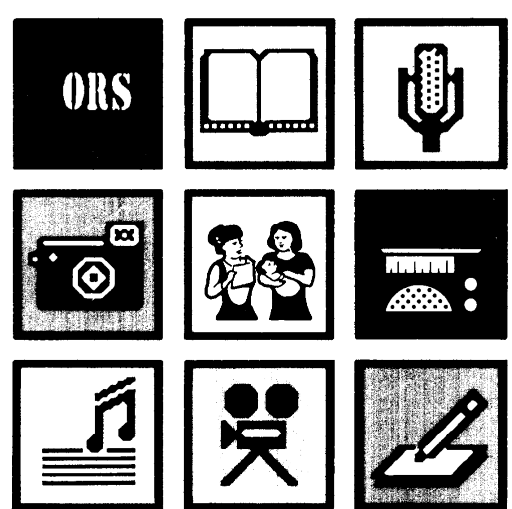
COMMUNICATION

A Guide for Managers of National Diarrhoeal Disease Control Programmes



Planning, management and appraisal of communication activities

Diarrhoeal Diseases Control Programme
World Health Organization
Geneva

It is expected that this Guide will need to be modified in different countries or communities in order to suit the needs of its users. All parts of it may be freely adapted, translated, or used in any form for non-profit-making purposes. Prior permission to do so need not be obtained from the World Health Organization, but appropriate reference should be made to this source. However, if a translation of the entire work is envisaged, enquiry should be made to WHO to ensure that such a translation is not already available.

WHO also welcomes comments on this Guide and information on experience in its use or adaptation; these should be addressed to:

Director
Diarrhoeal Diseases Control Programme
World Health Organization
1211 Geneva 27, Switzerland

COMMUNICATION

A Guide for Managers of National Diarrhoeal Disease Control Programmes

Planning, management and appraisal of communication activities

Diarrhoeal Diseases Control Programme
World Health Organization
Geneva
1987

Contents

Preface v
Introduction vii

Part I
Understanding Communication in a CDD Programme

Chapter 1
Why consider communication? 2

Communication can make a difference 3
Lessons learned 6

Chapter 2
What communication can or cannot do according to the emphasis of your CDD Programme 7

What is effective case management of diarrhoea 7
Communication is part of effective case management 7
Where is your national programme in terms of case management 8
What communication can do 9
But communication cannot... 11
Communication and the emphasis of your CDD Programme 12

Part II
The Communication Design Process

The public health communication design process 16
The public health communication design process applied to national CDD Programmes 16

Step One
Investigate 19

What areas should be investigated? 19

1. General characteristics of the audience 19
2. Specific characteristics of the audience 19
3. Communication networks 22
4. Communication resources 22
5. Feasibility of CDD policy and needs for communication activities 22

What communication research methods should be used? 25

Step Two
Plan communication activities 28

What is a communication plan? 28
When is it developed? 28
Who develops it? 28

(continued)

The communication plan 30

1. Definition of the target audiences 30
2. Behaviours to be adopted by the target audiences 31
3. Constraints 32
4. Communication objectives 33
5. Approaches to change 35
6. Mix of communication channels 36
7. Proposed institutions responsible 36
8. Proposed timetable 37
9. Proposed budget 39

Approval of the plan 39

Step Three
Develop communication materials 40

Step Four
Test and revise materials 42

Step Five
Implement the communication plan 44

1. Media mix 44
2. Message phases 48
3. Message design 48

Step Six
Monitor, evaluate and revise 50

1. What to monitor in communication 50
2. How to monitor 51
3. What to evaluate 52
4. When and how to evaluate 54
5. What to do with monitoring and evaluation results 54

The communication design process:
Summing up 57

Part III
The CDD Manager's Role in Communication

Task 1
Select a communication coordinator 60

Task 2
Involve other communication resources 62

Possible constraints 62
Possible communication resources 63

Task 3
Brief the communication coordinator and make financial arrangements 67

Task 4
Supervise and monitor 70

Checklist for managing communication 71

Glossary 73
List of photographs and illustrations 78

Preface

From its inception in 1978, the WHO Diarrhoeal Diseases Control Programme (CDD) has given primary emphasis to increasing access* to and practice of proper diarrhoea case management, including use of oral rehydration therapy (ORT)*. During these initial years efforts have concentrated on producer and provider-oriented* approaches. The number of packets of oral rehydration salts* (ORS) has increased steadily, to the point that some 300 million litres worth were produced in 1985, over half of these in developing countries.

Nearly all the world's developing countries now have a diarrhoeal disease control programme. As of 1985, global access to ORS was at least 50%, and use of ORT at least 18%. As a result of activities to train health staff, the global targets of 80% ORS access and 50% ORT use should be attained by 1989.

Two areas of activity have been included in the provider-oriented activities: **informing providers** of the advantages of good case management, and **training providers** to treat patients and to plan, implement, and evaluate control programmes. The group of providers that have been given the most attention are health staff employed by Ministries of Health; less emphasis has been given to traditional or private practitioners, or to pharmacists.

This deliberate decision to concentrate on government providers of ORS was made for the following reasons: the process of developing training material for health staff was relatively well understood; the evidence from a variety of other Primary Health Care programmes that training of staff influences access and use was impressive; the development of a credible source of proper case management was necessary prior to increased stimulation of public interest.

The time has come for national CDD programmes to put more emphasis on user-oriented* approaches to complement the provider approaches already underway. Experience in the more successful national CDD programmes, such as Egypt, Honduras, and the Philippines, clearly indicates the potential value of these approaches. Communication* has been a critical element in all of these countries, and to a lesser extent in some others.

One important reason why ORT is such a particularly attractive element of primary health care is that it enables the population to look after its own health, to make its own decisions on what sort of care is needed and where the care is best obtained. Emphasizing the communication aspects of ORT will take advantage of this important characteristic of the primary intervention of CDD programmes.

The decision to develop a guide for CDD programme managers on communication as an initial step in stimulating user-oriented programme activities comes from the recognition that while this subject is important, it is not well understood by those in charge of national control programmes. Often the communication activities of even the most successful programmes have been carried out somewhat separately from the rest of the programme. The concern is the sustainability of efforts in which the national programme itself is not fully involved.

* See the glossary for a definition of this term. Terms which are in the glossary are identified by an asterisk the first time they appear in the text.

This guide will be a useful introduction for programme managers who are considering including communication as a critical element of their programmes.

For those countries that find communication timely, WHO plans to make consultants and support for some operational costs available to assist with developing comprehensive and integrated communication plans and to provide additional support to countries in carrying out their communication activities. Other agencies, particularly UNICEF, will continue to play an active role in this area and collaborate with WHO.

Introduction

What is communication in a CDD programme?

Communication in CDD programmes deals with changing the behaviour of mothers and those who can influence them, such as doctors, nurses, and health workers. Its purpose is to get more of them to use correctly and continue to use oral rehydration therapy, feed children properly during and after diarrhoea episodes and seek further treatment when needed.

Communication in this context refers to planned information, motivation and education activities, together with associated research, training, monitoring* and evaluation activities. This set of specifically designed activities is called the communication component of an overall programme.

Communication also is the process of deciding how to get our messages across most effectively, including decisions about what to say, to whom and through which communications channels (such as interpersonal, print, broadcast, or traditional media).

A communication guide for CDD managers

This guide is an overview of communication written to provide managers of Diarrhoeal Disease Control (CDD) programmes with the background necessary to improve the communication component of a CDD programme. Specifically, this guide will help you, the CDD manager, to:

- Understand the function of the communication component of the CDD programme and how it will change as the emphasis of the programme changes.
- Understand the steps towards effective communication.
- Identify a communication coordinator and other resources to implement the communication component.
- Supervise and manage the people and other resources for the communication activities.

Although this guide provides examples of the application of the communication design process to the case management strategy, it is appropriate for use with other strategies of diarrhoeal disease control, for example, those aimed at the prevention of diarrhoea.

This guide is divided into:

Part I Understanding Communication in a CDD Programme
Part II The Communication Design Process
Part III The CDD Manager's Role in Communication

Part I

Understanding Communication in a CDD Programme

Chapter 1
Why consider communication?

The dictionary defines communication as a process by which information is **exchanged** between individuals to reach a common understanding and agreement. This guide is about communication as part of a national diarrhoeal diseases control (CDD) programme. Communication activities in that context are directed toward getting clear and compelling messages to mothers and other caretakers of children. They may also direct messages to health staff and other community members who can influence the mothers. The messages are about diarrhoea and how to care for children with diarrhoea.

The desired effect is to have more mothers properly and continuously use ORT and other diarrhoea-related management practices in order to contribute to a lower child mortality rate.

These communication activities are the results of careful planning based on communication research*. **Communication research**, which includes **audience analysis***, is the key to applying communication successfully in a CDD programme. This research yields information about the products and behaviours to be promoted and about mothers' and health care providers' knowledge, attitudes and practices concerning diarrhoea. Only with this information can communication activities, messages and materials be tailored to take into account the beliefs and constraints of the people the programme wants to reach.

The most significant initial communication activity in the CDD programme is user analysis*. As a result, concerns and needs of users are better understood, considered and addressed by both communication experts and the CDD programme managers.

Coordination of communication planning and activities with the other aspects of the CDD programme is essential. For example, health care providers should be trained **before** communication promotes their services, and their training - as well as providing clinical, managerial or supervisory skills - should prepare them to teach and support the **same** messages that mothers will hear on the mass media*.

Communication can make a difference

The following descriptions of CDD communication efforts in three countries will introduce you to some ways that communication can make a difference.

Egypt — Communication research

Communication research was vital to the success of the Egyptian CDD programme. It included communication activities which motivated millions of mothers to correctly use ORT.

Communication research identified audience misconceptions and provided planners with information to design useful and appropriate materials and messages.

Research revealed, for instance, that mothers added sugar to ORS to sweeten its taste. To correct this, communication messages stressed the fact that nothing should be added to ORS.

Through research it was also discovered that some mothers boiled ORS after mixing it. A new message was created to instruct mothers not to boil ORS.

It was found that mothers stopped giving ORS when the child vomited. Media planners developed messages informing mothers that ORS administration should be slowly resumed after the child stops vomiting.

Evaluation* of some initial communication activities revealed that women were more effective information sources than men. Subsequent activities relied more on women. Famous female actresses and singers, for instance, proved to be very credible sources of messages through the mass media, and their assistance increased mothers' compliance.

Honduras — Monitoring

Monitoring and supervision played a key role in the evolution and impact of the Honduras CDD communication component.

In 1979, the Ministry of Health decided to distribute a locally produced litre-sized ORS packet to prevent and treat dehydration. After communication research, the product was named LITROSOL. An instructional flyer was designed to give the mothers along with two packets. The distribution system was selected - primary health care workers, trained midwives, and village mayors.

After eight months of communication activities, including face-to-face communication along with the distribution of instructional flyers* and intensive radio broadcasts, the impact was monitored by focus groups and small-scale surveys. The results indicated that many caretakers had used the ORS packets but were not following the instructions on the flyer. Even though the flyer had been carefully designed for semi-literate rural women, they simply were not accustomed to following instructions on medicines. Results also showed little knowledge of proper feeding practices during diarrhoea.

The next six-month phase emphasized that caretakers should follow all of the instructions on the flyer and that they should continue feeding and breastfeeding during diarrhoea episodes. Creative radio spots were developed to teach the two key messages. Testimonials from rural women demonstrated what mothers should do.

Six months later, monitoring indicated remarkable changes in the use of the flyer. Caretakers reported following all of the instructions "so that ORS would be effective". Many caretakers kept their flyers and were able to show them to the researchers. Almost all of the women interviewed could explain all of the instructions on the flyer. Knowledge of the need for continued breastfeeding and feeding of soft foods during diarrhoea had also increased.

