing policy priorities, to become more cost-effective over time, and to play a strategic role in comprehensive national reproductive health strategies, according to Piotrow and colleagues (1997), is the last stage in the P Process of communication programme development.

The P-Process is generally the most comprehensive communication model, for health promotion, that this writer came across during the literature review. It presents a step-by-step procedure of designing and implementing communication programmes in support of health promotion.

This writer also identified a similar communication model propounded by Kotler and Roberto (1989). This model is known as the Social Marketing Management Process. Highlights of this model have been outlined below.

2.6.2 The Social Marketing Management Process

Social marketing is a strategy for changing behaviour. The term "social marketing" initially described the use of marketing principles and techniques to advance a social cause, idea, or behaviour. The term has now come to mean a social change management technology involving the design, implementation, and control of programmes aimed at increasing the acceptability of a social idea or practice in one or more groups of target adopters (Kotler & Roberto, 1989).

According to Kotler and Roberto (1989) the social marketing management process consists of five steps. These are:

(i) Analysing the social marketing environment;

(ii) Researching the target-adopter population;

(iii)Designing social marketing objectives and strategies;

(iv)Planning social marketing programmes; and,

(v) Organising, implementing, controlling and evaluating the social marketing effort.

2.6.2.1 Analysing the Social Marketing Environment

Agents of social change must look into the target-adopter population's situation concerning the issue. This allows the change agent to know the attitudes, practices and behaviour of the target adopter population in relation to the issue of interest, which is essential to developing effective communication strategies.

2.6.2.2 Researching the Target-Adopter Population

Agents of social change must achieve a thorough understanding of the target adopter group and its needs. This gives the best way to reach target-adopters since it defines the appropriate target-adopter segment. Social change agents must implement this step in order to break the target-adopter population into segments that have common characteristics in responding to social campaign.

2.6.2.3 Designing Social Marketing Objectives and Strategies

The social marketing strategy specifies the game plan for achieving the objectives of the social marketing campaign. It defines the broad principles by which the social organisation expects to attain its objectives in a target-adopter segment. It consists of basic decisions on the total marketing expenditure, marketing mix, and marketing allocation. Social marketers must first set specific, measurable, and attainable social marketing objectives. Objectives should not be set so high that they cannot be attained with the available resources or so low to be unchallenging.

2.6.2.4 Planning Social Marketing Programmes

After the broad strategy is formulated, the management of more detailed social marketing mix programmes must be prepared. The first element of the social marketing mix to be

formulated is the social product. The tactical programme for the social product includes determining the following:

(i) How the social product will be positioned on the basis of research into target adopters' perceptions, attitudes, and motivations about the use of the social product;

(ii) The suitable 'brand' name that would reinforce the product's positioning, and,

(iii) Suitable packaging, including the material, size shape, label, colour, and wording on the package.

The marketing mix elements of mass and selective communication must be turned into tactical programmes. This step may encompass the following actions:

(i) Carefully choosing the advertising agency;

(ii) Designing and presenting the advertisements; and.,

(iii)Selecting the right media and timing.

Tactical programmes must also be developed for distribution and direct personal communication.

Pricing is another marketing tool that requires its own tactical programme. Also of great importance is that social marketers must work out the tactical programme for delivering services. The social product determines the appropriate type of delivery.

2.6.2.5 Organising, Implementing, Controlling and Evaluating the Social Marketing Effort

In the social marketing management process, the final step is to organise the marketing resources, implement the social marketing mix programmes, control the performance of the programme and evaluate the results (the social and ethical impact) of that implementation. Careful attention must be given to implementation. Even the best and most carefully drawn plan gets no where until it is effectively implemented and controlled. Effective control and evaluation require data about the target adopter group's

responses to the implemented social programme, which are generated by social marketing research.

These five steps propounded by Kotler and Roberto (1989) can culminate into a successful social change if carefully implemented. These steps are similar in content with what Piotrow and colleagues (Piotrow, et al., 1997) have presented.

CHAPTER THREE
CONCEPTUAL FRAMEWORK

3.0 Defining Communication

The definitions of communication are just as many as the number of people who attempt to define it. Each scholar comes up with his or her own definition of communication. It seems that no scholar is satisfied with another scholar's definition. According to Infante and colleagues (Infante, Rancer & Womack, 1997:7), definitions differ on matters such as:

(i) whether communication has occurred if a source did not intend to send a message;
(ii) whether communication is a linear process (a source sending a message in a channel to a receiver who then reacts); or,
(iii) whether a transactional perspective is more accurate (emphasizing the relationships between people and how they constantly, mutually influence one another)

Infante and colleagues (1997) add that people disagree on definitions of communication because they disagree on the nature of communication. These authors argue that this seems to be an unavoidable condition when a science is less precise, as is the case with communication. If something is clearly understood, they say, it is possible to formulate a universally acceptable definition. Communication is difficult to define because it has too many properties. Because of the multiple properties of communication, its definitions are always varying from one attempt to another.

The definitions always go in line with what properties someone wants to highlight. Some emphasise the 'symbolic' property of communication. Others emphasise the 'social' aspect of communication and still others put prominence on the 'co-orientation' involvement of communication. Some people would still rather put emphasis on the 'individual interpretation' property of communication while others may opt to highlight the 'shared meaning' property of communication. In addition, some may have the bias towards the

contextual dimension of communication and thus try to emphasise 'context' in their definitions.

According to Infante and colleagues (1997), communication exhibits certain characteristics: it is a social, symbolic process that occurs in a context. These authors conceptualise communication as something that occurs when humans manipulate symbols to stimulate meaning in other humans. This definition, according to them, differs from others because it emphasises both sender and receiver. The definition is compared to the following five other definitions, which they have quoted:

(1) "Communication is the discriminatory response of an organism to a stimulus." (Stevens, 1950)
(2) "the transmission of information, ideas, emotions, skills, etc., by the use of symbols - words, pictures, figures, graphs, etc." (Berelson & Steiner, 1964)
(3) "the eliciting of a response through verbal symbols." (Dance, 1967)
(4) Communication has as its central interest those behavioural situations in which a source transmits a message to a receiver(s) with conscious intent to affect the latter's behaviours." (Miller, 1966)
(5) "Human communication has occurred when a human being responds to a symbol." Cronkite, 1976)

Each definition emphasises a slightly different aspect of communication. Steven's definition emphasises the response made by someone who receives a stimulus. Berelson and Steiner focus our attention on the transmission of symbols; Dance's and Cronkite's definitions combine the receiver's response with symbols chosen by a sender. Miller includes the ideas of symbolism and receiver's response, but he also emphasises the intentional nature of communication. (Infante et al., 1997: 8)

Having gone through several definitions of communication, this writer's conception of communication is that: -

Communication is the processing, transmission, exchange, interchange, or sharing of emotions or information on a particular issue or topic through feelings, thoughts, words, actions, symbols and signs.

This definition recognises the indisputable fact that communication is both intrapersonal and interpersonal. The definition also recognises the fact that communication is a two-way, interactive process.

At intrapersonal level, communication takes place through feelings and thoughts while at interpersonal level the process involves two or more individuals or groups interchanging ideas, signs, symbols, words and so on.

At interpersonal level, all participants in a communication process engage in encoding (creating and sharing) and decoding (perceiving and interpreting) information. This participatory orientation is very essential in the definition of communication. It manifests a departure from conceptualising communication as monologue to dialogue, which it is.

Though it may be so controversial to define communication, its role in our lives is paramount and self-evident. Infante and colleagues (1997), accordingly, give three important roles of communication.

One importance of communication is that of creating co-operation. Infante et al. argue that humans are interdependent. In society, each of us depends on others to provide what we need. For example, through communication we are able to co-ordinate efforts to produce goods and services, which would have been impossible if we were to work independently.

The second importance of communication is to help us acquire information. As human beings, we need vast information in our lives. For example, we want to know where to get goods, we want to know how to prevent disease and so on.

The third area, in which communication is useful, according to Infante and colleagues (1997), is in forming our self-concepts. One principle of communication, which is commonly accepted, is that how we perceive ourselves greatly influences our communication behaviour. For instance, people's verbal messages reflect optimism and unpretentious confidence in themselves, if they believe they are worthwhile and a success. Non-verbally, one notices that their posture, gestures, tone of voice, and facial expression say they have positive beliefs about themselves.

The importance of communication in our lives per se cannot be over-emphasised. Communication is very essential in promoting health. The health of the people depends very much on how they interact with their environment. Within the environment, there are things that can enhance life and there are things that can destroy life. Communication enables us to interact with our environment in an informed manner. Through communication, we learn from others about health-risky behaviour. Through communication, we teach others about health-risky behaviour.

In inducing social change, however, especially that social change to do with health promotion, the thinking about communication should not be in too simplistic a manner. Communication should not be conceptualised as a simple one-way transmission of messages from a source to a receiver with the intention of producing positive behaviour. Neither should the approach be reduced to 'let's-print-a-poster' kind of approach.

The intended effect of communication should not be limited to making the receiver aware of some point of view, new product, or course of action. Instead, the social process of communication and the influence of communication on behaviour must be accorded enough consideration. There is need for a shift from paying too much attention to the production of communication materials, so as to be seen by donors, to focusing on the content of the materials.

The tendency to focus too much attention on technical quality, rather than on how different audience members would interpret the meaning of the content within their

particular social context, is also retrogressive. There is so much emphasis on technical quality such that every organisation wants a Western consultant at one point or the other for technical backstopping. This tendency has led to the production of materials that have no meaning in local social contexts. Besides, this has also demoralised local professionals, who are only recognised in times of budgetary crises. They are called in when budgets are too meagre to support foreign experts and are made to do work in exchange with a meal at a low-class hotel.

There is an urgent need to revisit the approach to health communication. Moreover, the conceptual framework for health communication needs to be made clear. Experience in communication programming seems to point to (1) audience participation, (2) recognition of behaviour change as both a social and an individual process, (3) use of mass media, (4) development of entertainment for educational purposes, to be the pillars in ideal conceptual frameworks for health communication, and (5) systematic process for developing communication programmes.

3.1 Audience participation

The conceptualisation and approach to communication, especially in health promotion organisations, has to change. Communication should have a focus towards the understanding that it is a two-way, interactive process. The process involves two or more individuals or groups. All participants engage in encoding (creating and sharing) and decoding (perceiving and interpreting) information until the goals of each are adequately achieved. The participatory orientation must be emphasised in the approach to behaviour change communication. We need to view communication as dialogue rather than monologue.

Through experience, more and more people are realising that participants in communication create and share information with one another in order to reach a mutual understanding. It has been discovered that mutual understanding builds the foundation for mutual agreement, which in turn makes collective action possible. People find themselves

committed to decisions that they themselves make. If members of the community sit together to make rules to guide their lives, they feel committed to observe such rules compared to rules made by outsiders. This realisation is guiding the new thinking in communication.

In this new thinking in communication, the emphasis is shifting to three aspects: (1) to the interactive process of information sharing over time, (2) to the ways in which participants interpret and understand that information, and (3) to the dynamic process of feedback and adaptive behaviour.

In the process, there is convergence of both the ideas and the behaviour of participants. The distinction between sender and receiver must not be there because all participants in a communication process have the opportunity to be both senders and receivers as they interact. It does not matter whether it is a government ministry and the people engaged in the communication. At some point the ministry will send the message and people will give responses or feedback.

The practical implications of this shift in thinking about communication are readily apparent. Communication practitioners who attempt to bypass or shortcut this process by simply sending out whatever messages make sense or appeal to them should expect to have limited or unknown impact on their audience. Their communication efforts may sometimes even have effects on the audience contrary to those intended.

> One of the main lessons learned over the last 25 years is that effective communication begins with the audience, the client, or the consumer and continues over time as a process of mutual adjustment and convergence. (Piotrow et al., 1997:18)

Experience has shown that audiences usually have different ways of thinking, different vocabulary, even different ways of interpreting drawings and photographs from those of the experts who initiate communication programmes. Piotrow and colleagues (1997) cite

this as the main reason why the attitudes and predispositions - even the thought process - of potential audiences need to be taken into account when communication is designed to address them. These authors suggest that messages need to be: (i) based on information obtained from audience members themselves and (ii) pre-tested with them to make sure they were correctly designed. Only then can communication practitioners have any degree of confidence that audience members will interpret health messages in the way that they were intended. This implies that operations research should precede communication outreach.

Operations research, through small group discussions or in-depth interviews, gives audience members the opportunity to express themselves to communication experts first, before communication programmes are designed. Thus effective communication practitioners ought to pay attention to this valuable experience when designing their messages and then return to other members of the same audience to pre-test their messages to see if they have been produced correctly.

If communication practitioners ensure that the communication design process is followed, then the probability that health communication will be effective greatly increases. This is the new thinking in communication, which has given birth to market research and such formative research techniques as focus-group discussions, audience surveys, and message pre-testing. Communication research is now becoming a major component of communication programming. Communication research is simply a systematic dialogue with members of the intended audience, which aims at yielding information to direct or guide communication programming so that it is relevant to the target audience.

For effective communication interventions, emphasis should be placed on community participation. Community participation (Legoable, 2002) broadly can be conceptualised as maximising the extent to which communities become actively involved in their own development and empowerment. Narrowly, within the framework of information, we can look at community participation as the involving of communities in the whole

information cycle of creating, acquiring, storing, structuring, disseminating, evaluating, and feeding back.

Communities must be in charge of how to use information for promoting their own health. Community participation is very important. It promotes ownership, which is essential to the success of health initiatives. Actually, involvement creates awareness and awareness creates implementation. Moreover, community participation encourages inter/intra-dependence within communities and between communities and professionals.

Health promotion organisations must create an environment where all members of the community they are serving take an active part in their health affairs in terms of decision-making, planning and implementing societal aspirations. This is community participation (Ng'ayu, 1997), which requires strengthening of participatory mechanisms that ensure that all voices are heard in identifying problems, setting goals, priorities, mobilising resources and implementing policies.

Without community participation, communication programmes would lack relevance to the felt needs of the target groups. There would also be high risk of non-acceptance and non-utilisation of programmes. Furthermore, lack of maintenance and continuity of programmes in communities would also be a big threat.

The explanations given above, among other things, have caused modern communication thinkers to put audience participation as a priority. From the mid-1970s through the 1980s and 1990s, the concept of communication was undergoing expansion, mainly to encompass participation as a way of emphasising the interactive dimension of communication.

Where communication is concerned, participation in message making is very important. However, people's participation in message-making, in which identifying the problem, identifying and selecting audiences, outlining the message and context for message delivery, all rest in the hands of change agents, is not genuine participation.

Nair and White (1994) say that genuine participatory message development entails direct involvement of the intended audience in the various processes necessary for constructing and delivering a message, utilising both external and indigenous sources of knowledge. People may, for example, take part in:

(1) identifying and selecting audiences;

(2) conducting needs assessment;

(3) constructing receiver profiles;

(4) outlining message and media options; and,

(5) choosing channels and context for message delivery.

According to Nair and White (1994), a dialogue between the development communicator and the intended receiver, making basic decisions about message-design, would resolve such questions as:

(1) Where does the message content come from?

(2) Who needs information, to who should the messages be directed?

(3) How should messages be constructed and delivered?

(4) What effect is the message likely to have on its receivers?

(5) Who does what in the participatory message development process?

Nair and White (1994) argue that the highest level of participation would find the intended receiver representative involved from needs assessment through material production to final evaluation of effectiveness. On the other hand, a medium extent of participation would concentrate on meaningful participation of the intended receiver in design and production of messages. Low levels of participation would not involve the intended receiver but it is anticipated that the development communicator would, in fact, conduct needs assessment in contact with the receiver. In other words, the development communicator will interview the receivers for information needed for communication programming.

To enhance audience participation in communication, social marketing could be seen as an important alternative of health communication conceptual framework.

At approximately the same time that the concept of communication was being recast to recognise more interaction with the audience (Piotrow et al., 1997), a new and similar concept was introduced from the field of commerce and advertising - social marketing.

First proposed by Kotler and Zaltman in 1971, social marketing was defined by Kotler as "the design, implementation, and control of programmes calculated to influence the acceptability of social ideas and involving considerations of product, planning, pricing, communication, and marketing research" (Kotler and Zaltman in Piotrow et al., 1997)

Originally, social marketing focused primarily on influencing consumer behaviour by emphasising the "four Ps" - product, price, place and promotion. When social marketing was initially adapted to health promotion, especially in the field of family planning, this meant promoting and selling over-the-counter contraceptive products, such as condoms, at subsidised prices that were affordable to a defined population (Altman & Piotrow in Piotrow et al., 1997).

Nevertheless, each of the four elements gradually expanded. Thus, social marketing could promote not only a specific product such as a condom but also a practice such as breast-feeding or non-smoking. Price could mean the psychological cost of adopting a practice that others frowned upon. Place could refer to any distribution channels, commercial or otherwise, that would reach the intended client or consumer. Moreover, promotion could range from point-of-purchase information in pharmacies to billboards, mass media, or any form of advertising and even community entertainment events (Kotler & Roberto, 1989).

According to Piotrow and colleagues (1997), by 1995 the definition of social marketing had expanded to include not only voluntary public health programmes but also many social issues.

> Thus, in the words of Alan Andreason, social marketing is broadly defined as "the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programmes designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society" (Andreason in Piotrow et al., 1997:19).

Social marketing has brought a useful discipline and focus to health programmes, especially family planning, and to the communication component of these programmes. Emphasis on audience research, audience segmentation into identified markets, and the establishment of market niche for specific methods reinforced the new emphasis on addressing the concerns and unmet needs of the audience. Moreover, calling on the professional skills of the commercial communication industry, such as market research firms, advertising agencies, and public relations organisations, stimulated creativity in health communication. Social marketing is generally playing a critical role in promotion of health. Health promotion organisations ought to enhance social marketing skills to achieve positive behaviour change. Behaviour change is essential to promotion of health.

3.2 Behaviour change as a process

As more attention is focused on the audience, as individuals, as clients, and as customers, and on the exchanges between providers and clients, health communicators should employ theories of communication and behaviour change that emphasise process. These theories help to explain the process that individuals go through as they exchange information and as they interpret and react to different messages.

There are examples of numerous models of this process developed in different fields. In the late 1940s, Hovland and colleagues developed the first mass communication impact model that described the communication process as a hierarchy, leading from cognition to effective response to behaviour or action (Piotrow et al., 1997).

Another example is in the field of marketing and advertising, where the model specified six stages in an individual's change: attention, interest, comprehension, impact, attitude, and sales (Piotrow et al., 1997). According to Piotrow and colleagues (1997), this evolving model closely resembled the classic model of the diffusion of innovations developed in rural sociology, which now includes five stages: knowledge, persuasion, decision, implementation, and confirmation.

One additional example, cited by Piotrow and colleagues (1997), is the convergence concept of communication used in the revised diffusion model. This specifies five individual steps in the process - perception, interpretation, understanding, agreement and action. It goes a step further by adding three social outcomes: mutual understanding, mutual agreement, and collective action. In addition, a 12-step input-output communication/persuasion model was developed by social psychologists to describe the persuasion process (McGuire, in Piotrow et al., 1997).

According to Piotrow and colleagues (1997), the most recent model of health behaviour change comes from the field of psychotherapy. It consists of five stages of personal change: pre-contemplation, contemplation, preparation, action, and maintenance of new behaviour (the first two steps are examples of intrapersonal communication).This model has been applied to individual and group counselling for alcohol and drug addiction. Piotrow and colleagues (1997) argue that the striking similarity of these models across such diverse scientific and applied disciplines suggests that a "stage" model is almost appropriate for health communication.

Other behaviour change models emphasise different stimuli for behaviour change but are compatible with the concept of a gradual, systematic process. Social comparison and influence theories, for example, emphasise the effect of social interaction on individual behaviour. Network analysis illustrates how communication networks can provide a source of new ideas and a stimulus for behaviour change.

To facilitate the development of strategic communication programmes that are appropriate for family planning and reproductive health, Population Communication Services developed a theoretical framework termed the Steps to Behaviour Change (SBC). This framework, as stressed by Piotrow and colleagues (1997), is an adaptation of diffusion of innovations and the input/output persuasion model, enriched by social marketing experience and flexible enough to use other theories within each of the steps, or stages, as appropriate. It consists of five major stages of change: knowledge, approval, intention, practice, and advocacy.

The SBC framework shows how individuals and groups progress from knowledge to sustained behaviour change and advocacy. It emphasises that behaviour change - and thus communication intended to influence behaviour - is a process. It recognises that behaviour change is the goal but that people usually move through several intermediate steps before they change their behaviour. Further more, it suggests that people at different stages constitute distinct audiences. Thus they usually need different messages and sometimes different approaches, whether intrapersonal, interpersonal communication, community mobilisation, or mass media.

According to Piotrow and colleagues (1997), this SBC framework has been refined by advances in theory and by practical experience in implementing communication programmes. These modifications recognise the following:

(1) Not all individuals go through each step of the process in the same order, at the same speed, or at the same time.
(2) As knowledge and approval reach high levels in more advanced programmes, emphasis shifts to later steps, such as identifying effective cues to action, maximising access to and quality of services, identifying and removing barriers to change, reinforcing current users, and creating opportunities for advocacy.
(3) Social norms and public policies influence individual behaviour change. Therefore political leaders, policy-makers, and local people of influence are part of the audience

for most mass media communication, most community mobilisation activities, and much interpersonal communication.

(4) Advocacy for behaviour change, through public acknowledgement, promotion by satisfied users, and support for programmes, is the final stage of behaviour change. Once the benefit of behaviour change or any other health practice are confirmed by experience, a person's public advocacy of the practice to others cements conviction and sustains the new behaviour. Advocacy also helps other people move through the steps by offering them a behavioural model and confirming community norms. Advocacy is positive feedback to the process of behaviour change. (Piotrow et al., 1997:23-24)

Piotrow and colleagues (1997) makes a summary that the communication process is characterised by a sequence of intermediate outcomes and feedback. Progress from one step to the next increases the probability of behaviour change and continuation. Family planning and other forms of health communication is an adaptive social process, in which changes in a population have positive response effects that can accelerate the rate of change. Public policy and communication programmes influence both individual and social change, establishing new community norms and, over time, providing support for stronger and more effective policies and programmes.

To apply the SBC framework, a survey research is needed to identify different segments of the population in terms of their current stage of change. This again consolidates the preposition that research is an essential component of communication for social change. This implies that communication practitioners must have working knowledge of operations research.

3.3 Mass Media vs. Interpersonal Communication

The influence of mass media on health communication is becoming increasingly visible. Despite the fact that even without any modern communication media, people communicate, exchange ideas, and alter their behaviour, the unprecedented growth of

mass media - first print, then radio, then television and now computer communication - has raised new possibilities for rapid global communication and thus new theories about how people may react and change as a result of mass media.

The current theories, although they have been criticised in one way or the other, do have a lot of truth in them. In other words, these theories are valid except that they have loopholes and this is expected in social sciences. Social sciences, being studies of human beings, always have theories that are not universal in all circumstances. The reason behind this phenomenon is that humans cannot be 'boxed' to behave in the same manner consistently. Health communicators should know these theories and see how they can apply specific theories in promoting health.

In the early 1970s, expectations that mass media could have direct effect on mass behaviour had faded. A 'limited effects' view of mass media was gaining ground. Klapper (1960) concluded that mass media by themselves - apart from reinforcing the status quo - do not act as the sole cause of audience effects but rather as contributory agent through a set of mediating factors and influences. Research in the United States of America was showing that important individual differences in gender, age, education, and psychological pre-disposition led to selective exposure, attention, retention, and perception of mass media messages (Klapper, 1960). The notion of homogeneous 'mass' audience was being replaced by the notion of heterogeneous audience comprised of different types of individuals and different subcultures, each with different ways of looking at the world.

This discovery gave birth to the concept of audience segmentation. Audience segmentation emerged, consistent with theories of behaviour change and marketing that could guide political, consumer, and other types of mass media campaigns and focus resources where the potential for change was the greatest.

In another development, research on the US presidential campaign in the 1940s led to the 'two-step flow' hypothesis of mass media effects (Piotrow et al., 1997). This hypothesis

posited that the media had direct effects on opinion leaders, who then had indirect effects on other members of the audience by means of interpersonal communication (Karz & Lazarsfeld, in Piotrow et al., 1997). By the end of the 1970s the accepted view of the mass media was that they were effective for increasing awareness but that only interpersonal communication could persuade or motivate action (Rogers, 1983).

Recent studies have shown that even interpersonal communication cannot be persuasive in the absence of certain conditions. According to Infante and colleagues (1997), there are six dimensions of persuasion situations. These situations include intimacy, dominance, resistance, rights, personal benefits and long-term consequences.

3.3.1 Intimacy

Intimacy as a dimension of persuasion implies that persuasion situations will vary in terms of how personal, meaningful, and perhaps intimate the source's relationship is with the receiver. This communicates the idea that how personal, meaningful or intimate you are to the people you want to change influences your ability to succeed.

It is much easier to persuade people with whom you maintain a personal, meaningful or intimate relationship than those you are not close to. Hence, to persuade people in a particular community, concerning health behaviour, health communicators must use members of the target community. These maintain the ideal relationship with their fellow community members. Perhaps the past health campaigns have not been very successful because of the tendency of using people who are not known in the communities to conduct persuasion campaigns.

3.3.2 Dominance

Dominance as a dimension of persuasion situation communicates the idea that how dominant or submissive each person is in the situation has a bearing on persuasion. In a persuasion situation, you have the persuader and the persuaded. One of them may be

dominant while the other is submissive. If the persuader is dominant, persuasion is most likely to succeed. However, if the persuaded turns out to be dominant, persuasion might not succeed. Thus, in health promotion, working with the locals for intimacy sake is not enough. Health communicators ought to work with those local people who have some dominance in the community. Such people could be the likes of civic or traditional leaders; the clergy, professionals (such as doctors and teachers) and senior civil servants like school heads.

3.3.3 Resistance

The third dimension of persuasion situations is resistance. This alerts us to the fact that persuasion situations vary in terms of how agreeable the receiver is to the object of persuasion. The relationship between the persuader and the persuaded could be intimate or dominant but if the persuaded do not agree with the object of the recommended course of action persuasion may not occur. This happens because of many reasons. Sometimes the object of the recommended course of action may not be seen as appropriate by the target adopters. Sometimes the persuaded might misunderstand the object of the recommended course of action. To avoid such problems, health communicators must involve local opinion leaders in programme design as well as implementation. There must also be a lot of research, among other things, to look into collectively held beliefs that may hinder persuasion.

3.3.4 Rights

Fourthly, there is the 'rights' dimension of persuasion situations. This alludes to the justification that the source has for asking the receiver to do something; whether or not the source has reasonable grounds for the request. To this effect, if health communicators are to persuade people to adopt certain behavioural patterns, they ought to work with people whose right for asking people to do certain things would not be questioned.

People are much more likely to be persuaded once they see that the person requesting them to take a certain course of action has justification or reasonable grounds for doing so. For example, a medical officer is much more justified to ask people to use condoms. He/she is the one who treats them when they get infections. Similarly, the clergy are perceived to have reasonable grounds for asking people to abstain from casual sex. The clergy are the custodians of society's moral fibre.