Monitoring also uncovered some common questions that caretakers were asking about the new product. Could it be used with other medicines? How long should it be given? Was it good only for some kinds of diarrhoea and not for others? Radio spots and service provider training then emphasized the answers to these questions, while continuing to maintain the basic messages of the first year.

Monitoring six months later indicated that mothers had accepted these messages, but still did not understand the concept of dehydration. The next phase moved from trying to teach the theory of dehydration to teaching specific signs which indicated that children needed professional assistance immediately. Thus, communication monitoring continues to guide communication activities.

The Philippines — Standardization of messages

In 1983, the Philippine Control of Diarrhoeal Disease programme reviewed its communication work in an effort to improve the impact of the programme. Communication research was conducted with mothers and other caretakers to identify key constraints to correct ORT use. One problem was the lack of standardized messages and materials that taught caretakers how to mix ORS. Posters, flyers, leaflets, and brochures were found in rural communities. However, almost all of them suggested a different container for mixing ORS - soft drink bottles, beer bottles, or cups. These choices confused mothers. In addition, most of these containers were not readily available in households throughout the country. Some materials directed mothers to put the ORS powder in a soft drink bottle, add water, and then shake the bottle. Other materials instructed caretakers to measure the water into a container and pour the ORS powder into the water.

A second problem with mixing ORS was caused by the ORS packet itself. To increase the product shelf life, the product had been designed with one compartment for the salt and one for the glucose. Research found that some mothers believed that the small pouch (which contained the salts) was meant for young children and the larger pouch (containing the sugar) was for adults and older children.

The CDD programme realized the need to clarify the communication messages. Research identified the most common measuring container, a coffee glass which holds 200 cc of water if filled almost to the brim. The CDD programme planners developed streamlined and standard mixing messages, such as:

1. A message on how to measure one litre of water was given to mothers. The instruction given was:

   One litre equals 5 coffee glasses of water. The illustration showed the coffee glass with its distinctive design indicating the water level.

2. To teach mothers to use all the contents of both compartments of the powder packet, an illustration and text were included on the package label. The illustration clearly depicted powder being poured from both compartments.

3. Correct preparation of ORS was presented in four easy steps and shown in pictures. Instructions were simplified as follows:

   a. Pour 5 coffee glasses of water into a pitcher
   b. Pour all the contents from both compartments of the packet
   c. Stir
   d. Give to drink.

Lessons learned

With the emphasis of CDD programmes on the prevention and treatment of dehydration and undernutrition caused by diarrhoea, mothers are the key to your programme having an impact on mortality.

After ensuring that health staff is properly trained in and using good case management, your next concern is good access to and use of ORT - including home therapy - by mothers and caretakers of children in **unsupervised** settings. Your programme will reach these mothers only if your programme has an effective communication component.

An effective communication component:

- is based on audience field research
- is based on a comprehensive plan so that it is fully coordinated with the overall CDD programme
- has a flexible plan which can be adjusted as required
- uses a few practical and standardized messages
- uses various channels of communication in an integrated manner (such as interpersonal, print, mass media or traditional media*)
- encourages dialogue* between users and service providers and CDD decision makers

Chapter 2

What communication can or cannot do... according to the emphasis of your CDD programme

What is effective case management of diarrhoea?

Effective case management in the home includes:

a) Timely ORT using correctly prepared fluid in adequate volumes.
b) Continued feeding in adequate quantity.
c) Correct knowledge of when to seek treatment outside the home.

Effective case management in the health facility includes these main elements:

a) The patient is assessed correctly.
b) Treatment is appropriate for the degree of dehydration and any other problems:

- No dehydration: The mother is taught how to prevent dehydration by using recommended home fluids* and ORS and continuing to feed the child.
- Some dehydration: Treatment with ORS and feeding.
- Severe dehydration: Treatment with IV and then ORS and feeding.
- Other problems: Treatment with appropriate antibiotics or referral.

c) The mother is always taught how to treat the child at home, continue feeding the child, and recognize signs that the child needs to come for more help.

Communication is part of effective case management

When a doctor or a health worker teaches the mother how to
- continue treatment at home
- continue feeding the child
- recognize when the child needs to come to a health worker for help

he or she **communicates**.

Therefore, an essential part of improving case management at health facilities and ultimately in homes is improving the communication skills of service providers. This is the critical role of interpersonal communication*, i.e., talking with mothers and other caretakers of children about diarrhoea case management, either individually or in groups.

Where is your national programme in terms of case management?

Improvements in case management in a CDD programme are generally best achieved in a progressive manner. Table 1 describes a possible sequence of activities to improve case management; the emphasis of each stage is a logical expansion of the previous stages*.

Table 1

Stage	Emphasis	Programme activities focus on
1	Case management in major health facilities	Replacing poor diarrhoea treatment at major health facilities with effective case management, including education on home therapy as described in the WHO Treatment Chart
2	Effective case management in all health facilities	Increasing access to effective case management, primarily by training staff at more facilities and expanding distribution of ORS
3	Promotion of service	Increasing use of facilities offering effective case management, e.g., by promoting their services
4	Increasing access	Increasing access to ORS by adding new providers (e.g., by adding community health workers, pharmacists, or shopkeepers)
5	Home therapy*	Extensive promotion of home therapy through various channels such as the mass media or as interpersonal communication.

Communication is important at all stages of a CDD programme. Its functions will change and expand as the programme develops.

What communication can do

Communication efforts aim at overcoming three types of obstacles or problems by

informing
motivating
instructing

Some examples of these obstacles are:

- **lack of awareness or knowledge**

  For instance:
  - mothers are not aware that there is a new type of service for diarrhoea
  - mothers do not know where to obtain ORS
  - mothers do not know what foods to give during and after a diarrhoea episode

- **lack of acceptance**

  For instance:
  - health workers are reluctant to provide education to mothers as a part of treatment
  - mothers do not like ORS because it does not stop diarrhoea

- **lack of skill**

  For instance:
  - mothers do not know **how** to properly mix and administer ORS
  - health workers do not know **how** to educate mothers
  - mothers do not know **how** to prepare foods to give during a diarrhoea episode

The role of the communication component in the chain of events that contributes to lower diarrhoea mortality can be described as follows:

In order to:	Lower diarrhoea mortality
you need to:	Increase use of effective case management in health facilities and homes
In that respect, communication can:	Increase knowledge, skills and motivation of mothers to manage cases correctly and to go for help at health facilities
and:	Increase motivation and skills of health staff to educate mothers and use effective case management
and:	Increase motivation and skills of other providers of ORS to educate mothers and promote effective case management

Given that the service delivery system is already in place, communication can:

1. **Increase CDD programme managers' awareness and knowledge of providers and users'** constraints and resistance to the adoption* of effective case management and help design or revise national policy on use of ORS and solutions for home therapy.

2. **Increase support for CDD activities among physician**s and other opinion leaders. In Egypt, after two years of CDD communication activities, 90 percent of all physicians prescribed ORS. Before the CDD communication activities, use of ORS among physicians was more limited.

3. **Increase knowledge of the concept of dehydration** during diarrhoeal episodes. Data from Egypt showed that mothers' knowledge of signs of dehydration rose from 32 percent to 90 percent after the CDD communication intervention..

4. **Increase knowledge of correct ORS mixing and administration skills**. In Egypt, 65 to 70 percent of sample mothers were observed to correctly mix ORS packets after two years of CDD communication activities.

5. **Increase knowledge of and remind mothers to improve dietary management** in the home. In Swaziland, after eight months of intensive CDD communication, the number of mothers who reported that children should be fed more special foods after diarrhoea episodes increased from 16 percent to 44 percent.

6. **Increase demand for ORS.** In Honduras, ORS use increased from zero to 48 percent after only one year of intensive CDD communication. In Egypt, ORS use increased from one percent to 70 percent after two years of CDD communication. In Nicaragua, the use of ORS for diarrhoea episodes in children below six years of age increased from 24 percent in 1980 to 43 percent after two years of communication efforts.

7. **Increase use of case management services** in health facilities by promoting these services through information and public relations efforts.

8. **Contribute to lowering infant mortality** from diarrhoeal disease. In health communication, changing or influencing health practices aims at improving the health status in the long run. Communication efforts can have an important role but are not claimed to be sufficient.

In summary, communication can have a positive and even critical impact on the achievement of your targets related to **use** of case management by:

- motivating health staff to practice effective case management
- improving health staff's skills to educate mothers
- improving the image (or prestige) of the health services
- motivating other providers to distribute ORS and promote effective case management
- motivating and educating mothers on how and when to use home fluids, the importance of feeding and the criteria for referral.

But Communication cannot . . .

Communication is **only one** element of the programme, in addition to:

- national policy on case management of diarrhoea
- supply and delivery systems for ORS and other case management supplies
- training and supervision capabilities and resources
- monitoring and evaluation

Communication cannot have any impact on targets of access to effective case management which depend on such activities or factors as:

- geographic access of people to health facilities
- availability of containers and foods in homes
- clinical training of staff
- procurement and distribution of supplies

More specifically a communication component cannot:

1. **Compensate for an inadequate supply and distribution system and ensure by itself the success of the programme.**
   A communication component designed to increase demand for products and services can have serious negative consequences if the delivery system is not prepared to meet the demand created. Serious problems have occurred in several countries when health programme managers did not understand how rapidly communication can motivate and change some behaviour.

2. **Replace training of health staff in clinical, managerial and supervisory skills.**
   Mothers cannot be expected to properly use ORT without technical support of health workers, whose task is to provide correct advice, to make sure that their advice is well understood, and to provide a good referral system.

3. **Overcome a poor product choice.**
   If a programme chooses a 1/2 litre size packet for a population that only has a 350 ml measuring instrument, or promotes a sugar and salt formula with a population where sugar is rarely available, then communication will not solve the problems of user resistance, poor mixing, and low adoption.

4. **Produce totally self-sustaining change.**
   Even the most widely known and accepted commercial products must regularly remind their audience of their benefits and value. People change, new products enter their world, and delivery and distribution systems vary over time. This means that CDD communication activities must be adjusted as needed to take into account changes in policy decisions, in delivery systems, and in people's attitudes and behaviour.

5. **Radically transform fundamental cultural norms.**
   Changing the way mothers feed their children during a diarrhoea episode has proven more difficult than getting mothers to give more food after an episode of diarrhoea.

6. **Be equally effective teaching all types of messages.**
   Promotion of a particular product, such as an ORS packet, can be easier to accomplish than promoting a new feeding behaviour or training mothers to recognize the signs of dehydration. Teaching mothers to use a home-mixed solution is more difficult than teaching correct use of a pre-mixed packet of salts.

7. **Teach conflicting messages.**
   Sending inconsistent messages on the same topic, for example, promoting use of several different size packets and containers, may confuse the audience.

> Say "**no**" to communication activities that publicize services you are not yet ready to provide or that promote unsound practices or practices which the audience is unable to adopt.

The temptation is great to become involved in mass media communication. Success in countries like Honduras and Egypt seems to suggest that communication can solve key problems, almost by itself. It is tempting to think of the publicity and attention we can get by using mass media aggressively.

But these programmes also have mature service delivery components. They have made progress on the less visible and less immediately rewarding issues of training, supervision, logistics and monitoring.

Communication and the emphasis of your CDD programme

What you can expect to achieve with communication depends on the current emphasis of your programme in terms of case management. The decision process for establishing national policy for CDD programmes advocated by WHO emphasizes a logical sequence of improvements in case management. (See Table 1.)

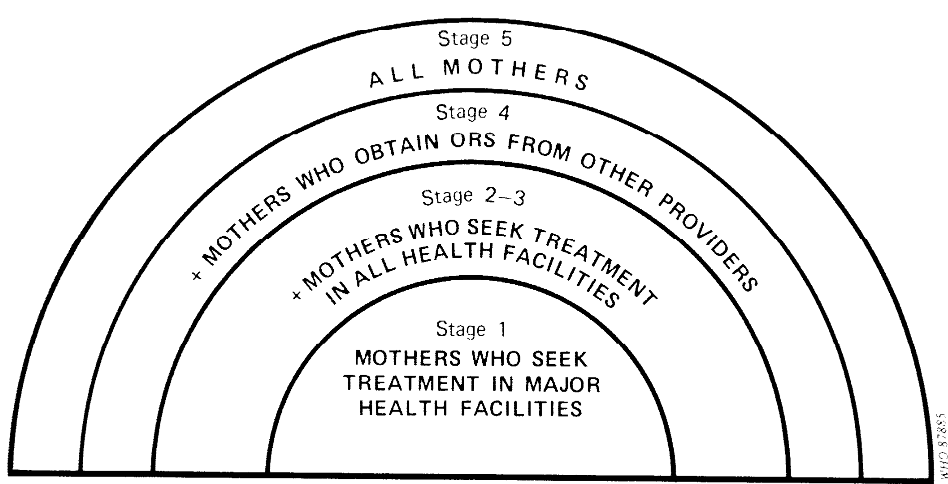
While training of health providers and of other providers is proceeding, and as your programme is progressing:

1. Target audiences* are expanding
2. Sources of messages are multiplying
3. Content of messages is changing

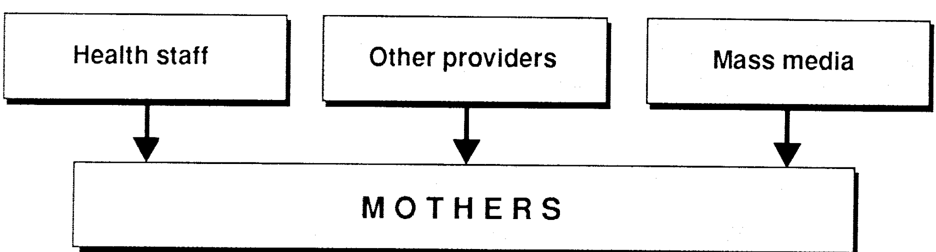
1. Target audiences are expanding from health facility staff to other service providers and then to mothers and caretakers of children.

   Experience has proven that physicians, pharmacists and other health providers need to be technically trained and fully involved in the programme. As access to effective case management increases, the number of mothers who could carry out the behaviours will also increase. (See Figure 1.)

Figure 1
The increasing numbers of mothers to be reached with communication



2. Sources of messages are multiplying. There is a network of sources such as trained health providers and other providers of ORS. They are reinforced by community leaders, printed materials and mass media.



3. Content of messages is expanding:

   - from advice on diarrhoea treatment and dietary management given at health facilities
   - to promotion of use of health facilities for diarrhoea treatment and referral
   - to promoting universal use of home therapy.

Part II

The Communication Design Process

The public health communication design process

The design of an effective communication component in any social programme requires following the same basic steps. These six steps are interdependent and should follow each other in cycles throughout the life of a CDD programme.

Step 1 Investigate: get a good understanding of your audiences and the problems to be dealt with before you make decisions

Step 2 Plan communication activities: use those results to set objectives and develop an approach

Step 3 Develop materials to be tested

Step 4 Field test materials under operational conditions, and revise as needed. Try out materials first with people very like those in the programme before full-scale implementation

Step 5 Implement the plan

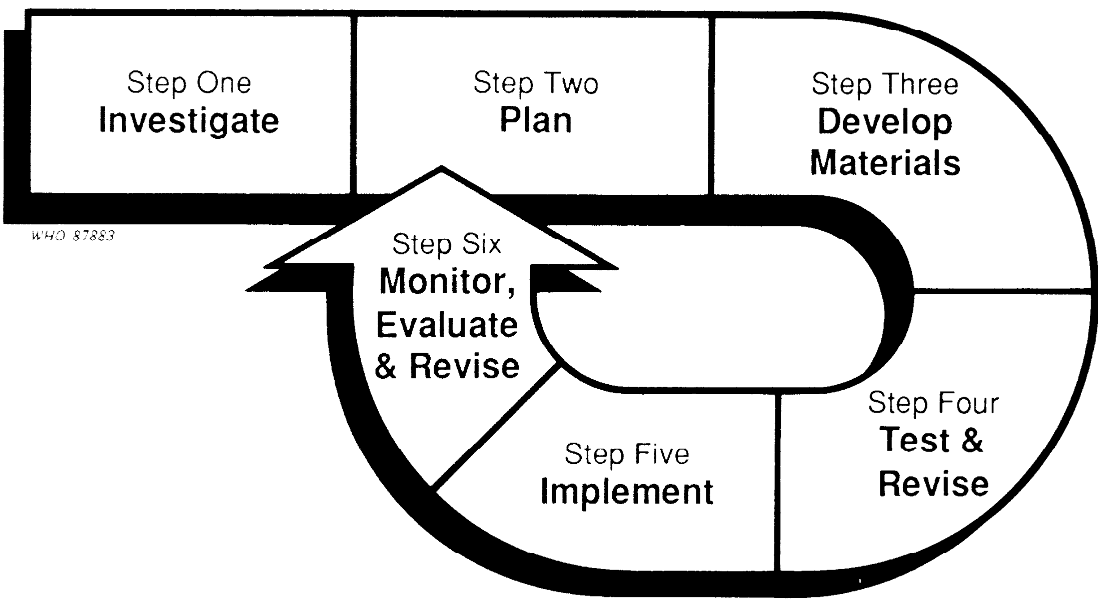
Step 6 Monitor and evaluate the implementation phase to detect problems or unexpected obstacles and make needed changes.

The public health communication design process applied to national CDD programmes.

Designing and supervising communication activities should be assigned to a communication coordinator. In order to help you hire, supervise and provide guidance to the communication coordinator, each step of the communication design process will be explained in more detail.

Temptation is strong to let the communication steps follow each other at their own pace, separately from the rest of the programme. However, communication activities play a supportive role in CDD programmes only as long as they coordinate with the overall time table. For example, distribution of ORS, training of health staff, and communication activities must be planned together so that mothers learn about a service which providers are trained and equipped to give.

Figure 2
Six steps towards effective communication



Step One

Investigate

When developing a programme, no one wants to wait twelve months while researchers develop questionnaires, implement large studies, and then deliver complex results.

However, this is not the type of research that is needed to plan communication activities. Practical and relevant research, which answers questions such as those on pages 20-21, benefits the programme. This important step is often referred to as the **communication research**.

Without research we are left with opinions (which may not be true), anecdotes (which may not be typical) and stories (which may not be accurate). Research which is poorly done and poorly analyzed is even more dangerous. It gives us a sense of false confidence and can lead us to poor decisions.

What areas should be investigated?

The communication coordinator needs specific information in several areas to design a communication strategy:

1. General characteristics of the audience
2. Specific characteristics of the audience
3. Communication networks
4. Communication resources
5. Feasibility of CDD policy and needs for communication activities

1. General characteristics of the audience

A description of the audience is needed including its:

- demographic characteristics
- socio-economic status
- child rearing and feeding practices
- community decision process
- media usage patterns
- leadership

2. Specific characteristics of the audience

Characteristics of providers of diarrhoea case management and characteristics of users need to be described. Studies of their knowledge, attitudes and practices (K.A.P. studies*) related to diarrhoea provide answers to questions such as those on the next two pages.

Diarrhoea and ORT:
Providers' knowledge, attitude and practices

Knowledge

1. Do providers know:

   - the signs of dehydration?
   - degrees of dehydration?
   - appropriate treatment for dehydration?
   - what to advise mothers about caring for the child at home?
   - the appropriate use of antibiotics for diarrhoea?

Attitude

2. How does infant diarrhoea rank as a health problem in the opinion of the medical community?

3. What is the local health community's perception of the leading health problem in their country?

4. What is the dominant attitude of the medical community towards the treatment of diarrhoea? (pediatricians, general practitioners, nurses, community health workers)

5. What is the specific attitude of health staff toward ORT? Toward home therapy?

6. What is the attitude of health staff towards the role of mothers in treatment (in hospitals and at home)?

Practices

7. How are providers presently treating diarrhoea?

8. What is their past experience with the CDD programme? (clinical guidelines used, etc.)

9. How are providers instructing mothers on diarrhoea treatment?

10. Are providers frequently prescribing anti-diarrhoeal drugs and antibiotics?

Diarrhoea and ORT: Users' knowledge, attitude and practices

Knowledge

1. Do mothers know where to get treatment for infant diarrhoea?
2. Is there a word for dehydration?
3. Is diarrhoea or dehydration recognized as a problem by mothers, i.e., do mothers know that diarrhoea can kill their child through dehydration?
4. What are the common beliefs about the causes of diarrhoea?
5. What are the perceptions and names of the different types of diarrhoea?
6. Do mothers know the signs to look for that indicate the child needs professional help?
7. Do mothers know about recommended home fluids and how to prepare and use them?

Attitudes

8. What do users like about the product they now use? What do they expect a diarrhoea treatment to do?
9. What is the attitude towards the use of liquids for diarrhoea case management, including liquids with salt and sugar?
10. What do users expect to pay for a diarrhoea remedy that works? What attitude do they have toward "give-away" drugs and public health facilities?
11. What does the audience believe is the benefit of ORT and ORS specifically? What benefits do they attribute to other diarrhoea treatment practices and remedies? What are the disadvantages to them of ORS, other remedies, and other treatment practices?

Practices

12. Who are the usual providers of diarrhoea treatment?
13. What are the most common folk remedies for diarrhoea?
14. How are children being fed during diarrhoea episodes? Which children are not fed, and why? How do feeding practices change according to the mother's feeling about the type of diarrhoea?
15. Who makes decisions in the home about medical treatment and diarrhoea treatment? (seeking help, buying remedies)

3. Communication networks

Assessment of the audience media usage patterns should determine:

- What sources of information about diarrhoea treatment are most credible to the target audience? To whom do they speak? To whom do they listen and for what types of information?

- What channels of information reach users most effectively?

- What language are the users comfortable with? What visuals do they understand?

The available communication channels* or media (from mass media to interpersonal communication) should be assessed in terms of:

- accessibility to the target audiences
- acceptability to the target audiences
- prior experience in use of educational materials or activities
- cost of use

4. Communication resources

The communication coordinator* should find out about all the available institutions and other communication resources that have capabilities in:

- research
- education/training
- production and distribution of information and educational materials
- mobilizing a network of field workers for interpersonal communication

5. Feasibility of CDD policy and needs for communication activities

The communication coordinator needs to understand the CDD policy and its implications in order to design the communication component. The CDD manager can provide much needed information about the policy. A useful framework used in market research* for studying a tangible product such as ORS, recommended fluids or recommended weaning foods is known as the "4 P's":

- product
- place
- price
- promotion

Product: In the case of effective diarrhoea case management the product includes the following necessary elements:

- Proper use of ORS and/or recommended home fluids
- Continued feeding during and after diarrhoea
- Timely referral to a health facility.

Place of distribution of effective case management or of ORS.This consists of all of the locations where people can obtain ORS. It includes health care providers who are involved and trained in the delivery of all the necessary elements of effective case management and shops or other vendors or distributors of ORS.

Price: In addition to the monetary price of ORS or ingredients of recommended home fluids and weaning foods, managers and communicators should know the time and effort that the user will have to invest to use effective case management in the home.

Promotion: The communication coordinator will need to understand ways that users have been convinced of the value of a product in the past and the channels of communication that were most effective.

Below you will find sample questions about the CDD policy that the communication coordinator would ask the CDD manager. They have been classified according to the "4 P's".