3.3.5 Personal benefits

Personal benefits constitute the fifth dimension of persuasion situations. This dimension looks into what the source would gain by succeeding in the persuasion attempt and may reflect advantages for the receiver in fulfilling the source's wishes. If, as health communicators endeavour to promote health, what they would gain by succeeding is appealing to the people, people are more likely to be persuaded. However, where people evaluate what the health communicators stand to gain by succeeding in their persuasion attempts negatively, they are not likely to be persuaded. People should also see the advantage for them for fulfilling the wishes of health communicators. They should not feel deceived or used.

3.3.6 Long-term consequences

The sixth dimension in persuasion situations is long-term consequences, which communicates the ideal that situations vary in terms of whether the persuasion will have long-term consequences for the relationship between the source and the receiver. If the relationship will indeed have long-term consequences, persuasion is likely to occur. Nevertheless, if it is short term, people might just agree to a proposal in order to please and get rid of the communicators and afterwards they abandon the proposal.

These six dimensions of persuasion situations namely intimacy, dominance, resistance, rights, personal benefits and long-term consequences are very essential to the success of interpersonal communication. Without them, interpersonal communication would just be

3.4 Entertainment for educational purposes

The development of entertainment for educational purposes is becoming the pillar in ideal conceptual frameworks for health communication.

Entertainment can be used effectively to promote health. The Johns Hopkins Centre for Communication Programmes (JHU/CCP, 1998) has coined the term "Enter-Educate". It is a contraction of two words "entertainment" and "education". This term was coined to describe any communication presentation that delivers a pro-social educational message in an entertainment format.

According to JHU/CCP (1998), every Enter-Educate product consists of two equally important parts: the format (entertainment) and the message (education). In this relationship, the purpose of entertainment is to attract and hold the attention of the audience by engaging their emotions. The purpose of education is to enhance the knowledge and skills of the learners so that they can reach their potential.

> Entertainment is enjoyable. Education is empowering. (JHU/CCP, 1998:vii)

Combining education and entertainment has been with us throughout history. For example, prophets of long ago are recorded to have used parables to illustrate religious tenets.

Lessons learnt globally show that popular approach has proven itself a persuasive and profitable means of communicating a pro-social message. It is believed that the passion that emotional performances convey can make many Enter-Educate messages resonate at a personal level, and often elicit a passionate participation from the receivers of the messages (JHU/CCP, 1998).

Enter-Educate products and performances have a huge potential of becoming more profitable and more capable of influencing people's attitudes, intentions, and behaviour.

To this effect, organisations and individuals engaged in social change, using Enter-educate, must explore new ways of developing the best products and performances.

In 1989, the first Enter-Educate conference was held in Los Angeles (JHU/CCP, 1998). By then people were not even sure that Enter-Educate approach could change health behaviour on a significant scale. Participants struggled then to try to explain why Enter-Educate were a useful approach. It was then that participants came up with the 4Ps - that is, that Enter-Educate works because of the 4Ps. It is (JHU/CCP, 1998:p6):

(1) Pervasive: it reaches everyone, everywhere, via media, local events, music, or drama.
(2) Popular: People like and enjoy entertainment.
(3) Persuasive: People are persuaded because they can see and copy role models.
(4) Profitable: it generates revenue and helps pay for itself.

According to JHU/CCP (1998), over the past few years after 1989 research has shown that Enter-Educate is important for many more reasons. For example, not only is it pervasive, profitable, persuasive, and popular, it is also passionate, personal and participatory. It evokes emotions that help to stir recall and action. It also enables individuals to identify strongly with the depicted characters. In addition, it provides opportunities for many people to join in simple entertainment.

The Enter-Educate approach relies heavily on the social learning theory advocated by Dr. Albert Bandura (JHU/CCP, 1998). This theory states that most behaviour is learned through modelling - a person observes other people and uses their behaviour as a model for future behaviour. This theory posits that people do not learn new behaviour unless it is demonstrated. Entertainment both attracts attention and provides a format for demonstrating new, desired behaviour.

JHU/CCP (1998) says entertainment works by creating an emotional arousal in the viewer - a reaction necessary for behaviour change to occur. In entertainment-education, entertainers, producers, writers, directors, and health professionals must work together to

produce quality products that have commercial and audience appeal as well as powerful, factually correct social messages.

Community drama or street theatre can be culturally appropriate and sensitive to the context. It may be an ideal communication vehicle for some settings because it has the strengths of both mass media and interpersonal communication.

Entertainment has been used as a teaching tool for thousands of years. It has not lost any value, as everyone likes to be entertained. Entertainment tells the audience things that mothers, for example, are too timid to say to their children.

Piotrow and colleagues (1997) record that some other scholars developed a dependency theory of mass media that specified a three-way interaction among audiences, media, and the larger social system. According to this theory, a group's (or audience segment's) dependency on a medium such as television or radio for information increases when:

(1) That medium supplies information that is central to the needs of that group; and,
(2) When social change, conflict, and social instability increase uncertainty and ambiguity.

Increased dependency on mass media for information increases the impact of mass media on knowledge, attitudes, and behaviour. Health communicators can make use of this assertion if they could know, through formative research, the needs of the target group. Generally, research will guide a systematic process for developing strategic communication programmes. Research must kick off the communication processes that are followed by heath promotion organisations.

3.5 Systematic processes for developing strategic communication programmes

Desired social change is one of the most challenging phenomena to achieve in health promotion. It rarely happens by chance. It is influenced by a number of factors, acting as

barriers, both at individual and societal levels. These factors range from individual attitudes to societal norms. To face this challenge, there is need for strategic communication planning and implementation.

This is the reason why there is increasing demand for development of communication programmes that are systematic and strategic. Many organisations are beginning to be systematic and strategic in the communication programming. For instance, the design, implementation, monitoring, and evaluation of Johns Hopkins communication projects follows "The Processes and Principles for Health Communication Projects," known as the P Process.

According to Piotrow and colleagues (1997), the P Process (in which P can stand for project or programmes) is valuable because it is:

(1) Systematic and rational;
(2) Continually responsive to research findings and data;
(3) Practical for field applications at all levels; and,
(4) Strategic in setting and pursuing long-term objectives.

The P Process consists of six steps that are followed in sequence to develop and implement effective national communication strategies, programmes, or, indeed, any organised communication activity. These are:

(i) Analysis - listen to potential audiences; assess existing programmes, policies, resources, strengths and weaknesses; and analyse communication resources.
(ii) Strategic design - Decide on objectives, identify audience segments, position the concept for the audience, clarify behaviour change model, select channels of communication, plan for interpersonal discussion, draw up an action plan, and design evaluation.

(iii) Development, pre-testing and revision, and production - Develop message concepts, pre-test with audience members and gatekeepers, revise and produce messages and materials, retest new and existing materials.

(iv) Management, implementation, and monitoring - Mobilise key organisations, create a positive organisational climate, implement the action plan, and monitor the process of dissemination, transmission, and reception of programme outputs.

(v) Impact evaluation - Measure impact on audiences and determine how to improve future projects.

(vi) Planning for continuity - Adjust to changing conditions; plan for continuity and self-sufficiency. (Piotrow et al., 1997:27)

On the other hand, Kotler and Roberto (1989) have propounded the social marketing management process consisting of five steps:

(i) Analysing the Social Marketing Environment - know the attitudes, practices and behaviour of the target adopter population in relation to the issue of interest.

(ii) Researching the Target-Adopter Population - break the target-adopter population into segments that have common characteristics in responding to the social campaign.

(iii) Designing Social Marketing Objectives and Strategies - specify the game plan for achieving the objectives of the social marketing campaign. Define the broad principles by which you expect to attain your objectives in a target-adopter segment.

(iv) Planning Social Marketing Programmes - prepare the management of social marketing mix programme in more detail.

(v) Organising, Implementing, Controlling and Evaluating the Social Marketing Effort - organise the marketing resources, implement the social marketing mix programmes, control the performance of the

programme and evaluate the results (the social and ethical impact) of that implementation.

The steps presented by Piotrow and colleagues (1997) and those propounded by Kotler and Roberto (1989) gave the writer the conceptual framework or model of communication processes expected in health promotion organisations. With this conceptual framework, the writer (student) was attached to the Zambia Integrated Health Programme, communication component (ZIHP-Comm) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

CHAPTER FOUR
PERSONAL EXPERIENCES DURING THE ATTACHMENT

The purpose of this chapter is to highlight some personal experiences of the student during the attachment. The chapter gives an overview of the Zambia Integrated Health Programme (ZIHP). It thereafter gives details of the student's experiences while at ZIHP. The later part of this chapter gives the overview of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and ends with the experiences of the student while at UNAIDS Inter-country Team for Eastern and Southern Africa (ICT/ESA).

4.1 ZIHP overview

ZIHP is one of the programmatic responses to health problems in Zambia. It was developed by the United States Agency for International Development (USAID), in partnership with the Government of the Republic of Zambia (GRZ). Its purpose is to address the main health problems of the people of Zambia and to continue the process of health reform.

ZIHP focuses on the following areas:

(i) Communication or behaviour change;
(ii) Community partnerships;
(iii) Improved health worker performance;
(iv) NGO strengthening;
(v) Private sector partnerships; and,
(vi) Systems support.

ZIHP functions in teams. There are specific teams working on different programmatic areas. For example, there is a team looking at communication (ZIHP-Comm.). There is another team looking at systems (ZIHP-Sys). Another team is looking at service delivery (ZIHP-Serv.). The other team looks at social mobilisation (ZIHP-Sob.).

This student was attached to ZIHP-Comm. ZIHP-Comm. is the Zambia Integrated Health Programme, communication component.

A Chief of Party heads ZIHP-Comm. team. Other staff positions include the following:

(i) Deputy Chief of Party;
(ii) Behaviour Change Specialist;
(iii) Community Partnerships Specialist;
(iv) District Co-ordinators;
(v) District Assistants;
(vi) Media Relations Co-ordinator;
(vii) Media assistant;
(viii) Radio Assistant;
(ix) Research and Evaluation Co-ordinator;
(x) Women's Package Co-ordinator;
(xi) Men's Package Co-ordinator;
(xii) Youth Package Assistant; and,
(xiii) Administrative/support staff

ZIHP-Comm. implements communication interventions in the following areas:

(i) HIV/AIDS;
(ii) Malaria;
(iii) Integrated reproductive health; and,
(iv) Child health and nutrition.

ZIHP-Comm.'s target audiences are:

(i) Adolescents;
(ii) Women caring for children;

(iii) Pregnant women; and,

(iv) Men;

4.2 The Beginning of the Attachment

When the student had his attachment proposal approved by the School of Humanities and Social Sciences, he approached the Chief of Party for ZIHP-Comm., six months before the attachment commencement date. He had a discussion with Ms. Elizabeth Serlemitsos, the Chief of Party for ZIHP-Comm. Ms. Serlemitsos said she had no objection to the attachment. She, however, wanted to know if the attachment had any financial obligations on her organisation. To this, the student replied that he was fully sponsored, in which case the sponsors were to meet all the expenses for the attachment. At this point, the attachment was approved and the Chief of Party requested the student to leave the approved proposal so that it could be put on file, for other staff members to know what was going on.

When the attachment was almost due, in August 2001, the student reported at ZIHP offices, to remind the Chief of Party about the pending attachment. However, the Chief of Party had gone out of the country and there was an Acting Chief of Party Ms. Uttara Bharath. Fortunately, Ms. Bharath was well aware of the attachment.

Although there was still about two weeks before the proposed starting date (August 20th, 2001) for the attachment, Ms. Bharath, who had worked with this student before, asked him to start the attachment sooner than that date. She said that there was some work that she wanted the student to assist with. The student obliged and reported for work a week before the official starting date.

The student attended a staff meeting on the first day of reporting for practical attachment. At this meeting, the student introduced himself and stated his terms of reference. The terms of reference were as follows:

(i) To be oriented with ZIHP-Comm., as a health promotion organisation;

(ii) To carryout an inventory of all communication materials that ZIHP-Comm. had produced in the year preceding the student's attachment;

(iii) To interview members of staff at ZIHP-Comm. who were involved in materials production;

(iv) To give feedback about the findings by means of an in-house seminar or any other appropriate means;

(v) To observe the communication processes employed among ZIHP-Comm. technical staff as they plan and implement communication activities; and,

(vi) To participate in ZIHP-Comm. activities.

Members of staff said they were happy to have the student in their midst. They pledged to work with him and support him as much as they could. The Acting Chief of Party said there was one issue for which she needed the student to report much earlier for his attachment. She said that there was an issue to do with setting up a non-governmental organisation.

She gave the background to this issue, which was that the Soul City production team, in South Africa, wanted to extend their project to Zambia (Soul City is an HIV/AIDS educational television programme). The production team was looking for partners in Zambia who could produce the programme locally while Soul City South Africa was to raise funds.

During their search for partners, the Soul City team identified ZIHP as a potential partner. The Soul City team found that ZIHP had professionals who could handle the production of the programme. The identified ZIHP component to carry on the production of Soul City was the communication component.

When negotiations were launched, it was discovered that ZIHP did not exist as an entity. It was just a concept, with no mechanism for receiving money from additional donors other than those funding specific ZIHP components. Following this hitch, parties to the

negotiation reached consensus that a non-governmental organisation (NGO) be formed. The NGO was to stand on its own but draw technical staff from ZIHP-Comm. To this effect, ZIHP-Comm. was given the responsibility of forming an NGO.

The NGO was given the name: Zambia Centre of Communication Programmes (ZCCP). In the process of registering this NGO, it was learned that the Registrar of Societies needed a constitution to register the NGO. In view of this development, ZIHP-Comm. needed someone to write the constitution. This task was given to the student.

This student wrote a 21-article constitution for ZCCP, on behalf of ZIHP-Comm. This process involved visiting several NGOs to look at their constitutions. The student read several constitutions to gather ideas of what to include in the ZCCP constitution.