Analysis of the 4 P's

A. Product

Who is the intended user?

ORS

1. How should the user prepare ORS? In exactly what containers and proportions should it be mixed?
2. How much solution should be given to the child during a day?
3. When should the user stop giving the solution?
4. Will ORS be classified as a drug?
5. When should the user seek help from the health system?

Home therapy

1. What fluid is recommended to prevent dehydration in the home? How should the user prepare the home solution?
2. What specific foods should the child be fed during and after diarrhoea episodes?
3. When should families seek help from a health facility? Exactly what signs can families observe that indicate that the child needs professional help?

B. Place

1. Where should the family go for professional help?
2. Where can the user obtain ORS? Who is allowed to produce, distribute, and sell it?

C. Price

How much money does ORS cost the mother? What are other costs (such as time)? What are the costs of the recommended home fluid (for ingredients, utensils, and time)?

D. Promotion

What was the focus (of messages) of past educational or promotional activities? Which institution was responsible for message design? What channels were used and in which manner? Has any research been done on the impact of such efforts?

Communication research also can provide the CDD manager with information about the feasibility of the existing or planned CDD policy

If a national policy on ORS and the recommended home fluids already exist, and some promotional or educational activities have been carried out, the CDD manager could use communication research to answer the following questions:

1. What is the degree of acceptability and attractiveness of the established national policy from a provider's and user's point of view? How much time, money, and effort does it cost the mother to obtain or to use ORS?

2. What is the evidence of success or failure of past communication activities? What do we learn from them?

3. What are the needs for new communication activities based on audience analysis?

If there is no national policy on ORS and recommended home fluids, and no communication activities have been planned yet, the CDD manager could use communication research to answer the following questions:

1. What are the users' knowledge, attitudes and practices in regards to diarrhoea diagnosis and treatment now?

2. What are the providers' practices in terms of diarrhoea case management now and why? (Is there a lack of knowledge, a lack of motivation and/or a lack of equipment or supplies?)

3. What are the characteristics of possible home fluids in terms of:

- the availability of appropriate foods and fluids, and of liquid containers for mixing ORS and other recommended home fluids
- the affordability of necessary ingredients for home therapy
- the likelihood of use of the recommended home fluids according to:
  - the appeal of the fluid as a therapy
  - the taste or colour of the fluid
  - whether or not the fluid fits into cultural norms about the treatment of diarrhoea and suitable foods for young ill children
  - ease of preparation or use: (Do mothers already know how to make the fluid? What supplementary education will its correct preparation require?)

4. What are the current needs for communication activities, based on answers to the previous questions?

Decision makers who establish CDD policy need to consider information provided by communication research as well as their clinical and managerial knowledge and experience. For example, in establishing a national policy on home therapy for diarrhoea, health professionals will analyze the safety and effectiveness of the composition of different possible fluids. They must also consider the availability and affordability of the ingredients required and acceptability in terms of taste, ease of preparation, etc. — information obtained from communication research.

What communication research methods should be used?

We have discussed the need to carry out studies on the audience and the type of information to collect. Audience studies do not necessarily require carrying out surveys. A variety of research methods are useful for this investigation, including qualitative* and quantitative* methods. They do not require large samples, high costs, or highly trained staff, but they do require **time**:

- to select areas of investigation
- to select institutions responsible for research and find resources
- to collect data
- to analyze data
- to **use** data for establishing a communication plan and perhaps a national CDD policy

This investigation is a necessary investment, not a waste of time. Only from this data can communication planners develop informed hypotheses of how to best influence the audience.

Several available research methods are compared in the following table.
(See Table 2)

Before reading this table, **remember**:

- Self-reporting* is often unreliable. Semi-literate, over-worked, poor rural mothers tend not to respond very well to questionnaires administered by government officials, students or hired researchers. Better information about our audiences may be obtained by other methods. For example, traditional birth attendants or peripheral health workers may be able to tell us in great detail about their clients' health practices. Interviewing them may be quicker and more economical than surveying mothers, and the data may be more credible and objective as they are not talking about themselves. People who are in but not of the community are less likely to be disturbed by contacts with outsiders, such as any interview process, however informal, would involve.

- These methods are complementary. Research can include a variety of these techniques. It is best to start with qualitative methods that provide a hypothesis to be confirmed by quantitative methods.

- The same methods can be applied for monitoring and evaluating of communication activities and other programme activities.

- It is the responsibility of the communication coordinator to select appropriate methods and identify experts and institutions able to carry them out. Areas of investigation and use of results should be decided on by the CDD programme manager and the CDD communication coordinator.

Table 2: **Some examples of communication research methods**

Research method	Data collected	Cost	Time	Staff needed	Remarks
Literature review	Research done to date: • clinical • epidemiological* • media studies* • ethnographies • market research • demography	Not very costly	A few months depending on quality of and access to information	Epidemiologist Social researcher	• Identifies what areas lack relevant research • Sets research priorities • Avoids duplication of efforts • Requires ability to synthetize
Observation of health practices	Determine actual behaviour pattern Identify obstacles in performing tasks **Qualitative**	Transport Repeated measurements required in different settings	Quick results	Supervisors Trained observers Participant observers	• Not very reliable if observation is unstructured (e.g. no rigorous definition of indicators) • Helps establish how widespread a practice or product is and whether materials or training are needed to support the practice • Also good for monitoring
Ethnographic profiles*	In-depth study of a culture into which a given health practice will fit. **Qualitative**	Depends on variety of ethnic groups to be studied.	A few months	Participant observer Informants* Anthropologist	• Determine how other cultural aspects can be used to promote a new idea • Reveal cultural taboos • Important as baseline information
Household surveys*	What proportion of the total target population have a given belief or behaviour? **Quantitative**	Expensive: may need large samples to be statistically significant	A few months to: • design questionnaire • pre-test • train • collect data • analyze data • write report • use results	Trained interviewers Supervisors Data analysts Statisticians	• Needed to validate hypothesis formed from qualitative research. • Also good for periodic evaluation of behaviour or knowledge changes • Can be biased by respondents who do not understand questions or are not willing to answer them or want to please interviewer

Table 2 (cont.): **Some examples of communication research methods**

Research method	Data collected	Cost	Time	Staff needed	Remarks
Central location intercept interviews*	To obtain target audience reactions to messages from large number of respondents at central location (market place for example) in a short period of time **Quantitative**	Not very costly	Use of close-ended questions (yes-no) allows quick analysis of results	Easily trained interviewers	• Very superficial insight • Inappropriate for sensitive or emotional subjects • Good for pretesting*materials and messages in a variety of locations
Focus group discussions*	Major trends in feelings, beliefs, attitudes of homogenous groups on product, practices and ideas **Qualitative**	Depends on number of group meetings necessary and what financial incentives are needed to have participants attend meeting. Cost of facilitator Sample size is small	Relatively rapid results	Trained facilitators	• Group setting useful in opening people up to talking more freely among peers. • Generate a lot of ideas on the reasons products are liked or disliked. • Form a hypothesis which can be validated by a survey. • Results may not be applicable to entire population.
In-depth individual interviews*	Further understanding of particular values or viewpoints previously identified during group discussions **Qualitative**	Expensive Difficult to get large numbers of interviewees	Time consuming to arrange, conduct and analyse results	Trained interviewers	Useful for getting private opinions of: • leaders • physicians • health workers on sensitive issues • hard-to-reach audience Cannot be used to make broad generalizations

Step Two
Plan communication activities

What is a communication plan?

A communication plan will guide the CDD communication activities. When the plan is first written, it is quite broad. Its primary purpose is to establish clear and feasible goals and outline the primary means to achieve those goals. However, the communication plan is meant to be adjusted or revised over time as more information on the audience is obtained through communication research, pretesting of communication materials, and monitoring.

A good communication plan should include the following sections:

1. A definition of the target audiences
2. List of behaviours to be adopted by these target audiences
3. Constraints to adopting these behaviours
4. Communication objectives
5. Approaches to change
6. Mix of communication channels that will be used to deliver messages
7. Institutions responsible for carrying out communication activities
8. Timetable
9. Budget

When is it developed?

Ideally, the communication plan should be made when planning for improvement in diarrhoea case management is undertaken and major activities of the national CDD programme are being planned. This is to make sure that communication will support and be relevant to the current emphasis of the programme (e.g., improvements in access to effective case management in health facilities, or widespread promotion of home therapy).

Who develops it?

Communication activities are best planned with communication specialists, such as the CDD communication coordinator. If there is a sociologist or anthropologist in the team, then he or she can work in close cooperation, particularly on communication research and on monitoring and evaluation* of impact.

The communication coordinator uses the information gathered during "Step One: Investigate" for communication planning:

1. General characteristics of audience
2. Specific characteristics of audience
3. Communication networks
4. Communication resources
5. Feasibility of CDD policy and needs for communication activities

Communication activities are planned in close association with CDD policy decisions and programme activities. Therefore, it is important to ensure that the person responsible for communication forms part of the programme team and can talk with the CDD manager, and with other specialists frequently.

The exchanges involved in communication planning between the CDD programme manager and the communication coordinator are shown in Table 3.

Table 3
Exchanges involved in planning communication activities

Role of the CDD Programme Manager		Tasks of the Communication Coordinator
Identifies overall programme objectives, strategies, emphases, timing, institutional arrangements, targeted geographic areas	→	1. **Identifies specific needs for communication activities**
		a) Reviews the health problem; reviews related beliefs, preferences and practices of the population concerned; reviews resources
Provides information on technology options being considered (ORS and home therapy), delivery systems under review, pricing/cost of product	→	b) Reviews the assumptions made about response of users
Reviews and revises national policy on ORS and home therapy	←	c) Identifies specific gaps between programme expectations and the likely response of the user; identifies those which are amenable to communication solutions; identifies other feasibility problems
		2. **Plans a communication component** (initial proposal of Communication plan)
Checks for technical accuracy	←	a) Messages and audiences
Sees how such arrangements fit in with overall CDD programme institutional arrangements	←	b) Institutions responsible for carrying out communication activities
Checks against CDD timetable Reviews linkages with other CDD programme activities	←	c) Timetable, including plans for monitoring and evaluation of communication activities
Checks for compatibility with training plans Revises training schedule	←	d) Proposed schedule for developing and pretesting prototype communication materials
Approves budget and makes financial arrangements	←	e) Different cost options

The communication plan

Each section of the Communication Plan is described.

1. Definition of the target audiences

A key word in communication is **"audience"**. It is often used confusingly to indicate primary beneficiaries of a programme, but the beneficiaries in CDD programmes are the children themselves. The audience is not the beneficiaries but, typically, mothers and caretakers of children under 5. It also includes other interest groups whose informed support is necessary at various times and at various levels if the programme is to proceed as expected.

Communication activities for CDD might, for example, involve establishing a dialogue with some or all of the subgroups in Figure 3.

The priority audience - also called **primary audience***, is parents, and particularly mothers and other caretakers of children (such as grandmothers and older siblings)

Figure 3 **Target Audiences**

Adapted from: *Reference Material in Programme Communication* - PSC and Training Section UNICEF/ EAPRO Handbooks in Communication and Training for CSDR No. 1

An important supportive audience to parents are the people with whom they interact daily and who influence decisions: typically senior relatives, community leaders, etc. We would also include these people in the primary audience.

The next important audience to be considered are the front-line health staff and the medical community. They should not only know how to provide the services but also how to communicate the needs for and benefits of ORT, proper feeding, referral and prevention practices. Therefore, health staff are an important **secondary audience*** to be informed about the programme and encouraged to inform and involve the primary audience.

Thus, we see that in public health communication, audiences have two functions:

a. They are our target audiences toward whom our messages are tailored and directed.

b. They function as channels of communication or media within the programme in relation to other subgroups or audiences.

What other groups do we need to reach and activate in order to communicate with our primary and secondary audiences? In Figure 3, the order in which we have presented our secondary target audiences reflected their relationship to the primary audience.

The rest of the plan describes how to influence these primary and secondary audiences.

Remember:

- The definition of target audiences also depends on the emphasis of the CDD programme in terms of case management. For example, when the focus is on major health facilities, only mothers who attend major health facilities and health staff who are receiving training in these facilities would be included in the target audiences. (See Figure 1.)

- Once the primary audience has been defined, it is very helpful to partition it into homogeneous subgroups, also called audience segments*, according to different criteria (such as rural/urban, literate/illiterate, ethnic groups, geographic location) in order to better tailor messages and select the best channels for message delivery.

2. Behaviours to be adopted by the target audiences

Defining the behaviours to be influenced is key to establishing an effective communication plan.

The CDD policy outlines the product and behaviours that the programme is recommending. Communication planners may need to restate these more clearly. They will describe the behaviours that the audience is expected to do after the communication activity.

Describing the desired behaviours involves breaking down a task into successive steps. In the example from the Philippines, mixing ORS was described as follows:

a. Pour 5 glasses of water into a pitcher
b. Pour all contents of the ORS sachet from both compartments of the packet
c. Stir
d. Give to drink

It is necessary to establish priorities for the behaviours to promote. If communication activities try to achieve too many changes at once, they may change nothing. The most successful programmes have focused on just a few behaviours.

In selecting priority behaviours, you should consider the following:

Questions	Result
• Does the behaviour help to solve the most serious health problem in the most effective way? • Does it have a high probability of making improvements which the audience will observe as positive? • Does it provide some advantages, from the audience's point of view, over what they are now using or doing?	If so, it has **effectiveness and appeal**
• Does it require few changes from what the audience is already doing? • Does it represent the least complicated alternative available?	If so,it will be **easy to use or practice.**
• Does it require that users have relatively few outside resources in order to use the product or practise the behaviour correctly?	If so, **resource availability** is not a problem.
• Are there few or no potential dangers in using the product or practising the behaviour? • Are there few or no side effects?	If so, it is **safe**.

3. Constraints to adopting these behaviours

Communication planning is a problem-solving approach based on the results of investigation.

Once desired behaviours to be performed by each subgroup of the target audiences have been specified, we want to know: **What prevents people from doing them now? What are people doing now and why are they doing it?**

Is there:

- a lack of information?
- a lack of motivation?
- a lack of skills?
- other obstacles that cannot be solved with communication efforts (for example, a lack of health facilities, a lack of supplies, a lack of access to trained staff, work overload)?

One needs to know what changes in life-style or habit will be required of individuals who will practice effective case management. *Change in deeply-rooted habit is a high social price to pay for the adoption of an idea, a behaviour, or a technology. Change is especially difficult when continuous compliance is required or when success is not instantly apparent (as in the example of preventive measures).

The analysis of constraints recognizes that provision of services does not necessarily change behaviour. It also recognizes that simple top-down provision of information about those services will not affect **audience response** unless the services in question and the communication activities address the audience's interests and needs. Continuous audience or user analysis will uncover the important interests, needs and obstacles.

4. Communication objectives

Communication objectives are specified for each target audience and may include one or all of these, depending on the constraints or obstacles that must be overcome.

An objective should be:

a) meaningful, based on the priority behaviours to be changed
b) realistic, describing what can really be accomplished given existing resources
c) clear, so that other programme personnel understand it
d) measurable, so that it is possible to evaluate whether or not the objective was met
e) ranked (because not all objectives are equally important with limited budget and staff, planners must carefully set priorities for a given set of objectives)
f) consistent over time:

   If objectives are changed frequently, it will disrupt the continuity needed to move users beyond awareness of the programme to trial and adoption of CDD behaviours.

Communication objectives are best stated in terms of:

- access (to material or to a medium)
- exposure* (to a message)
- knowledge (of a product or of a skill)
- trial (of a behaviour)
- adoption (continued practice of a behaviour)

Examples of possible communication objectives for home fluids are in Table 4. The same types of objectives can be applied to ORS.

Table 4
Examples of communication objectives

a. **Access**	• 50% of the rural mothers of children under 5 possess a CDD flyer • 35% of the urban mothers of children under 5 have consulted with a CDD service provider
b. **Exposure**	• 70% of the target audience have heard a CDD radio spot during the last two months • 30% of the mothers read and understood the pamphlets they received
c. **Knowledge**	• 50% of the target audience will state that infants need special attention during diarrhoea episodes • 45% will state that children with diarrhoea should be given rice gruel
d. **Trial**	• 45% of the target audience will report having given rice gruel at least once when their child had diarrhoea during the last 3 months
e. **Adoption**	• 30% of the target audience will report always giving rice gruel when their child has diarrhoea or 25% of the target audience will be observed giving rice gruel to their child during diarrhoea episodes.

We would like to be able to predict the effectiveness of each channel of communication in increasing access to and use of home therapy. However, the user is reached by multiple and mutually supportive channels. The effect of one channel cannot be isolated from the others.

The communication specialists will base their objectives on past experiences in health-related communication efforts in the country, and on the amount of resources that the programme can mobilize. Existing market research or audience research can estimate the probability of reaching a certain number or proportion of users given the frequency and time of exposure to various channels of communication.

For example, if a programme is setting very high objectives for access to and use of home therapy in a short period of time (a large increase compared with the present situation), then reaching and influencing the users will require mobilizing major resources (e.g., intensive mass media campaigns). If it is unlikely that the programme can mobilize this amount of resources, then alternative objectives can be proposed to the CDD manager.

5. Approaches to Change

First of all, messages will be designed according to the emphasis of the programme in terms of case management. They will focus on promoting the use of health facilities or other providers and the use of home therapy.

At the planning stage, messages are not final yet, but the communication specialist may already have some useful hints about the following questions:

- What will be the key benefit to the audience in applying the desired practice that the message will emphasize?
- What incentive or what external support will be given to the audience to make sure they follow the advice or believe what we are saying?

Some approaches to change then can be chosen from among those presented in Table 5.

An educational campaign can make an emotional appeal to audiences to adopt ORT, or present the factual, scientific basis for ORT. Most of the successful ORT communication components identified earlier such as in Egypt and Honduras used a combination of these change strategies.

Strategic decisions may also include providing users with a measuring and mixing container, re-labelling or re-designing the ORS packet, etc.

Table 5
Approaches to change

Strategy	Method	Example
Power	Sanction/Force	Ban anti-diarrhoeals
Logic	Facts	Teach dehydration concept
Appeal	Emotion	Tonic to restore appetite of sick child
Incentive	Reward	Distribution of an attractive plastic measuring cup
Facilitation	Remove obstacles	Package salts in convenient glass-size packets
Fear or Danger	Emotion	A child with diarrhoea and dehydration dies

6. Mix of communication channels (media mix)

Different communication channels do different things for different segments of our target audiences. Posters alone, radio alone, or community meetings alone, that is, used in isolation from each other and without a comprehensive plan, will not be effective.

This section of the plan deals with selection of communication channels. Selection of a channel or a group of channels is based on consideration of:

- the characteristics of the channel
- the characteristics of the audience
- the nature of the communication task or tasks required in particular circumstances

In general, an effective communication component should use a combination of channels which maximize exchange - otherwise known as **two-way communication***. The selection process made by the coordinator will be further explained in the Implementation Step (beginning on page 44).

Some alternatives:

- audio-visual aids: posters, flyers, pamphlets, brochures
- mass media: radio, television, newspapers
- interpersonal (or face-to-face): this includes the use of well-informed or trained change agents at the community level such as health workers, school teachers, field workers, community leaders, and shopkeepers to instruct or motivate individuals or groups of people, for example, to teach women how to prepare weaning foods. There is also the use of community organizations such as village councils, development associations, women's groups, and welfare groups to involve communities and support the behaviour change, for example, to reinforce improved weaning practices.

7. Proposed institutions responsible for carrying out communication activities

There are four basic options available to a national CDD programme which needs various communication capabilities. The selection of ways to obtain personnel and other resources required to carry out the work of the communication component is further explained in Part III (Task 2: Involve other communication resources). It depends on:

- the programme's long-term commitment to or interest in communication
- the budget
- existing communication resources

The four basic options are:

Institutionalize:
create a new division or unit with skills needed for the communication component

Collaborate:
with another agency which has suitable experience and staff

Integrate:
through in-service training of existing staff (for example, train field staff)

Contract out:
to a university, an advertising company, a private institute, etc.

A combination of these options could be chosen. For example, communication research, monitoring and evaluation can be carried out by a university, broadcasting by a private radio station and face-to-face communication by field staff, health staff or school teachers.

8. Proposed timetable

The communication tasks that need to be scheduled are:

a. conduct further audience analysis

b. develop communication materials

c. pretest and revise communication materials

d. produce and distribute communication materials

e. train field staff in communication skills and mass media staff in technical content

f. diffuse messages through various channels

g. monitor communication activities

h. evaluate communication activities

Ideally, the implementation of these communication steps should be coordinated with the major programme planning and management steps of the CDD national programme, as indicated in the table on the next page.

Coordinated timetables

Communication		Overall CDD programme
1. Audience analysis	→ ↙	Establishing or revising a national policy
2. Communication Planning	← dialogue →	Plan for improvement in case management and plan for involvement in other diarrhoea control strategies
3. Develop, pretest and revise communication materials	→ dialogue ←	Develop training materials Develop resources and system of support for the programme
4. During training of health staff, distribute materials to be used for face-to-face communication with mothers. Train staff on why and how to use them and how to conduct and monitor communication activities. Brief and train media people	←	Train personnel and organise: • Production of ORS • Distribution of ORS • Health workers' responsibilities • Supervision
5. Teach mothers at health facilities how to control and treat diarrhoea	←	Health care delivery, e.g., effective case management at health facilities
6. Diffuse messages through other channels such as - local media - other providers - mass media	→	Conduct other activities as planned (e.g. supervision, procurement, routine data collection) Encourage health workers' participation and community's involvement
7. Monitor communication activities. Provide feedback to decision makers and to health staff	→ ←	Monitor programme activities Solve problems Provide feedback
8. Evaluate behaviour change (effective case management by mothers and health workers)	→	Evaluate the programme
9. Revise plan and strategy	← →	Revise plan

9. Proposed budget

The budget in the communication plan should only indicate the major expense items. Costs will depend on the selection of institutions responsible for implementation and the size of the audience that needs to be reached.

Activities	Costs to be expected:
a. communication research including: pretesting monitoring evaluation	salaries transportation per diem supplies data processing
b. Printing costs	including cost of mock-up* designs and layout
c. Distribution of outreach educational materials	can be done during training for interpersonal communication
d. Broadcast cost	technicians/producers' salaries audio-visual supplies/equipment rental air time
e. Training for interpersonal communication including: seminars workshops meetings home visits etc.	transportation per diem training materials salaries

The communication coordinator could consider the proportion of the overall CDD programme budget which will be devoted to communication. This may be 10-20 percent. The communication coordinator should try to present alternative budgets to clearly show the range of options and facilitate approval of the budget by the CDD programme manager.

Approval of the plan

Once the Communication Plan is developed, it is necessary to obtain the commitment and endorsement of relevant authorities who are directly involved or who have some kind of authority over the CDD programme. These might include the CDD Programme Steering Committee or Advisory Board. The plan may also need to be approved by other institutions, such as the government radio or television station, if they are involved in the plan. Getting the Communication Plan approved by key authorities helps elicit their commitment and prevents disagreements or controversies which would otherwise emerge once implementation has begun.