Most of the articles from other constitutions were adaptive. Articles to do with membership, organisation structure, meetings and so on were very much adaptive. The only problem was to do with objectives because there was no NGO in Zambia that was entirely devoted to communication programmes. It was thus a bit difficult to find ideas relating to what a communications programme NGO would aim to achieve.

After some time of research, ideas were gathered. Internationally, there were some countries with similar NGOs. The following were the 13 objectives formulated for ZCCP:

1. To promote/adapt/develop/undertake/implement communication activities for the health of the people.
2. To provide technical assistance to government and non-governmental organisations, private sector agencies, co-operating agencies and other institutions in adapting, developing and implementing communication programmes in terms of research, strategy development, media materials and training to achieve goals of enhanced health.

3. To follow the steps of social change communication as the conceptual framework for meeting unmet communication needs at the individual and community levels through collaboratively designed regional, national and local communication strategies.
4. To organise and hold workshops, conferences, seminars and training programmes with a view to build and enhance capacities of individual professionals and institutions of the principles and processes for strategic project design and implementation, material development and evaluation, state of the art protocols to enhance health knowledge and skills to improve programmes from inception to replication.
5. To involve with a broad range of communication activities and promote community mobilisation, interpersonal communication and mass media designed to have an impact on social change by increasing advocacy, knowledge approval and practice.
6. To conceptualise, design and launch national campaign in collaboration with other organisations with a view to promote coverage of health services in the community.
7. To conduct research/studies/surveys with a view to generate reliable data on human attitudes and behaviours with regard to health and related activities and impact of specific interventions in these areas, to identify barriers (individual and social) to the acceptance of recommended services and to suggest appropriate measures to overcome these.
8. To forge appropriate linkages with STD/AIDS prevention, integrated reproductive health, child health, malaria and programmes to promote health in the family, community life and leadership.
9. To produce and distribute various communication materials and job aids in the field of health through activities like films, videos, booklets, leaflets, posters and counselling tools for promoting health issues.
10. To produce, sponsor and support enter-educate programmes, television and radio serials, drama, magazine, songs and other entertainment programmes to bring persuasive health message to a wide audience of women, men, young adults, policy makers, providers, and many others.
11. To conduct specific activities under specific projects based on contract/agreement with other organisations/institutes/agencies in the field of health.

12. To disseminate information on health related matters through publication of reports/journals/newsletters and other printed materials.
13. To carryout other lawful acts which are conducive to the attainment of the above objectives and to the upliftment and welfare of the people of Zambia.

ZCCP could not, however, be immediately registered. At the time of the student's practical attachment, there was a debate of whether to establish a new NGO or to use existing ones. The main argument from the donor community was that there were already enough NGOs that could house the Soul City project. On the other hand, ZIHP-Comm. findings had revealed that nearly all the NGOs with objectives that could support production of Soul City were too busy with their own activities. The NGO was finally registered and it is currently fully operational.

While the NGO issue was pending, awaiting a way forward, which never came until the practical attachment was over, the student carried out an inventory of communication materials that had been produced a year before his attachment. This process involved asking all technical staff at ZIHP-Comm., who were involved in material production, to submit a list of materials that they had produced in the previous year. The inventory was followed by interviews with the technical staff. The findings are discussed in a later chapter.

As for the experience during this exercise, the process was quite slow. The technical members of staff were very busy with new activities. They found it cumbersome to start digging out work that they had already done rather than focussing on new things. The student had to send numerous reminders before they could respond. Three of the eight technical staff did not even submit the lists until the practical attachment period was over. Even the time for interviews was also a problem. Two technical staff could not be interviewed.

All the technical members of staff at ZIHP were very busy with fieldwork. They had to conduct supervisory visits in districts, attend workshops, meetings, conferences and so

on. It was very difficult to have all of them at the office premises. Among other reasons, this made it even impossible to have a seminar to discuss the findings of the interviews.

In terms of the student participating in ZIHP-Comm. activities, there were only a handful of members of staff who were willing to share their work with the student. Most of them did not understand the ultimate goal of the student's attachment - whether he had come to learn or to look for a job. It was feared, perhaps that the student could be recommended for their jobs. The participation only revolved around attending meetings and reviewing materials that had already been produced.

The student was, however, kept busy enough with meetings and materials review. He was also given assignments by other organisations outside ZIHP from time to time. These organisations included Zambia Information Services (ZIS), United Nations Population Fund (UNFPA) and Women in Law and Development in Africa (WiLDAF).

During the same period, the student made contact with the Joint United Nations Programme on HIV/AIDS Inter-country Team for Eastern and Southern Africa (UNAIDS ITC/ESA). This organisation invited the student for a two-month contract, as Temporary Adviser and the following were the terms of reference:

1. Work with the ICT/ESA Communication advisor to host the UNAIDS-UNICEF consultative meeting on the Communication Framework;
2. Initiate dialogue with all co-sponsors on the establishment of the Technical Resource Network for Behaviour Change Communication (BCC) practitioners in the region;
3. Work with ICT/ESA Communication Advisor to conduct a technical review of the Media and HIV Report for publication; and,
4. Carryout any other duties as directed by the Team Leader or the 'telling-the-story' (TTS) Programme Manager.

4.3 Overview of UNAIDS ICT/ESA

The UNAIDS Inter-country Team for Eastern and Southern Africa (ITC/ESA) is the regional office that co-ordinates HIV/AIDS programmes in Eastern and Southern Africa. Its coverage extends from South Africa to Eritrea, covering all countries in Southern and Eastern Africa.

UNAIDS, as an agency of the United Nations (UN), was established in 1993. It is the main advocate for global action on HIV/AIDS. UNAIDS leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV. It provides care and support, reducing the vulnerability of individuals and communities to HIV/AIDS and alleviating the impact of the epidemic.

UNAIDS is a joint programme that was outlined by a resolution of the World Health Assembly in 1993. It is made up of eight UN agencies, which are referred to as co-sponsors. These are:

1. United Nations Children's Fund (UNICEF);
2. United Nations Development Programme (UNDP);
3. United Nations Population Fund (UNFPA);
4. United Nations Education, Scientific and Cultural Organisation (UNESCO);
5. World health Organisation (WHO);
6. World Bank;
7. United Nations International Drug Control Programme (UNDCP); and,
8. International Labour Organisation (ILO).

The goal of UNAIDS is to catalyse, strengthen and orchestrate the unique expertise, resources, and networks of influence that each of these organisations offers. Working together through UNAIDS, the co-sponsors expand their outreach through strategic alliances with other UN agencies, national governments, corporations, media, religious

organisations, community-based groups, regional and country networks of people living with HIV/AIDS, and other non-governmental organisations.

UNAIDS operates at three levels. It is at global, regional and national levels. At global level, policies are made. At regional level, support is given to countries through regional advisers. At national level, UNAIDS supports country programmes.

The student was attached to a regional office. A Team Leader heads the regional office. The Team Leader presides over regional advisers and support staff. Advisers travel around member countries to give technical backstopping. The student was working under the Communication Adviser.

4.4 Experiences During the Attachment

When the student arrived for attachment, he had a de-briefing with the Communication Adviser. After the de-briefing, he was invited to a staff meeting where he was introduced to the rest of the team members and he was thereafter given an office. The student received very good reception from the team.

On the first day of the attachment the student took some time to read literature about UNAIDS and its activities. On the second day, he started doing assignments given by the Communication Adviser. The assignments revolved around the terms of reference stated above. The student was mainly involved in writing papers in relation to expanding the use of the Communication Framework for HIV/AIDS, among co-sponsors.

UNAIDS has published a book entitled *"Communications Framework for HIV/AIDS: A New Direction"*. This book covers a new and more adaptive framework for HIV/AIDS communications. Unlike many earlier approaches, this framework is based more on social and environmental context than on individual behaviour. Most of HIV/AIDS communication programmes have been aimed at achieving individual-based changes in sexual and social behaviour. This publication has revealed that five domains of context

are virtually universal factors in communications for HIV/AIDS preventive health behaviour - government policy, socio-economic status, culture, gender relations, and spirituality. These interrelated domains form the basis of the new communication framework that UNAIDS wants the co-sponsors to adapt.

Almost all the activities the student engaged in where related to making the new communications framework accepted and appreciated among co-sponsors. Outside this, the student participated in a staff retreat, which was about team building.

The rest of the details are given in chapter six, which discusses the student's input. The next chapter discusses the problems and constraints of ZIHP-Comm. and UNAIDS ICT/ESA.

CHAPTER FIVE

PROBLEMS AND CHALLENGES

This chapter highlights problems and challenges of the two institutions (ZIHP and UNAIDS) where the student was attached. The chapter focuses on the communication problems and challenges, which the two organisations face in their efforts to promote health. For the purpose of this piece of work, communication problems refer to any problem that can be solved through communication. In addition, communication challenges refer to barriers to achieving communication objectives.

The chapter does not thus give prominence to logistical problems of the institutions but to the problems and challenges affecting health. To this effect, the writer has only alluded to logistical problems where they affect the institutions' attempts to solve communication problems and challenges.

ZIHP is focusing on HIV/AIDS, Malaria, integrated reproductive health, child health and nutrition. UNAIDS is focusing on HIV/AIDS. In all these areas, there are numerous communication problems and challenges that the two institutions are facing. The writer has tried to discuss some of these problems, as he perceived them during the six months practical attachment with the two institutions. The writer also brings out the attempts by the institutions to solve the problems.

5.1 HIV/AIDS

HIV/AIDS is a new global problem and every nation worldwide is threatened by it. It kills by damaging the body's defenses against other diseases. So far, there is no known cure for HIV/AIDS. Nevertheless, prevention of infection and of early death for those who are already infected is possible.

Both of the institutions to which the student was attached were tackling the problem of HIV/AIDS. The student identified the problems and challenges that both institutions were

facing in their efforts to fight HIV/AIDS. Generally, ZIHP is dealing with the problem of attitudes and behaviours of the target audience (Zambian population) while UNAIDS is dealing with the problem of co-sponsors' and partners' approaches to HIV/AIDS programming.

In Zambia HIV/AIDS is mostly spread through sex. Virtually every community in Zambia has people that engage in sex whether by their own choice or forced by others. ZIHP-Comm., as a health promotion organisation, is implementing various activities to educate the communities about HIV/AIDS. The student identified a number of communication problems and challenges confronting ZIHP-Comm. efforts. These problems and challenges ranged from individual behaviour and attitude to societal norms. The identified problems and challenges make people get infected, even with all the educational campaigns by organisations such as ZIHP-Comm.

5.1.1 Men's Attitude and Behaviour

The first problem that the student identified is that men refuse (or society does not assist them) to protect themselves. Men tend to believe that they are more manly if they can have multiple sexual partners. Moreover, society does not pay attention when a man has multiple sexual partners. Society allows a man to marry more than one wife (polygamy), which is not the case with women. Men thus tend to do what is 'expected of them'. They tend to have multiple sexual partners, which puts them at a very high risk of contracting HIV, consequently creating a problem and a challenge for ZIHP-Comm., as a health promotion organisation.

The other problem is that most men want to prove that regardless of their age they are still 'on' and 'dangerous'. They refuse to grow up. When their wives reach menopause, some men would still go to look for younger women. This puts them at a very high risk of contracting the AIDS virus.

As an attempt to solve this set of problems, ZIHP-Comm. is encouraging male involvement in its interventions. In the structure of the institution, a co-ordinator for male involvement package has been included. In the male involvement package, ZIHP-Comm. purports to encourage men to be fully involved in the prevention of HIV/AIDS and in other reproductive health related issues. The institution seeks to reach men with the message that they are at a higher risk of dying from AIDS because of their externally influenced behavioural patterns. As men attempt to do what society prescribes for them, they end up contracting the AIDS virus and spreading it further. ZIHP-Comm. is encouraging men to act responsibly in matters related to sexuality. ZIHP is targeting men with messages encouraging condom use and faithfulness to one sexual partner.

5.1.2 Boys' Attitude and Behaviour

Another problem is that most boys also want to prove the issue that they can impregnate a girl. They want to prove that they have grown into men by trying to make babies. By so doing, most of them end up contracting the AIDS virus.

As an attempt to solve this problem, ZIHP-Comm. is supporting youth organisations that are reaching out to young people, with safer sex promotion messages. The organisations that ZIHP-Comm. was supporting at the time of the student's attachment were:

(i) Youth Activists Organisation (YAO);
(ii) Youth Media Group;
(iii) Africa Alive! Zambia; and,
(iv) Directions Africa.

These organisations were reaching out to the youth in various ways. For example, YAO was conducting football camps, among other activities. Members of YAO would go to various places, including rural areas, to conduct football camps. The camps were organised in such a way that youths of a particular community would be gathered in a

camp to learn football skills and at the same time be taught about reproductive health. ZIHP-Comm. was responsible for the funding of the football camps.

Youth Media Group was publishing a youth newspaper known as *Trendsetters*. This newspaper was being circulated to all parts of the country. ZIHP-Comm. was responsible for the financing of the publishing of *Trendsetters*.

Africa Alive! Zambia was reaching out to the youth through music shows. These were being organised in such a way that famous musicians would hold road shows to play their popular songs and songs of HIV/AIDS awareness.

The offices for YAO, Youth Media and Africa Alive! Zambia were located along Lusaka's Longolongo Road. ZIHP-Comm. furnished and equipped the offices for these youth organisations.

Directions Africa was reaching out to the youth by making recreation facilities available. It was discovered that most youths engaged in illicit sex because they lacked recreation. Directions Africa intervened by making available recreation facilities, such as pool tables, to the youths and provided reproductive health lessons during recreation times. The Directions Africa centre was situated in Mtendere township of Lusaka.