Step Three
Develop communication materials

After drafting the Communication Plan, the first task is to prepare the educational messages and materials. These could include:

- Printed materials and audio-visual aids such as flyers, posters, flipcharts, audio-cassettes, comic books, etc. These will include materials to be used in interpersonal communication with mothers, community leaders, and community health workers.
- Product packaging, including mixing instructions.
- Promotional materials, such as the CDD logo.
- Mass media materials, such as radio and television spots and programmes.

These materials should be developed by individuals with production expertise and then tested with the target audience. They should be as close to their final form as possible when tested.

It is important that individuals who will produce communication materials be well-briefed on the CDD programme goals and objectives. They should understand:

1. the technical aspects of diarrhoeal disease control,
2. the results of the communication research and how the results were incorporated into the Communication Plan,
3. their own scope of work and activity schedule,
4. how their work fits in with other CDD activities,
5. evaluation criteria, including the name of their supervisor and the plan for review and supervision of their work, and
6. the need for pretesting and revising their products.

The CDD Programme Manager should:

1. check for technical accuracy of messages
2. allow enough time for pretesting and revision of materials
3. make sure that development, pretesting, revision and production of communication materials is taking place before organizing training sessions of field staff so that during their training you can :
   - distribute communication materials
   - brief staff on key messages
   - teach them how to communicate and how to use these materials
   - get feedback from trainees on other communication issues.

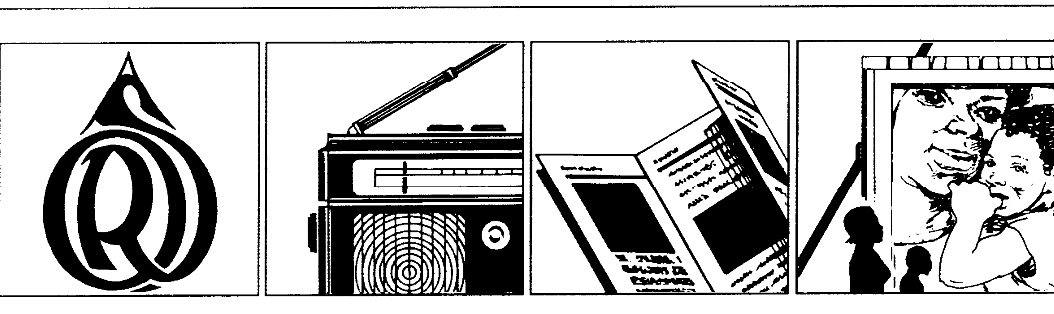
4. Select communication materials appropriate to the emphasis of the programme:

   - While emphasis is on increasing access to and use of effective case management in the health facilities, communication materials might be mostly audio-visual aids and printed materials that will help the health workers and other field workers in their interpersonal communication activities. Mass media materials would mainly aim at promoting services.

   - When the emphasis is on increasing use of home therapy by all mothers, it is important to brief health staff about future broadcasts. Health workers can use these broadcasts to reinforce their routine interpersonal communication activities. Some examples of ways to take advantage of these broadcasts are:

     - distributing printed materials that would complement broadcasts
     - organizing radio or TV forums at community health or cultural centres
     - recording radio spots on a tape-recorder to introduce educational talks at the health centre
     - teaching students to sing a popular song on CDD-related matters aired on the radio

Figure 4 **Hints for appraising communication materials**



A good logo*

- Simple, not cluttered
- Explicit and not abstract, the audience should understand it immediately
- Related to the key programme benefit, a symbol of a key idea
- Positive, uplifting, gives the idea of results
- Easily reproducible
- Works in different sizes and settings
- Dramatizes the overall tone of the change approach*

An effective radio spot

- Presents one idea
- Begins with an attention getter
- Is direct and explicit
- Repeats the key idea at least two or three times
- Asks listeners to take action
- Makes the audience feel part of the situation
- Maintains the same tone as the overall change approach

A useful flyer, visual aid, or clinic poster

- Carries the information most likely to be forgotten
- Uses visuals to tell the story, not only words
- Shows people doing key behaviours
- Uses images attractive to the audience
- Concise
- Maintains same tone as overall change approach
- Organized so that it favours a logical action sequence
- Designed for easy use as a visual aid
- Matches graphic and language skills of specific audience

An effective public poster

- Dramatizes a single idea
- Attracts attention from at least ten metres away
- Uses visuals to carry message
- Memorable
- Models the behaviour whenever possible
- Shows the product benefit to audience
- Consistent with tone of overall change approach

Step Four
Test and revise materials

The materials and products are tested with representatives of the target audience to ensure that they are understandable, appropriate, and attractive. Testing should be systematic. Asking just one or two people is not enough. Some of the methods used for the initial communication research are equally appropriate for testing materials and products with the target audience.

Materials testing involves demonstrating the materials and products to answer a series of questions:

1. Does the target audience understand the material and products?
2. Do they feel that the materials were made for them or for other people?
3. Is there anything offensive or culturally inappropriate in the materials?
4. Does the target audience think they are attractive?

Frequently, the same material is presented in two or more different formats, so that people can choose the one they prefer. If possible, it is best to actually observe people using the materials or products. For example, if a flyer teaches how to mix and administer ORS, it is best to ask mothers to actually perform these behaviours, using the instructions on the flyer. In this way it is possible to observe whether the mothers can follow the instructions.

Materials and products are revised based on the test results. Revision may involve changing vocabulary, eliminating a particular element such as distracting sound effects in a radio spot, combining parts of two different materials, or actually beginning from scratch with a new idea resulting from the tests. If new materials are developed, they should also be tested before being produced in their final form. Frequently developers hesitate to make changes because they have invested time and resources in the material. They must be supported and encouraged to improve materials through testing.

Figure 5 **How testing improves a logo**

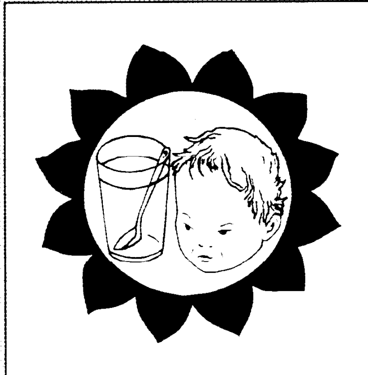
The first Executive Director of the Egypt ORT Project examined more than one dozen logo ideas submitted to the project by different artists and designers. He liked one particular logo much more than the others and was tempted to adopt it for the ORT project without further deliberation. Even so, he agreed to withhold his final decision until all logos were thoroughly tested.

The logos were shown to a sample of mothers who were asked to choose their favourite. To the Director's surprise, the logo he preferred was the one least favoured by the test respondents.

The tests also showed that the logo chosen could be modified to make it more effective. A large number of mothers felt that the logo colours should be changed and that the mother pictured in the logo should wear a wedding ring.

The Executive Director adopted the logo selected by the mothers for the ORT campaign. The experience so impressed him that he frequently recounted this story to emphasize the significance of audience research. Indeed, the story illustrates the importance of research in maintaining a user-orientation for successful communication in a CDD programme.

This was the Director's original choice.



This was another test idea.

This was the mothers' favourite.

Step Five
Implement the communication plan

The coordination of communication activities with other CDD programme activities, as indicated in the timetable (page 38) is essential to reach overall CDD goals. For example, trained providers, ORS, and educational materials must be in place before the mass media begin creating a demand for services and ORS products.

CDD programmes should begin with an active training component. This may involve:

1. Improving and accelerating the training of Ministry of Health service providers in correct case management if sufficient providers have not already been trained,

2. Teaching service providers about the communication objectives and the use of the newly developed educational materials,

3. Informing groups such as private physicians, pharmacists, traditional healers, media people, or other important opinion leaders about the goals and strategy of the CDD programme and what is expected from them as providers or communicators. Frequently print materials are distributed to these groups during training or briefing sessions.

Important issues during implementation are:

- Media mix
- Message phases
- Message design

1. Media mix

Media mix is the term used by communication planners to define the combination of media (or channels) - face-to-face, print, radio, television, etc. - used to deliver messages.

The combined use of several channels of communication, for example, giving a message in interpersonal exchanges and reinforcing that message in print and broadcasts, is the key to successful implementation. The same messages using the same vocabulary should be repeated by nurses, physicians, radio spots and posters.

Media mix is determined by considering:

Audience

- its level of education
- its access to information technology (e.g. traditional media or electronic media)
- its media usage patterns and preferences

Communication objectives or tasks

- to inform
- to motivate or reinforce behaviours
- to teach specific skills

Characteristics of the medium* or channel

To what extent does the channel:

- allow for **dialogue and exchange**? That is, is it a two-way communication channel? This will enable checking for understanding. Two-way communication is best accomplished by well informed, well trained, motivated and empathetic health workers.

Interpersonal Communication
Professional health staff, village health workers, traditional healers, and other opinion leaders give CDD products and messages credibility. The interactive dialogue between the audience and a credible source of information is an effective channel for teaching about ORT and reinforcing correct behaviours, especially at the community level. Techniques to strengthen interpersonal communications include demonstrations, which are particularly effective for modelling desired behaviour and audio-visual aids such as posters, slides, cassettes or printed materials, which help the audience visualize or memorize key ideas.

- allow for **timeliness and act as a reminder**?

> **Audio-visual aids and printed materials**
> Each kind of printed material has its own strength. Flyers and ORS packaging give the mother detailed instructions on correct preparation and use of ORS **in her home** at the time she most needs it. **Point-of-purchase** materials displayed where ORS is sold or given, such as bill-boards, posters, and containers reinforce simple messages, but are not an effective medium to teach complicated skills. Flip-charts, slidetape shows, and other audiovisual aids ensure the delivery of correct messages in interpersonal communications. Press releases, magazines and newspaper advertisements can give status to programme messages. It is important, however, that printed and audio-visual materials be designed for a particular target audience. Booklets would not be effective materials for illiterate mothers, for example.

- allow for **culture or audience-specific** messages? That is, is it familiar to the audience and entertaining?

> **Folk Media***
> Community theatre, puppets, singing groups, and other folk media are important traditional channels in many countries. These can be used to give CDD programme messages credibility within traditional cultural patterns. Used on mass media, they can help give credibility and creativity to radio and television materials. At the community level, they help trigger community involvement for promotion of services and adoption of preventive measures.

- allow for **"reach and frequency*"**? That is, do we achieve good coverage with messages? Reach is the number of members of the target audience who can see or hear a programme message during an established period of time. Frequency is the average number of times the target audience hears or sees a specific message. The key is for the target audience to be exposed to messages a sufficient number of times over a period of time so that they will remember and act on them.

Broadcast Media
Both television and radio can extend coverage with CDD messages. Radio is more widely available in most developing countries, but television is becoming increasingly widespread. "Reach and frequency" are key words in the use of mass media materials. Effective mass media use includes repetition of a few practical messages on the most popular broadcast stations during "prime time" (hours of greatest audience listening or viewing) for a sustained period of time. Mass media has been demonstrated to create awareness of ORT and increase demand. In many countries, television can also increase the prestige of the CDD programme and teach skills for correct ORT use.

Longer radio programmes are more time consuming and costly to produce but can discuss behaviours in more detail. They also are a cost-effective way to reinforce training given to health staff and other providers by increasing community interest and support.

- not involve a lot of **recurring costs**?

Use of sophisticated audio visual equipment such as video can be expensive.

Reaching enough people with interpersonal communication requires a very large number of trained personnel and a way to supervise them and can involve buying means of transportation and gas for field staff.

Private sector broadcast time is more expensive than donated government station time. However, it may be more cost-effective to pay for air time on stations and programmes which will deliver the messages with the reach and frequency needed to be effective.

Printed materials can also be very expensive if they are to be attractive and printed in the quantities needed.