5.1.3 Non-empowerment of Women and Girls

The other problem identified is that, at society level, females are not accorded real power to effectively negotiate for safer sex or refuse sex. More power in sexual issues has been ascribed to men, who at most times do only what is pleasing to them and not to their female counterparts. This makes it very difficult for women to protect themselves from contracting the AIDS virus.

As a response to this problem, ZIHP-Comm. has a Women's Package, with a co-ordinator. In this package, ZIHP-Comm. purports to promote reproductive health for

women. The package has a gender aspect that tries to promote equality between men and women, so that there is equal decision-making power on sexual matters.

The student noted several other problems during the attachment. One other problem was that where a couple fails to have children, society usually tends to put blame on the woman. This forces women to go out of their way and seek other sexual partners to make them pregnant. As they engage in this activity, women find themselves being exposed more to contracting the AIDS virus.

5.1.4 Poverty

Compounding the problem of HIV/AIDS, due to poverty and hunger, many people are offering unprotected sex. They know that the virus will kill them after many years but hunger will kill them in a matter of days.

ZIHP-Comm. is generally concentrating on behaviour change by emphasising the main dangers, which such attitudes may cause the people. ZIHP-Comm. has a strong component of behaviour change communication, as a response to the many behaviour patterns that are influencing the spread of HIV/AIDS. In the structure of ZIHP-Comm., there is a position of Behaviour Change Communication (BCC) specialist.

5.2 Malaria

Malaria is spread by the bite of a mosquito. Mosquitoes breed wherever stagnant water can collect: in ponds, swamps, pools, pits, drains, sometimes even tin cans and hoof-prints. They may also breed along the edges of streams.

Though the problem of malaria seems as if it is a problem that can just be solved by issuing an instruction, it is also complicated. The major complication arises from the fact that people in Zambia have much more serious concerns than draining ponds, pools and the like. With the kind of poverty around, people are more concerned about finding

means of economical survival. They would rather engage in economically gainful activities than in executing malaria preventive measures.

A notable attempt to solve the problems associated with malaria prevention was the promotion of the use a treated mosquito net. The treated mosquito net has been designed to kill mosquitoes. When a mosquito comes in contact with the net it dies instantly. It works very well, by not only preventing mosquitoes from biting a person covered by the net but also by reducing the number of mosquitoes in homes.

The student also identified other ZIHP-Comm. attempts to solve the attitudinal problems associated with malaria prevention. For example, the problem was being addressed through a radio and television programme called "Your Health Matters". Print educational materials were also being produced to campaign against malaria.

5.3 Reproductive Health

Reproductive health is defined as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters related to reproduction. Reproductive health addresses the reproductive processes, functions and system at all stages of life. It demands that people are able to have a responsible, satisfying and safe sex life, and that they have the capability to reproduce and the freedom to decide, if, when, and how often to do so.

Many factors affect reproductive health in Zambia. Attaining reproductive health is a big challenge to health promotion organisations like ZIHP. Its attainment is not limited to the interventions by the health sector alone. Reproductive health affects and is affected by, the broader context of people's lives. These include economic, education, employment, living conditions, family, and environment, social and gender relationships, and traditional and legal structures within which they live. In short, reproductive health behaviour is governed by complex biological, cultural and psychological factors.

As an attempt to solve the problem of reproductive health, ZIHP-Comm. has adopted an integrated approach to reproductive health. The reproductive health component is thus known as 'integrated reproductive health'. This approach involves working with different stakeholders who are able to approach reproductive health from different angles. By using an integrated approach, ZIHP is able to intervene in the complex biological, cultural, and psychological factors that govern reproductive health. ZIHP-Comm., produces educational materials on reproductive health, including print and audiovisual materials.

5.4 Child Health and Nutrition

In child health and nutrition, as a subject area, ZIHP purports to promote health of children by educating the people in Zambia on the kind of food necessary for the child to grow healthy.

The problem of promoting child health and nutrition, as perceived by this student, is that most families in Zambia can hardly afford to provide good food for the children. The main reason behind this unfortunate situation is that a majority of the people of Zambia (about 80%) live below the poverty datum line. Another reason is that people generally lack knowledge about looking after children.

As a response to the problem of child health and nutrition, ZIHP-Comm. has a Children's Package. In this package, ZIHP-Comm. promotes child health and nutrition among members of the community. This is done through radio and television programmes, such as 'Your Health Matters'. Print materials are also produced to disseminate the information on childcare.

5.5 Programming for HIV/AIDS Interventions

UNAIDS looks at HIV/AIDS programmes at different levels, including global, regional and country level. In terms of HIV/AIDS communication programmes, UNAIDS is faced with the problem that most HIV/AIDS programmes focus on an individual.

UNAIDS has found it problematic that most HIV/AIDS communication programmes have been aimed at achieving individual-based changes in sexual and social behaviour. Seeking to influence behaviour alone is insufficient if the underlying social factors that shape the behaviour remain unchallenged.

It is a problem to UNAIDS that many communications and health promotion programmes proceed on the assumption that behaviour, alone, needs to be changed, when in reality, such change is unlikely to be sustainable without incurring some minimum of social change.

UNAIDS has noted many inadequacies and limitations of current theories and models derived from them. While on attachment at UNAIDS ICT/ESA offices in Pretoria, Republic of South Africa, this student was oriented to several weaknesses in current theories and models. They included the following:

(i) The simple, linear relationship between individual knowledge and action, which underpinned many earlier interventions, does not take into account the variation among the political, socio-economic, and cultural contexts that prevail in the regions.

(ii) The emphasis on quantitative measures (rather than qualitative inferences or a combination of both) results in distorted interpretation of meanings and realities in observed behaviours.

(iii) External decision-making processes that cater to rigid, narrowly focused, and short-term interests tend to overlook the benefits of long-term, internally derived, broad-based solutions.

(iv) The assumption that individuals can or will exercise total control of their behaviour has led to a focus on the individual rather than on the social context within which the individual functions and a disregard for the influence of contextual variables, such as culture and gender relations.

(v) There is an assumption that decisions about HIV/AIDS prevention are based on rational, volitional thinking with no regard for more true-to-life emotional responses to engaging in sexual behaviour.

(vi) There is an assumption that there is a sequential, linear relationship between knowledge, attitude, belief, behaviour, and practice (KABBP), when engagement in sexual intercourse often precedes any rational decision based on full or even partial knowledge of risk-taking behaviour.

(vii) There is an assumption that creating awareness through media campaigns will necessarily lead to behaviour change.

(viii) There is an assumption that a simple strategy designed to trigger a once-in-a-lifetime behaviour, such as immunisation, would be adequate for changing and maintaining complex, life-long behaviours, such as consistent condom use.

(ix) There is nearly exclusive focus on condom promotion at the exclusion of the need to address the importance and centrality of social contexts, including government policy, socio-economic status, culture, gender relations, and spirituality.

(x) Approaches based on traditional family planning and population programme strategies tend to target HIV/AIDS prevention to women, so that women, rather than men, are encouraged to initiate the use of condoms, for example.

In addition to the theory limitations discussed earlier, this student was also oriented to notable communication frameworks. These included:

(i) Academy for Educational Development (AED);

(ii) AIDS Control and Prevention Project (AIDSCAP);

(iii) Program for Appropriate Technology in Health (PATH); and,

(iv) Johns Hopkins University's Population Communication Services (PCS).

Some common elements in the above-mentioned frameworks were considered immensely useful in developing a context-based communications strategy for UNAIDS. These were traditional elements in the social marketing approach, but which could add to the contextually focused framework. The elements included the following:

(i) Information gathering and analysis;
(ii) Planning process;
(iii) Pre-testing the strategy (messages);
(iv) Elements of implementation;
(v) Monitoring and evaluation; and,
(vi) Feedback to planning.

Like in the theories, the lack of contextual focus has been seen as a major limitation in all these frameworks. As a response to this problem, UNAIDS recognised that a new communication framework was needed, especially to focus on populations in Africa, Asia, and Latin America and the Caribbean, which have not been adequately served by conventional prevention strategies and packages.

UNAIDS reasoned that while any new framework may draw on relevant components of existing theories and practices, a new focus, based on experience gained and research carried out in these regions, should be placed on responding to varied social contexts. In particular, communication strategies - particularly when addressing HIV/AIDS in Africa, Asia, and Latin America and the Caribbean - should evaluate ideas and assumptions that may be considered foreign. Effective approaches can only be developed and refined when the framework for each region, nation, and locality is locally derived.

Most theories underlying the models and frameworks used in HIV/AIDS prevention were derived from social psychology and communications. Furthermore, many of these formulations have been borrowed from family planning and population programmes, which have successfully advanced the understanding and use of Information, Education and Communication (IEC). Nevertheless, in-depth evaluations of the applicability of the

borrowed theories, models, and frameworks to the special circumstances of HIV/AIDS prevention and care are rarely if ever, made.

One of the principal uncertainties, for instance, is whether communications can be credited as a determining factor in observed behaviour changes. This is particularly true when the mass media form part of the mix. How the differences between the social contexts of the origins of the behavioural models and the contexts where the transplanted models are expected to yield positive results influence outcomes is also unclear.

In response to the overwhelming burden of new cases of HIV in Africa, Asia, Latin America and the Caribbean, UNAIDS, in 1997, initiated a project to examine the application of existing communication theories/models to HIV/AIDS prevention and care in these regions. Following that project, a new communications framework for HIV/AIDS has been developed. It marks a departure from a focus on the individual to a focus on five domains of 'contexts' that influence behaviours: government policy, socio-economic status, culture, gender relations, and spirituality.

Following the development of this communications framework, the current problem that UNAIDS ICT/ESA office in Pretoria is facing is that its use has not expanded among co-sponsors. The institution is making every effort possible to expand the use of the new communications framework among co-sponsors. Regional workshops are being organised and several publications are being written to expand the use of the new communications framework.

CHAPTER SIX

INPUT OF THE STUDENT

The previous chapter alluded to some of the problems that the institutions, which the student was attached to, were facing. This chapter discusses the student's input in helping to solve those problems and the reaction of the institutions to the suggestions, as well as results of trying out some of the suggestions. The first part of the chapter deals with the input during attachment at ZIHP while the later part deals with the input while at UNAIDS.

6.1 Input During Attachment at ZIHP

As stated earlier, the student was attached to ZIHP-Comm. for a period of four months. During this period, the student endeavoured to work with ZIHP-Comm. professional staff closely. There was however, a slight problem in that a few of the professional members of staff were not quite sure as to whether the student had gone to learn or to secure employment. There was a very strong suspicion that the student wanted to make a mark with management so that he could be taken on board. This perceived suspicion resulted in the unfortunate situation that the student was rarely involved in most of the institution's activities.

The only major assignment that the student undertook at ZIHP-Comm. was the drafting of a constitution, which he has alluded to in chapter four. For the rest of his stay at ZIHP-Comm., the student participated in meetings at the institution. Sometimes he could also represent a member of staff at a meeting called by collaborating partners of ZIHP-Comm. Apart from meetings, the student could also be given communication messages and materials to review.

6.1.1 Input During Professional Meetings and Workshops

6.1.1.1 Advice on materials production

At meetings, the student gave hints on producing communication for social change materials. In the hints, the student emphasised a shift in the approach to communication.

The kind of problems and challenges that ZIHP-Comm. was facing, as discussed in chapter five, there is need for communication with a vision. Gone are the days when communication was done with the sole purpose of just informing people, exposing scandals, showing things as they are or merely presenting facts.

For today's communication problems and challenges, there is need for comprehensive programmes of intervention that must aim at having some specified influence upon individual or collective knowledge, attitudes, and behaviour using a combination of communication channels.

To overcome communication problems in health, communication must encompass planned interventions aimed at influencing knowledge, attitudes, awareness, beliefs, values, behaviour or norms within individuals or groups of individuals using a variety of communication channels in a complementary manner. Communication must be used to create awareness on emerging issues in health. It must also be used to motivate people to adopt new attitudes or behaviour, or to utilise existing services in responding positively to emerging issues.

The student emphasised that the purpose of communication should be to change attitudes, beliefs, values, behaviour or norms within individuals or groups of individuals. Thus, the expected outcome of a communication intervention in health is a change in individual or community awareness, attitudes, values, behaviour or norms. Communication intervention must strive at creating awareness and increasing knowledge on health issues. Awareness and knowledge are pre-requisites to people's approval of new ideas and practices. For example, people will only approve the use of condoms when they are

aware of the risk to contract the AIDS virus and they have the knowledge of avoiding infection.

Applied effectively, communication can serve as a tool in contributing to solving problems that are assumed could be solved by changes in attitude and/or behaviour of designated audiences.

6.1.1.2 Advice on the use of communication

The student at one ZIHP workshop, held at Andrew's Motel, pointed out that ZIHP could use communication to reduce the knowledge, attitude, and practice (KAP) gap that exist in the area of HIV/AIDS. A hypothetical illustration is that you could have 100 people who know about HIV/AIDS, 60 out of these 100 could have the positive attitude that they are vulnerable to HIV/AIDS but only 30 of the 60 could be practicing safer sex.

This represents gaps between knowledge, attitude and practices. Communication practitioners must thus aim at closing these gaps, such that the number of people who know the dangers of HIV/AIDS should be the same as those who recognise their vulnerability and those who practice safer sex.

6.1.1.3 Advice on the mandate of communication practitioners

Communication practitioners ought to recognise the fact that people must make their decisions freely, responsibly and in an informed manner in all aspects of their lives. Communication practitioners must only assist them to make informed choices. This affirms the principle that people cannot be forced or manipulated in matters pertaining to their attitudes and behaviour. They make their own decisions. For example, you cannot force or manipulate people concerning condom use. When you are not there, they will do what they think is right. As such, you only need to help them make informed choices. Create awareness, increase their knowledge, persuade them to adopt recommended practices, build approval for the new practice and give them the skill for implementing the new practice.

6.1.1.4 Advice on identifying target audiences

In the issues that ZIHP was dealing with, the student pointed out that communication needed to be based on the needs of well-defined and researched audiences. Audiences have to be specific in terms of their needs, where they live and so on. Communication practitioners must take into account people's concerns, perceived needs, beliefs and their current practices.

Communication for social change addresses two main audiences, that is, the primary and secondary audiences. A primary audience refers to those people whose behaviour, attitudes and practices you want to change. A secondary audience refers to those people who have a direct influence on the primary audience. For example, if you want to promote condom use among sexually active adolescents, the boys and girls aged 14 to 24 could be the primary audience. The parents and teachers, among others, could be the secondary audience.

Dividing the audiences into primary and secondary is very important. Success to change the primary audience entails that you have met your communication objective. Success to change your secondary audience means that the behaviour induced in the primary audience will be sustainable. In other words, if you change boys and girls alone, their parents may not approve of the new behaviour such as condom use. Once this happens, it will mean that the boys and girls will be scared to posses condoms, which makes it difficult for the boys and girls to practice the new behaviour.

6.1.1.5 Advice on advocacy

The student also spoke about advocacy. Advocacy is a form of social change communication that aims at influencing legislation, policies, programmes, strategies and positions held by influential people (opinion leaders). This was to remind health promotion institutions that it is not enough to target individuals. There is need for a supportive environment for individuals to practice their newly acquired behaviour. For instance, a health promotion organisation may successfully persuade people to use condoms but laws of a country might not permit the provision of condoms in certain

places. To solve this dilemma, advocacy for the change of laws is needed so that condoms are made available.

Advocacy can broadly be defined as a set of actions undertaken by a group of individuals or organisations to create a favourable environment in terms of introducing, changing or ending specific policies, laws, strategies, programmes or views of influential people. Advocacy is concerned with policies, legislature, programmes, and positions of groups of individuals or organisations. It requires networking and coalition building to broaden the base of support to bring about desirable changes.

Advocacy objectives introduce, end, or change policies (including traditional values/norms), programmes or legislation or shifts the position of influential individuals or organisations on specific issues. Advocacy objectives focus on a specific action that an institution or group can take. They are normally specific and measurable.

Advocacy audiences are in four categories namely beneficiaries, partners, adversaries and decision makers.

(i) Beneficiaries

Beneficiaries are those individuals or groups of individuals who stand to benefit directly from a positive outcome of an advocacy intervention. For example, if you want a policy that entails that every toilet at University of Zambia (UNZA) should be stocked with condoms, as an HIV prevention measure, the students are the beneficiaries. The students become a target of your advocacy. They must see sense and appreciate want you want for them. If they do not, your intervention may fail because they can simply tell the decision-makers that they are not for that idea. They can even shun to use the facility if the decision-maker went ahead to implement the policy. For such reasons, an agent of social change ought to target the beneficiaries of the new policy, law, programme etc. This is important for the reason of winning the support of the beneficiaries. As an advocate, you need to take beneficiaries to a level were they begin to demand for the services that will

emanate to the policy or programme that you are advocating. When the beneficiaries are in the forefront, the success rate for advocacy is increased.

(ii) Partners

Partners, as an audience for advocacy interventions, refers to all individuals, groups and organisations who hold a similar view or position on the issue or cause and who are sufficiently convinced and committed to join in a coalition to fight for the cause. In the example given above, ZIHP-Comm. could identify partners like Society for Family Health (SFH), Family Health Trust (FHT) and the like. Such organisations could be targets for advocacy interventions. They need to be targeted so that they understand the cause and the role they can play. With successful advocacy tactics, partners are able to contribute their own resources to fight for a cause, even when they are not the initiators.

(iii) Adversaries

Adversaries, as an advocacy audience, refers to all individuals and groups that hold a view or position different from, or opposed to the issue or cause being advocated for. In the example of condoms, religious bodies could be such an audience. Adversaries usually have a reason. As a change agent, you ought to listen to the reason that they have. You need to negotiate with them. Adversaries should not be seen as enemies. Once they are convinced, they end up becoming very influential partners. You need to employ strategies to convince adversaries.

(iv) Decision-makers

Decision-makers constitute another advocacy audience. These are individuals or groups of individuals with power or authority to act to bring about the changes being sought. In the example of condom provision to UNZA, the University management is the decision-maker. This is the audience to which more effort must be directed. It is their action that will lead to the success of the advocacy intervention. Beneficiaries, partners and adversaries may be won over but if the decision-maker has not been won over, then the advocacy intervention has failed.

To be a successful advocate, one needs to develop skills in applying advocacy tactics. Below are some examples of advocacy tactics that the student shared with ZIHP workshop participants at Andrews Motel in 2001:

1. *Building Alliances* - for example forming coalitions, which is a group of several like-minded organisations working together to achieve common goals.
2. *Networking* - Networking is simply initiating and maintaining contact with other individuals and organisations who share or support the coalition's goals and who can help to achieve them,
3. *Lobbying* - the process of achieving public policy goals through the selected application of political pressure.
4. *Canvassing* - going from door-to-door or approaching people in the street, to educate them about the issue and recruit their support.
5. *Debating* - arguing for and against a particular issue.
6. *Negotiating* - process of trying to reach a compromise.
7. *Petitioning* - Act of sending formal written supplication from one or more persons to sovereign authority.
8. *Dialoguing* - Exchanging opinions and views through round table discussions.
9. *Social Mobilisation* - bringing together partners and allies to raise awareness of/demand for particular programmes.
10. *Testimonial* - self-account or narration of someone who has gone through some experience, either positive or negative.

Communication practitioners ought to sharpen skills in advocacy tactics for successful advocacy interventions. To this effect, the student was never short of emphasising continuous training for communication practitioners at professional meetings. At the office level, the student engaged in message review.

6.1.2 Input in Message Review

Occasionally, some professional staff at ZIHP-Comm. brought materials that they were in the process of producing to the student for review. The student developed a checklist for reviewing communication materials. The checklist consisted of the following elements:

1. *Simple* - a message must be simple for the target audience to understand. The student made sure that the messages given to him for review were not written in jargon or in big words. Communication professionals sometimes want to make an impression that they are very educated. Consequently, they use big words that the audience fails to comprehend. In this light, the student suggested that some messages be developed in local languages so that the target audience may understand them.
2. *Specific* - a message must be specific to the audience and to what it is telling the audience. For example, if you want a man to look after his wife and children well, do not say 'look after people well'. It is more effective to say 'married men provide for your children and wives so that they do not become prostitutes'.
3. *Accurate* - a message must be truthful. In this line, the student cross-checked the statistics given in the materials to ensure that they were accurate. Accuracy in health messages may include causes of diseases, effects of diseases, impact of diseases and many more. The student took time to see that there was accuracy in the messages.
4. *Clear* - a message must be clear. The target audience must be able to get the meaning of a message without external help. Most people receive messages without anybody around to explain the meaning. As such, messages must be self explanatory, with no degree of ambiguity.
5. *Directed towards an objective to be obtained* - a message must be able to relate to an objective to be achieved. If the communication objective is to persuade young people to abstain from sex, the message developed must persuade the target audience to abstain from sex.
6. *Compatible with physical, social, mental and economic capabilities of audiences* - a message must not ask the target audience to do something that is contrary to their physical, social, mental and economic capabilities. For example, it is not wise to

market a million-dollar car to peasant farmers. It is not compatible with their economic capabilities.

7. *Appropriate to the channel selected* - a good message must suit the channel selected. For example, a message requiring demonstration cannot go in a newspaper. It is better placed on television where people can see the demonstration.
8. *Appealing* - a message must be appealing to the target audience. A message should cater to the heart of a reader or listener.
9. *Attractive* - a message must catch the attention of the target audience. It must be attractive by way of matching the aspirations of the target audience. Along this line, the student checked if the message communicated a benefit.
10. *Timely* - a message must come at the right time. Regarding this characteristic, the student checked to see if the message was coming at the right time to the target audience. An example of a message that is not timely might be one that asks people to vote for a particular candidate long after the elections. In health, an example could be a preventive message that is sent to people who are already suffering from a disease.
11. *Applicable to the issue* - a good message must be applicable to the issue at hand. If the issue at hand is condom use, a message should not talk about the number of hospitals in the country, for example.
12. *Action oriented* - a good message must ask the target audience to take a specific course of action. Along this line, the student checked if the message had a call to action.

The checklist enabled the student to give a near professional review of materials. He suggested changes to materials objectively, regardless of the officer who produced them.

6.1.3 Results of trying out suggestions

Almost all the suggestions that the student made to ZIHP-Comm. were taken without reservations. On message reviews, it was very rare that suggestions were not accommodated. The suggestions were always based on professional guidelines that were difficult to dispute.

6.2 Input during Attachment at UNAIDS ICT/ESA

The student was attached to UNAIDS ICT/ESA for a two-month period. This attachment had specific terms of reference for the student's participation in the activities of the institution. The terms of reference were as follows:

1. Work with the ICT/ESA communication adviser to host the UNAIDS-UNICEF consultative meeting on the Communications Framework;
2. Initiate dialogue with all co-sponsors (especially UNICEF) on the establishment of the Technical Resource Network for behaviour change communication practitioners in the region;
3. Work with Communication Adviser to conduct a technical review of the Media and HIV Report for publication; and,
4. Carry out any other duties as directed by the Team Leader or the 'Telling-the-Story' (TTS) Programme Manager.

Under these terms of reference, the student served as UNAIDS ICT/ESA communication temporary adviser for two months. During this period, the student undertook various assignments specifically relating to expanding the role and use of the new UNAIDS Communications Framework for HIV/AIDS. As stated in the previous chapter, UNAIDS was concerned about the approaches to HIV/AIDS communication programming. This concern led UNAIDS to develop a communications framework for HIV/AIDS, which would address the concerns. Having successfully developed the framework, UNAIDS wanted to expand its role and use among UNAIDS Co-sponsors and partners.

Among the strategies of expanding the role and use of the Communications Framework for HIV/AIDS, UNAIDS had planned to have a consultative meeting with UNICEF and other partners. UNICEF was singled out among the Co-sponsors outlined in chapter one because it is the Co-sponsor funding communication programmes for UNAIDS.

6.2.1 Consultative Meeting

The student in collaboration with the Communication Adviser hosted the said consultative meeting. Representatives from UNICEF Kenya, Tanzania, and South Africa attended the meeting. Other participants came from Health Scope, Tanzania, British Council, Kenya, and PACT, Ethiopia.

The purpose of this consultative meeting was to explore the formulation of a joint communication strategy for UNAIDS and UNICEF. Consensus was reached that UNICEF and UNAIDS would use the integrated approach to help governments in Eastern and Southern African region to develop communication strategies for HIV/AIDS, which focus on the social and cultural context for change, rather than the behaviour of individuals.

6.2.2 Working Paper

Following the discussions during this consultative meeting, participants resolved to write a working paper to guide communication practitioners. It was agreed that the working paper should state that current communication responses to HIV/AIDS do not address the complexity of the problem. The integrated communication strategy would respond to the complex nature of the pandemic by facilitating community ownership of HIV/AIDS programmes and helping to realise the rights for people infected and affected by the pandemic.

UNICEF and UNAIDS ICT/ESA, where the student was attached, was given an assignment to write a chapter for the working paper to include the following aspects:

1. Definition of community - UNAIDS domains - what it means to live in a community; and shared values.

2. Programme shifts to human rights processes and principles - communities as subjects, not objects of change. The challenge of operating at a community level on a national scale.
3. The need for a new language/vocabulary.
4. The need for community information and knowledge systems so that rights holders can participate in HIV/AIDS programmes more effectively, and be accountable to themselves.

The student's input in this exercise was to draft the segments of the chapter for the ICT Communication Adviser to edit and finalise. At the time the student was leaving the ICT/ESA office, the draft chapter had been sent to Nairobi, Kenya where UNICEF Eastern and Southern Africa Regional Office (ESARO) was consolidating the working paper.

6.2.3 Technical Resource Network

At the time of the student's attachment, the establishment of the Technical Resource Network (TRN) for behaviour change communication practitioners in the region was high on the agenda. UNAIDS ICT/ESA wanted to have a team of experts in each member country that would give technical backstopping to country communication programmes. The main task was to visualise what the TRN would be like and what the terms of reference were going to be. The input of this student was that he held discussions with the ICT Communication Adviser to decide what the work of the TRN was going to be. It was agreed that the TRN was going to help in designing communication strategies for member states. To this effect, it was resolved that behaviour change communication experts would constitute the TRN. By the time the student was winding up the attachment, he had drafted the terms of reference for the TRN and forwarded them to the Communication Adviser for editing and finalisation.

6.2.4 Editing Workshop Reports

This student also had input in the editing of workshop reports. At the time the student reported for attachment, UNAIDS ICT/ESA had held two major workshops. One was held in Zimbabwe and another in Malawi. The student was requested to edit the reports for the two workshops so that they could be sent to participants. At the time the student left South Africa, the reports had been edited and handed over to the Communication Adviser for proof reading and dispatch.

6.2.5 Online Research and Report Writing

The student undertook several other assignments at the UNAIDS ICT/ESA office. The additional assignments included searching the Internet for specified information and writing reports after meetings. As an added advantage, the student was given an opportunity to attend two workshops. One was on costing HIV/AIDS programmes and the other one was on 'team building'. Both of these workshops were highly beneficial to the student.

Generally, the student enjoyed the practical attachment at both ZIHP-Comm. and UNAIDS ICT/ESA. It was a good learning experience.