Media mix determines:

a) which channels will be used for each message and for each target audience. Different media may reach different segments of the audience or may be valued by a particular audience for different purposes.

b) what particular role each channel will play: dialogue, credibility, coverage, reminder, educator

c) with what frequency each channel will be used and how the messages will be scheduled

d) how the channels will be combined and mutually supportive (for example, health workers could inform mothers when to listen to the radio to hear CDD programme; printed materials could show the steps for correct use of ORT; radio could motivate users to follow all of the instructions on the printed materials about ORT).

2. Message phases

Not all messages should be delivered at once. Phasing messages wisely can increase impact and save money. For example, the first messages would be those which are absolutely necessary for initial knowledge and successful trial of ORT, first by health staff and then by mothers. During the diarrhoea season, more messages on treatment might be appropriate. The communication planner should also be careful to coordinate with other health or developmental messages in order to avoid giving so many messages that the audience loses interest.

3. Message design

The message is the heart of communication. In public health communication, message design is the art of highlighting the benefits the audience receive for adopting a new behaviour or technology, in order to reduce their perception of the social cost of adopting it.

Messages should be:

understandable	**memorable**
technically correct	**convincing**
brief	**practical**
attractive	**relevant to the target audience**
standardized	

Meeting these goals is accomplished, not by following a standard recipe, but through creativity and use of audience research results to determine:

- how to "position" or place the product or behaviour into the audience's mind. Psychology applied to market research has helped uncover the symbolic value that we often unconsciously assign to products or events (e.g., pleasure/pain, young/old, power/weakness, etc.). For example, "Give **power** foods to your child during diarrhoea episodes" might be attractive to a given audience.
- what key benefit to emphasize to make it appealing to the audience. For example, "ORT restores appetite of your child" might be an important benefit.
- how to make your message more credible. For example, identifying the Minister of Health or a famous physician or actress as the source of the message might increase compliance.
- the tone of the message. Will you use threat, fear, ego, self-esteem, positive features or negative, modernity, or another approach? For example, "ORS is the medicine for diarrhoea used by the modern, loving mother".

"A healthy child, a happy family"

Step Six
Monitor, evaluate and revise

Monitoring and evaluation are already activities of national CDD programmes. The goal of monitoring is to identify any problem in the activities early, so that they can be solved without delaying the programme's progress.

While some monitoring results reveal general areas for programme improvement, some will relate to specific programme activities. Relevant monitoring results should be used for improving some parts of the Communication Plan with new strategies, messages, and materials. In this way CDD communication becomes a process of continuous development and improvement.

Like monitoring, evaluation is a means of finding out what is happening in a programme. However, evaluation is usually done at less frequent intervals than monitoring. Evaluation should also help a programme manager figure out why a programme is where it is.

Planning to monitor and evaluate communication activities should be part of the overall CDD programme plan for monitoring and evaluation. The communication coordinator should assist the CDD programme manager in proposing a plan for monitoring and evaluation of communication activities, in proposing answers to such questions as:

- what to monitor and evaluate
- who will monitor and evaluate
- when to monitor and evaluate
- where to monitor and evaluate
- how to monitor and evaluate.

1. What to monitor in communication

Monitoring communication generally includes examining:

- messages and materials in the course of their development
- communication inputs
- communication results

Messages and materials in the course of their development

As the CDD programme progresses, it may provide more or different services, and the characteristics and practices of the target audience will change. Therefore, new communication messages and materials should be developed on an ongoing basis to meet the current and future communication needs. Testing and improving these materials during development is an important part of monitoring.

Communication inputs

Communication does not always involve producing or distributing communication materials. However, it is more and more common and cost-effective to complement interpersonal communication with audio-visual aids and mass media materials. Inputs to monitor could be:

- the number and categories of health staff who received communication training
- the number of home visits or meetings made by community health workers
- the number of educational talks at health centres
- the number of print materials and audiovisual aids produced
- if printed materials were distributed and used as planned
- the number of radio or TV programmes produced
- if mass media materials were aired as planned

Communication results

Changes in target audience knowledge and practices are assessed periodically to permit revision of communication messages, materials and strategy.

Key questions for monitoring communication results include:

a) Are the target audiences receiving and in contact with the programme materials and messages? For example:

   How many mothers can show a flyer on ORS?
   What proportion of our target audience heard a CDD radio spot during the last 3 months of broadcasting?

b) Are target audiences using the programme materials? How can the materials be improved to make them more useful?

c) Are the target audiences learning the programme messages? Which ones have they learned? For example:

   How many mothers can state which foods to give to their child during a diarrhoea episode?

d) Are the target audiences performing the programme behaviours correctly? Which ones are they performing? Why aren't they performing the others?

2. How to monitor

Monitoring communication activities requires frequent measurements. It aims at understanding why certain things are not happening and at finding solutions with the target audience. Therefore, methods of data collection that allow for dialogue and exchange with target audiences will be favoured, such as:

- home visits

- in-depth individual interviews with health staff and opinion leaders

- focus group discussions with providers or users
- observation of practices by an outsider (e.g., supervisor) or by a participant (e.g., community health worker)
- some methods among those described in the section on communication research (pages 26 - 27) are also relevant to monitoring, such as intercept interviews.

It is important that monitoring activities be practical and viewed as a tool for decision-making. They must not become cumbersome research exercises or activities which alienate health staff. Monitoring should:

- be presented to health staff as a way of improving the programme and not as a mechanism to criticize staff performance.
- produce succinct, practical, and timely results.
- ask WHY certain things aren't happening and then identify what to do to make them happen.
- involve the target audience in identifying solutions to the problems or constraints identified in the monitoring. When a problem is studied from the point of view of the target audience, a practical solution is more likely to be discovered.

3. What to evaluate

Communication evaluation measures inputs, and intermediate outcomes as well as long term changes in behaviour. Evaluation is carried out less frequently than monitoring. Useful communication indicators can be placed in three categories:

1. Final outcomes, i.e. long term adoption of recommended practices
2. Intermediate outcomes
3. Inputs, i.e. the amount of resources put into communication activities of the programme

Examples of communication indicators

1. Final outcome indicators

Target audience: **Mothers**

- ORS/ORT use rate
- continued feeding use rate
- % of target audience correctly preparing ORS and/or recommended home fluids
- % of target audience seeking treatment outside the home when necessary

Target audience: **Health workers**

- % of cases correctly given advice on home treatment (and prevention)

2. Intermediate outcome indicators

Exposure

- % of target audience who heard or read or saw communication messages and materials

Knowledge

- % of target audience who know about
  - correct preparation and use of ORT/ORS/home fluid
  - what foods to give
  - when to seek treatment

Trial

- % of target audience who have tried correct home treatment at least once

3. Input indicators

Examples:

- Number of health workers who received training in interpersonal communication
- Number of printed materials (of a given type) produced
- Number of mass media programmes or spots produced
- Quantity of broadcasts (number and frequency)
- Quantity of educational talks given in a given setting with a given audience

4. When and how to evaluate

Evaluations are often large-scale studies which provide quantitative data (statistics). In CDD programmes, communication questions can be integrated into on-going CDD monitoring and evaluation activities - routine reporting, supervisory visits, household surveys, or a Comprehensive Programme Review. If resources permit it, evaluation can also be carried out by private or public research institutes.

Because of the high cost of large scale studies and the slow rate of behaviour change over time, evaluation need not be done more than once a year.

5. What to do with monitoring and evaluation results

Monitoring and evaluation aim at improving programme activities. Following are a few examples of constraints identified by communication monitoring and evaluation in CDD programmes and solutions that might be used to overcome those constraints.

Identified constraints	Possible causes	Proposed communication solutions
Graphic materials are not reaching the target audience	• Breakdown in the distribution system	• Review the distribution system to identify the point of the system which broke down. • Conduct a feasibility study of alternative distribution systems using private voluntary organizations (PVOs), the mail, bus systems, or other existing transportation systems. • Distribute new materials through the most cost-effective system.
Broadcast stations are not airing materials at programmed times	• Competition for airtime such as advertisements or other government agency materials	• Renegotiate with the station. • Pay for airtime if necessary. • If prime time cannot be negotiated, develop a promotional strategy to increase the audience during times CDD materials are being aired.
Production of mass-media materials is ahead of service delivery	• Training of staff has been delayed or distribution system for ORS is not yet operational	• Postpone distribution of mass media materials, so that product or service delivery demand is not created until sufficient staff has been trained and ORS packets have been distributed.

Identified constraints	Possible causes	Proposed communication solutions
Target audience has not heard/seen mass media materials	• Broadcasting time is inappropriate for audience's habits • Broadcast did not take place at scheduled time • Broadcasts are not attractive or easy to understand • Mothers do not have access to mass media	Potential changes to improve mass media materials include: • developing new, more creative materials • increasing the frequency of broadcast or changing broadcast times • increasing the "reach" by broadcasting materials on more stations, and • promoting CDD mass media programmes to increase the number of listeners or viewers
Target audience has not had contact with trained service providers	• Users may not know where to obtain services, especially if the programme is using new or relatively unknown providers such as village health workers • Target audience may be going elsewhere to obtain diarrhoea treatments	• Promote services through mass media and tell when and where to obtain services and products • Coordinate with other providers: traditional healers, pharmacists and small store owners, for example
Target audience has not learned the messages	• Users do not have access to CDD messages frequently enough • Users do not understand the messages • Programme sending too many messages at once	• Reconsider media selection and frequency of diffusion • Redesign messages and improve specific materials • Select priority messages and increase the ways in which the same message is delivered • Simplify and standardize messages
Target audience is not performing desired behaviour even after programme intervention, communication efforts	• Target audience does not have access to necessary ingredients and containers • Target audience is not motivated to adopt behaviour (e.g., child refuses to eat) • Audience does not know **when** to perform behaviour	• Not a communication problem. No communication solution. Change national policy • Reinforce other behaviours mothers have already adopted • Inform

Remember:
There are limitations on measuring the effects of communication inputs in a programme.

The effect that programme activities may have on behaviour is influenced by all the other factors and influences present in the community. Effective communication is integrated into the CDD programme. The only way of isolating the effects of the communication input is through complex experimental design which compares groups who are alike in all respects except their communication exposure.

A similar study design is needed to compare the relative impact of different channels. This type of study is time consuming, expensive, and rarely feasible on a large scale. Therefore, for the communication component, monitoring and evaluating inputs and results as described on the previous pages (50-55) is important and realistic.

The communication design process: Summing up

Effective communication requires:

- careful research and planning
- creativity and pretesting

The same basic scheme of any social intervention should be followed:

1. Investigate the problem
2. Plan
3. Develop materials to be tested
4. Test the materials and approach
5. Implement the plan
6. Monitor and evaluate the implementation phase to detect problems and unexpected obstacles and make needed changes

The main points about the communication component are reviewed below:

- **The communication component must be coordinated with other elements of the programme.** Demand for services or products should not be created before having the capability to offer an adequate and operational service delivery. Different communication inputs must be planned in advance and properly phased relative to other aspects of the programme and to each other.

- Communication relies heavily on **audience analysis**. Information from and about target audiences, their characteristics, and their current beliefs and behaviour is needed to help shape the programme overall, as well as the communication component. Investigation can use a variety of qualitative and quantitative methods.

- To communicate means to share ideas, to participate. The media used must be carefully selected according to their functions and strengths and the audience to be addressed. The **combination of media** used must allow the audience to also speak back if there is to be real communication.

- There is no one way a good communication component is designed. Not all programmes will rely primarily on radio and TV; not all programmes will have a poster, or flip chart. Every programme will have to carefully analyze its own audience, set communication goals which are consistent with overall programme goals, and build upon local resources.

Part III

The CDD Manager's Role in Communication

This chapter outlines your four principal responsibilities for the communication component:

Task 1
Select a communication coordinator

Task 2
Involve other communication resources

Task 3
Brief the communication coordinator and make financial arrangements

Task 4
Supervise the coordinator's work, and ensure communication activities are coordinated with the rest of the CDD programme.