CHAPTER SEVEN

FINDINGS AND DISCUSSION

This chapter discusses the findings of the attachment on the communication processes employed by health promotion organisations. In chapter three, the student established a theoretical framework for health communication. In this chapter, the student tries to relate the findings of the attachment to the theoretical framework. This was a qualitative study in which the student used informal discussions, in-depth interview questionnaires and participant observation to find out the communication processes employed by ZIHP-Comm. and UNAIDS.

7.1 The Findings about ZIHP Communication Process

ZIHP-Comm. reaches its audiences through different communication channels. The student conducted an inventory of communication materials that ZIHP-Comm. had produced in the previous year. His findings were that professional members of staff had produced a variety of materials. The materials ranged from print to audio-visual. Various sections reported that they had produced brochures, posters, booklets, fliers, leaflets, newspaper articles, radio broadcasts, television broadcasts, calendars, books, cue cards, and counselling packages.

The organisation, however, registered a minor weakness in that most professional staff rarely kept record of what they had produced. Most of the sections could hardly tell this student the materials that they had produced in the previous year. Some of them could remember that they produced some materials but could hardly remember on what topic they were.

From the onset, the student set to find out the communication process that ZIHP-Comm. was following. The institution informed the student that it was using a communications framework known as the 'P Process', where 'P' stands for planning. This did not come as

a surprise to the student in that ZIHP-Comm. had full backing of the Johns Hopkins University (JHU), which has developed the P-Process communication framework discussed in the previous chapters. The P-Process is a step-by-step planning process for communication programming.

The attention of the student thus shifted to finding out how individual communication professionals in ZIHP-Comm. utilised the P-Process communication framework. To this effect, the student designed a questionnaire to establish how the professionals implemented the aspects of the P-Process. The questionnaire information was supplemented by four-months of participant observation technique. The writer first highlights the findings yielded through a questionnaire and then discusses these findings and those yielded through participant observation technique in the light of the theoretical framework.

This student asked the professional staff in the different sections of ZIHP-Comm. a set of questions to establish how they implemented the different steps of the P-Process. The P-Process, as discussed in chapter two and chapter three, has six steps, namely:

1. Analysis;
2. Strategic Design;
3. Development, Pre-testing, and Production;
4. Management, Implementation and Monitoring;
5. Impact evaluation; and,
6. Planning for continuity.

Following are the questions this student asked and some of the notable responses:

(i) How do you get started with the production of materials?

"We identify the needs of the target audience through communication diagnosis. This is where we go into the community and see what is lacking. We actually

involve the target audience in the identification of needs, through participatory learning methods."

"Young people come up with the concepts. Concepts are pre-tested then the design team look at the most popular concept and endorse it for an agency to develop final products."

"The workplan for the better health campaign has different topics for each month. We just follow the topics and produce mass media materials. These could be newspaper articles, radio or television programmes."

"We identify a group of people with the expertise and interest in the subject. Then we explain the concept to the group and come up with draft messages or write-ups."

"We begin by developing materials for pre-testing then pre-test them with the intended audiences."

(ii) Before producing materials, how do you identify what the people already know about the subject covered, if at all you do?

"We look at the materials that have already been produced to see what information was left out. We also look at previous survey reports and focus group discussion reports."

"In the case of radio programmes and support materials, we have pre-test questionnaires sent out then when they are sent back we are able to see the gaps and work on them."

"Before material production we either do a literature review on the subject or if information is not available we do an assessment to find out what people know."

"We run a quiz which gives us an idea of how much people already know and whether they get our messages correctly. We also ask them to write in."

"Through research and participatory learning methods."

"We bring people together to find out what they already know and through that we are able to identify the gaps."

(iii) Before producing materials, how do you investigate the people's attitudes, beliefs, values or practices in relation to the subjects covered, if at all you do?

"Letters that come in give us the understanding of their attitudes."

"Before final production of any materials a pre-testing is done among audience members to find out about the attitudes, beliefs, values or practices."

"We send a pre-test questionnaire."

"Through in-depth interviews."

"Through focus group and information discussions"

"Through participatory learning approaches."

(iv) What are some of the examples of the objectives set to be achieved by any of your materials, if at all you do set any?

"Neighbourhood health committee (NHC) cards were produced to support neighbourhood health committees - information sharing on planning and implementation of interventions as specified in the cards."

"The 'You Can't Tell by Looking" poster was produced to emphasise that you cannot tell who is HIV positive just by looking. In other words, the objective was to correct the misconception that most young people have, that they can tell who is HIV positive just by looking."

"The NHC cards were produced to increase knowledge among NHC members so that they in turn pass on this knowledge to community members for the purpose of preventing diseases in the community."

"The counselling kit was produced to assist providers to be able to counsel clients on the risk of contracting STI including HIV and the use of the condom even within a marital relationship."

"One episode of 'Your Health Matters' was produced with the objective of creating awareness about the need for eye health and to encourage people to take care of their eyes."

(v) If at all the target audience participate in the development of the messages contained in your materials, how do they participate?

"Audience takes part in the quiz. Besides, draft message strategy is taken to the community for comment."

"The target audience is made to participate either from the design stage or during any of the other stages e.g. pre-testing."

"They are involved in pre-testing of materials."

"Through the youth advisory group. This is a consortium of young people in the target group. For each phase new people are brought in."

"We involve the target audience in the identification of needs. We use participatory learning approaches."

"Most of the materials do not have participation of the audience per se but they give information during research and they participate through pre-testing."

(vi) If at all subject specialists are involved in the production of your materials, how are they involved?

"They are called to look at the materials to see if there are any gaps."

"The design team consists of communication practitioners and subject specialists."

"They give input on the technical content of the materials. This includes scripts for the radio programmes."

"Once a subject specialist is identified, he/she advises on what should come on the programme."

"We have a technical group that has different subject specialists."

(vii) If at all your materials are pre-tested, how are they pre-tested and what components of effectiveness do you investigate?

"Pre-testing is done with the experts."

"Suitability of language. Are they realistic? If stories are used, are they real and culturally sensitive?"

"All materials are pre-tested for language simplicity, cultural correctness and correctness of the information."

"We do two rounds of focus group discussions, one for pre-testing and the other for re-testing. The components we look for are the relevance of message, cultural appropriateness, appealing capability and believability."

"We pre-test to see if the message is understandable and if it is addressing the problem. We also pre-test to see if the materials are culturally acceptable to the target audience and the secondary audience."

"We pre-test for clarity, picture meaning, language appropriateness, and required improvements. Technical people from the districts and CBOH do the pre-test."

(viii) What dissemination plan have you put in place for the dissemination of materials, if at all there is any?

"We post."

"Collection of different newspaper cuttings are sent to some members of the target audience. Health supplement are also produced sometimes."

"Through training workshops with target audiences."

"We distribute materials to Neighbourhood Health Committees (NHC) who register with us."

"We have no dissemination plan. We give to people as they travel. We do not even have a budget for dissemination."

"During training workshops trainers give out materials. We also have partner organisations that help in the distribution. We have no specific budget for dissemination."

(ix) What monitoring mechanism have you put in place for monitoring materials, if at all there is any?

"NHC cards have a monitoring plan. NHC groups are visited. Fliers are monitored by visiting the educators. Organised sectors are visited but for sectors like farmers it is difficult to monitor."

"There is no definite plan."

"We have a pre-test and post-test questionnaire."

"The materials are given out with a monitoring questionnaire that is sent back to us. This ensures that materials are produced and distributed according to plan."

"We monitor through survey and interviews."

"Central supervisors carry a monitoring instrument to administer to the centres. Interviews with people attending the facility and figures of people attending the facility are collected."

(x) What evaluation plan do you have for materials that you produce, if at all there is any?

"There is no systematic plan. Sometimes the number of people, who attend a facility, gives us an indication of how successful our efforts have been."

"We have no evaluation plan."

"We have a record review to give us an indication of the impact. Sometimes we have interviews with both clients and providers. We also compare information from baseline surveys."

"We conduct a mid-term review survey."

7.1.1 Discussion of the findings

7.1.1.1 Analysis

The respondents were asked how they got started with the production of materials because in chapter three we learned that health communication is strategic. The kind of communication that we need to solve health-related problems, such as the type ZIHP-Comm. was dealing with, goes beyond the ad-hoc 'let-us-print-a-brochure'.

There must be a variety of things to consider before coming up with that brochure. Most cardinal is for a communication practitioner to find out primary and secondary audiences. When you are faced with a health communication problem, you must identify whose behaviour must change for communication objectives to be achieved. For example, if ZIHP-Comm. finds that people are not planning their families, the institution cannot just decide to print brochures. It might so happen that the involved people are unable to read, for example. If the audiences are already known, then from the onset one would know how best to reach them.

Beginning with identifying primary and secondary audiences is therefore the best way to get started with production of materials. It is an essential aspect of operationalising the 'Analysis' step of the P-Process. A communication analysis must always begin by identifying primary and secondary audiences. From this step, you get to know the message to send, the channel to use, the language to use and many other things.

Respondents were also asked as to how they identified what the people already knew about the subject covered, and what the people believed, hoped for, and practised, before producing materials for them.

As shown by the responses above, respondents applied some techniques to find out what people already knew about the subject matter. What may be questioned is the seriousness with which this was being done. The methods used as seen in the responses above and the student's on-the-scene observation show that this aspect of analysis was not taken seriously. This aspect of finding out what people already know, believe, hope for, and practice is very vital in persuasive communication. Persuasive communication takes the audience's way of seeing things. Messages that tend to have an effect on the target audience build on the audience's current thoughts, feelings, and needs and do not disregard or contradict them.

This aspect being so important, communication practitioners ought to listen to what people say. This will take them to live among the target audience for a while. It contradicts the idea of producing materials in Lusaka for the people in rural areas, where communication practitioners have never lived.

Although analysis is a very essential step of the P-Process, the results of the attachment showed that it received little attention. The institution as a whole seemed not to have guidelines on doing an analysis for communication materials development. Generally, although the professional staff represented one organisation they reported different approaches to conducting analysis. To this, the student deduced that ZIHP-Comm., as an organisation, did not have a common approach to applying analysis to the communication process. How each person approached the exercise depended on their own preferences and capabilities.

7.1.1.2 Strategic Design

To investigate how the respondents operationalised the second step of the P-Process, which is Strategic Design, respondents were asked as to whether they set objectives for

their communication interventions. Both the responses from the in-depth interviews and from the observations showed that the professional members of staff were very alert to objective setting. Nearly each message was sent with an objective to accomplish.

The importance of setting communication objectives cannot be over-emphasised. An institution measures whether it is making an impact or not by referring to the objectives set. Whether a programme should be scaled up, continued or discontinued is a decision based on the achievements measured through pre-set objectives.

7.1.1.3 Development, Pre-testing and Revision, Production

The third step of the P-Process, which is development, pre-testing and revision, production, was largely a matter of observation. The student observed whether the institution was developing messages and producing materials. He however had to investigate whether the materials where being pre-tested. From the in-depth interviews, respondents registered that they did pre-test the materials for various components of effectiveness. Nevertheless, this student observed that the materials that ZIHP-Comm. sub-contracted professionals from outside to produce were never pre-tested. One example was a radio and television programme, 'Your Health Matters'. There was no evidence of this programme being pre-tested. In chapter three, we learned that the participation of representatives of intended audiences in pre-testing helps ensure that the materials will speak effectively to actual audiences. Emphasis was laid that even the most careful preparation cannot guarantee that the intended audience will understand messages and materials or find them appropriate, relevant, and persuasive.

> "Pre-testing - that is, asking selected members of the intended audience what they think about the messages and materials - is an excellent way to make sure that the audience is involved and the best way to ensure that materials do indeed evoke the intended response." (Piotrow et al., 1997: 100-101)

Audience participation was very eccentric or unusual in message development by ZIHP communication practitioners. As seen from the responses of the in-depth interviews, the

audience mainly came in during materials pre-testing. Only a few professionals engaged the audience from the onset of message development. Audience involvement as discussed in chapter three is very important. Most successful programmes are those in which the target audience has played a notable role. People feel committed to observing rules that they have set. If people participate in setting rules of how they want to behave, they will feel bound to behave as they have collectively decided.

In terms of subject specialist involvement, ZIHP-Comm. had a very effective and practical strategy. The institution has a concept of 'Design Team'. These teams are made of communication practitioners and health specialists. Health professionals provide input and review materials for technical accuracy. The input of health professionals is essential throughout the process; not only in the selection of appropriate broad objectives and accurate messages but in the design of specific materials.

7.1.1.4 Management, Implementation, and Monitoring

When it came to the fourth step of the P-Process, which is Management, Implementation, and Monitoring, the student asked respondents about dissemination of materials and monitoring mechanism.

The results did not suggest any effective dissemination plan and monitoring mechanism. This is not a very healthy situation in communication. Without a proper dissemination plan, materials may be produced but end up in a storeroom. As we saw in the previous chapters, dissemination is a separate activity, requiring a specific plan and budget. It is a waste of resources to produce materials that fail to get to the target audience.

Monitoring is equally important. Regular and accurate monitoring helps ensure that outputs are produced as planned. It also ensures that materials get to the target audience and are being used as intended. The target audience may sometimes discover a new use of a communication material. For example, people may find a magazine meant to teach them a skill very useful for wrapping vegetables in the markets. This may increase

demand for the magazine that you may mistakenly take for magazine popularity. With regular monitoring, it becomes easy to catch up with such eventualities.

7.1.1.5 Impact Evaluation

On the fifth step of the P-Process, which is Impact Evaluation, the respondents were asked about the evaluation plan. From the responses listed earlier in this chapter, the indications are that ZIHP-Comm. communication practitioners do not produce communication materials with definite evaluation plan at hand.

Impact evaluation is a very essential step in the P-Process. The impact that a programme has feeds into the next and last step of the P-Process, which is planning for continuity. Without impact evaluation it is difficult to plan for continuity of programmes.

7.2 UNAIDS Communication Process

7.2.1 The Findings

The UNAIDS ICT/ESA office does not deal directly with the communities. In terms of communication, it supports countries in the development of communication programmes. The office has a Communication Adviser who visits member countries to assist in developing country communication programmes. In addition to support missions, UNAIDS ICT/ESA organises communication workshops for communication practitioners in the region. The office also engages in the dissemination of best practices. This is a situation where the office records the best practices in communication in member countries and disseminates to other countries.

The ICT/ESA engages in producing many publications in communication to disseminate best practices and to improve the professional capabilities of communication practitioners in member countries.

It was not possible to evaluate the communication process employed by UNAIDS ICT/ESA, in the light of communication for development, because the institution is not involved in direct communication with the communities. The institution is itself involved in re-thinking and developing new communication processes in form of frameworks.

Currently UNAIDS is trying to promote the use of its most recently developed communication framework for HIV/AIDS communication. The office is producing publications and organising workshops to this effect. As stated in the previous chapter, this student participated in some activities aimed at expanding the role and use of the UNAIDS Communication Framework for HIV/AIDS. This framework is a reaction to the current communication programming for HIV/AIDS, which has no contextual dimension. According to UNAIDS, all the current programming focus on an individual, ignoring contextual domains that influence individual behaviour.

CHAPTER EIGHT

CONCLUSIONS AND RECOMMENDATIONS

This chapter re-examines the attachment findings to draw conclusions and make recommendations. The chapter opens with conclusions on the specific findings about how ZIHP-Comm. uses the P-Process. Each conclusion is followed by a recommendation. There after, one overall recommendation is made to UNAIDS ICT/ESA about its support to communication practitioners in member countries.

8.1 The Application of the P-Process

8.1.1 Analysis

The general conclusion about the way that communication practitioners conducted their analysis is that a well-defined procedure was missing. This conclusion can be deduced from the responses that came out when the communication professionals where asked how they got started with the production of materials. Below are samples of the responses that they gave through in-depth interviews:

> "We identify the needs of the target audience through communication diagnosis. This is where we go into the community and see what is lacking. We actually involve the target audience in the identification of needs, through participatory learning methods," one communication practitioner said.

> Another practitioner said, "young people come up with the concepts. Concepts are pre-tested then the design team look at the most popular concept and endorse it for an agency to develop final products."

The ideal way to start developing communication materials is to identify and understand the specific health problem that is the focus of the proposed communication material. You need to identify, from among a set of problems or one general problem, the specific health problem to address. You have to be specific because the key to a successful health communication strategy is to focus on one problem at a time, although many health problems exist and could benefit from your communication effort. Picking too many problems at one time or too general a problem often creates messages that confuse or overwhelm the audience, leading to the audience ignoring the message altogether.

You need to understand the problem clearly. This entails having a clear perception of the extent of the problem. You also need to understand the behaviours that will prevent or treat the problem. Such information will be essential to assisting you in determining potential audiences.

You need to identify the primary and secondary audiences. The primary audiences for a communication effort will usually be the people who are at risk of or who are affected by a particular health problem. To help identify these people, you need to review the available research about the extent of the problem. Medical practitioners are in a better place to explain how the problem spreads and to identify those at risk or who are affected by that problem.

When you identify potential audiences, you need to group them according to common characteristics. Examples of characteristics include age range, gender, occupation, residence, or number of children, as well as lifestyle and access to print, radio, and television media. You have to look for characteristics that differentiate the potential audience from persons who are not at risk or do not face the health problem. You have to be contextual especially by making sure that your analysis is gender-sensitive. You have to consider the different gender roles and relationships among potential audience members.

For each audience, look for information that identifies current health behaviours compared with desired or recommended health behaviours. How close or far away are they from adopting the behaviours? One useful approach is to categorise your potential audience according to the process of a behaviour change model such as those presented in chapter three.

When you interview programme workers, health experts, and members of the potential audience, ask why they think the audiences are not adopting the desired health behaviours. The problem often goes beyond awareness and knowledge. Understanding the barriers to change - even those that may be beyond the ability of communication to

change - is important for making strategic communication decisions. This knowledge will help you to estimate the degree of change that can be achieved within a given period.

After you have identified your potential audiences, find out who influences their health behaviours. Talk with programme managers who work in the community as well as community workers who visit the audience regularly. Make informal visits to communities. Talk with members of the potential audience and community leaders about the health problem.

Another important thing is that you have to gain an understanding of communication environment, including current health communication activities and available resources. It is worth noting that identifying and assessing potential resources that can help you carry out a communication programme is very essential.

You need a delivery system for messages to reach intended audiences. These could be categorised as interpersonal, community-oriented, and mass media.

Interpersonal channels focus on either one-to-one or one-to-group communication. One-to-one channels include peer-to-peer, spouse-to-spouse, and health clinic worker to client. Interpersonal channels use verbal and non-verbal communication.

Community-oriented channels focus on spreading information through existing social networks, such as a family or a community group. This channel is effective when dealing with community norms and offers the opportunity for audience members to reinforce one another's behaviour.

Mass media channels reach large audiences. They are particularly effective at agenda setting and contributing to the establishment of new social norms. Formats range from educational to entertainment and advertising, and include television, radio, and print media, such as magazines, newspapers, and outdoor and transit boards.

Although a variety of communication channels is available, not all channels are suitable for your potential audience. You need to identify those that can reach the potential audiences you have targeted. For guidance, you have to describe communication efforts already going on through the identified communication channels and media. You also need to talk to other people who have conducted communication campaigns in the country. This approach is a good starting point for identifying local partners and for understanding the obstacles and opportunities involved in local communication efforts. Finally, you need to categorise these activities according to the channels, for example interpersonal, community-oriented or mass media.

To ensure effectiveness, remember to look for media use surveys of potential audiences. Demographic and health surveys can be helpful resources for such information. In addition, many countries survey media use by the population. It would also be of great benefit to ask advertising agencies if a media survey is available. Interview programme managers at organisations communicating with your audiences. They can give you a good idea about what has worked and what has not. You may also consider visiting the community where your audience lives and make an inventory of existing media channels, describing the sizes and types of the audience they reach.

Another practical approach to identifying the essential communication channels is to interview the programme managers of existing health projects. Take note of the main channels and formats used by these organisations. Focus on their messages as well as the intended audience. This activity will give you an understanding of the messages that the organisations are already communicating and the extent to which they are well received.

Besides identifying health-related programmes and activities, identify the organisations and professionals who are helping to carry them out. These may be useful to your own efforts.

Last, but not the least, remember to assess important aspects of the environment where the communication effort will be implemented. Assessing the availability, accessibility,

affordability, and acceptability of services and products will lead to knowledge of the capacity of service providers and supply outlets to help the communication effort.

Do not ignore the fact that social, economic, and political conditions can limit health communication. For instance, crime, unemployment, poverty, and social upheaval all affect health behaviour. Ask about pending legislation that might affect the effective promotion of health behaviours. Consider other development issues that are likely to be competing for resources and the attention of your audiences.

In light of the discussion above, to get started with materials development ZIHP-Comm. communication practitioners must:

1. First understand the problem;
2. Then determine possible audiences;
3. Exploit complementary communication resources; and,
4. Assess the environment where they intend to implement communication efforts.

8.1.2 Strategic Design

The general conclusion that can be drawn from the way ZIHP-Comm. applies the P-Process, in terms of strategic design, is that they are very serious about it. This student observed that for ZIHP-Comm. officers, every communication effort, large or small, had a strategic design. Every effort had objectives, means of implementation and partner organisations.

8.1.3 Development, Pre-testing and Production

The conclusion on this step of the P-Process, concerning the way ZIHP-Comm. applies it is that officers have a full understanding of it and they are able to put the step into practice. This student observed that the officers develop message concepts, pre-test with audience members, revise and produce messages and materials and re-test materials. The

only shortcoming concerning this step was that sometimes ZIHP-Comm. sub-contracted external professionals to produce materials. According to the observations of this student, the external professionals were not pre-testing the messages or materials. They produced and aired programmes that had not been pre-tested.

The recommendation to improve on the application of the Strategic Design step is that ZIHP-Comm. should allocate pre-testing resources to external professionals. Alternatively, ZIHP-Comm. could be getting material prototypes from the external professionals to pre-test. Pre-testing, as seen in the previous chapters, is very important.

8.1.4 Management, Implementation, and Monitoring

On this step, the conclusion is that ZIHP-Comm. as an organisation was doing quite well. The organisation was in most cases able to mobilise important organisations, create a positive organisational climate, implement the action plan, and monitor the process of dissemination, transmission, and reception of programme outputs. There were only a few instances when professional staff did not move with the vision of the organisation. During interviews, this student observed that some professionals did not have dissemination plans or a monitoring mechanism for the materials they produced. Their concern was just to have materials produced and sent somewhere like to a district office. Whatever happened after that was not their concern.

This student's recommendation is that dissemination and monitoring mechanism be introduced to the professional staff so that materials reach the target audience and that the materials are utilised as purposed by the producer.

8.1.5 Impact Evaluation

From the observations and the responses from in-depth interviews, this student concludes that ZIHP-Comm. has not fully integrated impact evaluation in its operations. Most of the professional staff spoken to said they had no impact evaluation plan while some seemed

to only have been using their initiatives to evaluate the impact of their efforts. Below are some responses given when the officers were asked as to whether they had an impact evaluation plan:

> "There is no systematic plan. Sometimes the number of people, who attend a facility, gives us an indication of how successful our efforts have been."
>
> "We have no evaluation plan."
>
> "We have a record review to give us an indication of the impact. Sometimes we have interviews with both clients and providers. We also compare information from baseline surveys."
>
> "We conduct a mid-term review survey."

Further evidence of the lack of impact evaluation at ZIHP Comm. was that most officers could not produce a list of materials that they had produced in the previous year, during the student's inventory. If the materials are long forgotten then it becomes impossible to determine what their impact is or has been.

It is very important to measure impact on audiences and determine how to improve future projects. ZIHP-Comm. should develop distinct impact evaluation guidelines so that each professional staff knows how to evaluate their own communication efforts.

The overall conclusion is that ZIHP-Comm. is among the very few health promotion organisations in Zambia with a distinct systematic communication process. The organisation has highly qualified professionals with vast experience, some up to 15 years experience. The organisation is doing a commendable job in health promotion. It is offering technical assistance even to other organisations in the country.

8.2 Support to Country Programmes

UNAIDS ICT/ESA gives support to member countries in their development of communication programmes. The organisation organises communication workshops and produces numerous communication publications.

The general recommendation to UNAIDS ICT/ESA is that the organisation should try to develop guidelines for the application of the UNAIDS Communication Framework for HIV/AIDS. The document makes good reading but communication practitioners may not know how to operationalise it. A workshop should be organised to operationalise the Communications Framework and thereafter guidelines be published.

UNAIDS ICT/ESA is making a notable contribution in fighting the HIV pandemic in the region. The organisation has highly qualified professionals who are working very had.

8.3 Conclusion

The entire six-month attachment to ZIHP-Comm. and UNAIDS ICT/ESA was a very enriching experience. The attachment was of great benefit to my practical enrichment of communication skills. I look forward to more interactions with the organisations where I had my practical attachment. many thanks to the people that I worked with at ZIHP and UNAIDS.

REFERENCES

CSO (Zambia), MOH & Macro International Inc. 1997. *Zambia Demographic and Health Survey.1996.* Calverton, Maryland: CSO and Macro International Inc.

Infante A. Dominic; Andrew S. Rancer and Deanna F. Womack.1997. *Building Communication Theory.* Waveland: Press Inc.

JHU/CCP (August 1998). *A report on the second International Conference on Entertainment and Social Change.* Baltimore: JHU/CCP

Joint USAID/UNICEF/SIDA/Study Fund Project.2000. *Orphans and Vulnerable Children: A Situation Analysis, Zambia 1999.* Lusaka: GRZ.

Klapper, Joseph. 1960. *Effects of Mass Communication.* New York: Free Press.

Kotler, P., and E. Roberto. 1989. *Social Marketing: Strategies for Changing Public Behaviour.* New York: free Press.

MOFED.1996. *Revised National Population Policy.* (Draft Document)

MOH.1991. *Facts for Life.* Lusaka: Ministry of Health

MOH, CSO, UNFPA & UNZA.1998. *A Study of Factors Associated with Maternal Mortality in Zambia, 1998.* Lusaka: Ministry of Health.

Mody, Bella.1991. *Designing Messages for Development Communication: An Audience Participation-based Approach.* New Delhi: SAGE Publications.

Noelle-Neumann, E.1993. *The Spiral of Silence.* Chicago: University of Chicago Press.

Piotrow T. Phyllis; D. Lawrence, Kincaid; Jose G. Rimon II; and Ward Rinehart.1997. *Health Communication: Lessons from Family Planning and Reproductive Health.* Westport: Praeger Publishers.

Rogers, EM.1983. *Diffusion of Innovations*. New York: Free Press.

The Population Council, Inc. and the International Centre for Research on Women.2001. *Community Involvement in initiatives to Prevent Mother-to-child transmission of HIV.* New York: PC&ICRW.

UNAIDS.2002. UNAIDS. http://www.unaids.org

UNFPA.2002. UNFPA. http://www.unfpa.org

UNICEF.2002. UNICEF. http://www.unicef.org

White, Shirley; Sadandan, Nair; and Joseph Ascroft.1994. *Participatory Communication: Working for Change and Development.* New Delhi: SAGE Publications.

WHO.2002. WHO. http://www.who.org

Williams, Glen; Lucy Ng'ang'a; and John Ngugi. 1999. *Youth-to-Youth: HIV Prevention and Young People in Kenya*. UK: Oxford.