You do not have to write radio programmes, design posters, or conduct audience interviews. You do have to know what to ask your staff, how to assess materials, and how to integrate communication with other programme activities.

Task 1
Select a communication coordinator

A communication coordinator is very important to effective CDD communication, especially at the onset of major new communication activities. The CDD manager has responsibility for the entire CDD programme and would not have the time, skills, or background to effectively design and implement the communication component. In countries where resources permit, the CDD manager should contract a full-time coordinator to lead the communication component.

In addition to carrying out the six steps of the communication process, the communication coordinator should also help you with the following specific tasks:

1. Analyze the communication research, including:
   - initial assessment of the situation
   - pretesting of messages and materials during their development
   - data collected for monitoring and evaluation results.
2. Assist in the review and definition of the CDD national policy.
3. Contract and manage outside production experts of communication materials, e.g., advertising agencies, PVOs, etc.
4. Assist outside communication resources to understand the CDD programme and the communication strategy reflected in the design and implementation of the CDD communication component and materials, and ensure their involvement.
5. Brief outside resources and other institutions involved in the communication component.
6. Provide in-service training to the MOH Health Education Unit and other collaborating institutions in communication planning and management, communication research, media design, and production.
7. Liaise with other collaborating institutions.
8. Assess cost estimates from production experts and prepare alternative budgets for the communication component.
9. Supervise procurement schedules of communication materials and audio-visual equipment.

Selecting a communication coordinator

The following list reviews the main issues involved in the identification and selection of a CDD communication coordinator. The idea is to select the most capable expert whom you can afford, given your level of resources. Ask as many questions as you can and do not hesitate to ask what you believe may be obvious questions.

Assess potential candidates by considering the following:

1. What kind of successful experience has this person had in each of the key areas - communication planning and management, communication research, mass media and graphic materials design and production?

   It is preferable for the expert to have had some experience with:

   - primary health care issues
   - community development and adult education (field experience)
   - educational materials development
   - development issues (including rural development if your primary audience is mostly rural)
   - marketing of medical products.

   Since you will be providing technical guidance, successful experience in communication is more important than a health background.

2. What is the quality of previous work the expert has done? All experts will show you their best work first. Ask to see a representative sample of the work they have done, not just their best. Breadth of experience and creativity is more important than quantity or similarity of work.

3. What is the reputation of the expert? Ask other people who have worked with the expert for references. Remember, this person will be representing the CDD programme.

4. Ask the expert to prepare a sample communication plan based on this guide. You may have to pay the candidates for their costs in preparing these sample plans.

5. How interested is he in working with the CDD Programme? Can he commit himself full time?

6. Does the expert have competing interests? If the expert is already working for a client who sells another type of drug which is promoted for diarrhoea, it might be difficult for him to work for CDD.

7. What does the expert charge? As in most fields, quality expertise is more expensive. You may have to pay more for the quality of the work required to make the CDD communication component effective.

Places to look for candidates for the position of communication coordinator:

- MOH Health Education or Training Unit
- Ministry of Information (and radio and TV stations)
- Ministry of Education or Agriculture (e.g. Adult Education Units)
- Advertising agencies
- Universities
- Non-governmental organizations
- Market research agencies
- Consultants.

Task 2
Involve other communication resources

The communication coordinator will need technical assistance and personnel to carry out communication activities in the areas of research, planning, and audiovisual production. The organizations that may help to carry out communication activities will have varying degrees of experience and different specialities such as:

- research
- programme design and planning
  (message development, instructional design, broadcast scheduling, etc.)
- radio programme production
- graphic design and production
- training in communication skills
- distribution of promotional materials
- network of field workers

This experience and capability can exist locally, in either the public or private sector, including donor agencies.

Ultimately, the selection of the organizations that will carry out communication activities will depend on:

- the size and scale of your programme
- funding available for communication activities
- political commitment to the CDD programme to ensure other ministries' collaboration and coordination (especially for the promotion of preventive measures)
- availability of capable communication institutions

Possible constraints

1. Scarcity of accessible communication institutions

In some countries, there is a serious scarcity of the skills necessary to implement effective communications programmes - programme planning and management, instructional broadcasting, graphic design, research, and evaluation - as well as of the material resources needed, such as printing facilities, recording equipment, and travel allowances.

Poorly paid and ill-trained staff in the Ministries of Information or Health may be difficult to motivate to higher performance. In countries where some individuals have the needed skills, they are often employed in the private sector, in advertising or marketing firms, for example, and it may be difficult to hire them. It is often a problem that a large number of development ministries and other organizations all compete for a severely limited communication resource: time on the government radio service.

One of the tasks of communication research is to identify accessible and capable communication institutions, and recommend an appropriate mix of public and private sector institutions.

2. The contractual process

However outside resources will be involved in your CDD communication activities, you need to consider the amount of time it takes to select and contract them. Ministries and donor agencies frequently require many administrative steps to contract an outside firm or person. It is important to discuss with the ministry and potential donor contributors the processes and timeframe required and to allow time in the Communication Plan for these bureaucratic steps.

Possible communication resources

The following compares the strengths and constraints of working with various communication resources and offers management strategies for overcoming those constraints.

Ministry of Health, Health Education Unit

Strengths
The health education unit already exists in-house and is available for frequent, unscheduled consultations. It is relatively easy to develop a daily working relationship with such a unit. In addition, because the head of the unit is frequently a doctor, he sometimes has a better understanding of the medical and technical issues involved in the CDD programme.

Constraints
Most health education units generally are not experienced in planning and managing a large-scale communication component which is based on audience research and integrates mass media, print materials, and interpersonal communications. Most of them focus on developing print materials and audiovisual aids which are used to support training. These are sometimes supplemented by mass media materials, but generally not in a planned or integrated manner or in a way which has enough reach and frequency to have an impact. Health education units are frequently under pressure to produce materials for many of the ministry programmes simultaneously and may not have sufficient time to dedicate to CDD communication.

Management strategies
Health education units generally need assistance in planning and management of CDD communication. Emphasis generally must be on how to use communication research to define the strategy and messages, how to integrate channels, how to focus on a few messages over a period of time, and how to coordinate communication with ORS packet supply, service delivery, and training. Consultants can assist in improving these skills within the unit, or advertising agencies or other outside organizations can be contracted to provide this expertise. If the programme works only with the unit, the CDD manager will need to obtain decision-maker support to make CDD a priority activity for the health education unit. This will help give unit staff sufficient resources and time to produce a more effective communication component.

Government radio and television stations and other public sector expertise

Strengths

The availability of a government media system which has a substantial audience significantly lowers the cost of CDD mass media materials. Government stations generally welcome quality materials to fill their air time. Likewise, coordination with other government agencies such as a Ministry of Information research unit or a Ministry of Agriculture training unit can lower costs and extend CDD coverage.

Constraints

Government broadcast stations and other ministries have their own priorities, production schedules, and obligations. CDD programme activities may be perceived as "outside work" and will be the first activity to be delayed if there is other work. Government stations tend to produce longer, more didactic radio and television materials which are broadcast only a few times. Government stations are sometimes hesitant to use familiar vocabulary or discuss diarrhoea on the air. It can be difficult to get a formal commitment to airtime and set a clear contract.

Management strategies

If other government ministries or organizations are to be used, they must be a part of communication planning and management from the onset. Ideally, commitment should be obtained from the minister and solidified through inter-institutional workgroups at the operational level. If other government organizations are involved, the communication schedule should allow more time to implement activities because of unforeseen changes in workloads which cannot be directly controlled by the Ministry of Health.

Broadcast stations may need assistance in developing more innovative short announcements and in understanding the importance of "reach and frequency" — repetition of a few key materials frequently for several months at a time. Broadcast station staff should be involved in the communication research and testing of materials so that they understand why materials need to be broadcast at certain times and why local vocabulary is important to the impact of the CDD materials.

Non-governmental organizations

In many countries, private sector or private voluntary organizations (PVO's) develop and produce educational materials or programmes.

Strengths

Such organizations generally have resources for the communication research needed to design their materials. Frequently they produce high quality materials in a timely manner. They often have a highly motivated network of field workers who can distribute communication materials and use them effectively.

Constraints

Generally such organizations produce basic graphic materials for training community workers. They are usually not experienced in planning and managing large-scale programmes or in using mass media in coordination with graphics and interpersonal communications.

Management strategies

PVOs could be used as one of several resources to implement a specific part of the communication component — audience research, graphics design and production, or village-based training, for example. They could also be assisted to expand their planning and management capacity.

Universities

Strengths

University faculty members are experienced in designing and conducting research, frequently in rural areas or with lower income groups. Social science faculties, particularly in anthropology, sociology, and the behavioural sciences, provide unique insights and research skills which may be critical to designing effective communication for traditional or rural target audiences. This experience also serves to train students who may become future leaders in CDD or other public service programmes.

Constraints

Formal coordination between a Ministry of Health and a university is frequently difficult and time consuming and sometimes not feasible. Universities may produce very theoretical or abstract reports that will be difficult for communication planners to interpret.

Management strategies

If formal coordination must be obtained, the communication component schedule must allow for delays caused by the bureaucratic processes. Informal coordination with a specific professor's research or class work may be a more practical, timely mechanism for coordination, or the CDD programme may want to contract with a particular professor or students as consultants. The research protocol may indicate that the project is operational research and the language should stay simple and practical.

Advertising agencies

Strengths

Advertising agencies are experienced in planning and managing large-scale communication activities, designing and producing creative materials in a timely manner, and conducting communication research. Generally they produce higher quality communication strategies and materials than the public sector.

Constraints

Advertising agencies are generally not accustomed to marketing for lower income audiences, the target audience of CDD programmes. They generally evaluate communication impact by measuring product sales, not by correct product use. They are usually unaccustomed to considering instructional or health issues such as correct ORS mixing and administration and dietary management. They are usually not experienced in coordinating promotional activities with a Ministry of Health "training plan" or with limited service delivery. They often are fairly expensive.

Management strategies

The CDD manager should be especially explicit about the instructional requirements of CDD communication such as correct mixing and administration and dietary management. He will also need to discuss with the advertising agency the unique

constraints of marketing CDD behaviours and products to lower-income families. The CDD manager will also need to ensure that the promotional activities are **well coordinated** with ministry training and service delivery. Frequently materials developed by the advertising agency will be used and distributed during training of staff by the ministry. A good Communication Plan will outline this coordination, and the CDD manager will only need to check for correct implementation.

Market research agencies

Many countries have private sector firms that specialize in research to help commercial firms to design marketing plans.

Strengths
Market research agencies are experienced in designing and implementing qualitative and quantitative research. Once they are contracted, they generally produce the research quickly and effectively.

Constraints
Since most marketing is aimed at middle to upper income or urban audiences, such agencies may not have experience in conducting research with lower income or rural families. They can be expensive.

Management strategies
The research protocol and methodology will need to reflect strategies to overcome constraints of conducting research in rural, traditional, or lower income audiences. The agency may need to contract additional expertise or seek assistance from anthropologists or rural sociologists to assist in the design and implementation of the research.

Long and short-term consultants

Strengths
Experts with successful experience in the specific skill areas — communication planning and management, communication research, media design and production, or training — can provide in-service guidance and training to strengthen the health education unit. They can also assist the Ministry of Health to better utilize private sector resources and provide full time technical assistance at the beginning of the CDD communication component or while ministry staff are being trained. They can give greater status and priority to CDD communication activities than in-house personnel.

Constraints
Consultants are frequently not familiar with the political, economic, and other constraints within which the CDD programme and ministry must operate. Consultants tend to push their own area of expertise at the exclusion of others.

Management strategies
The scope of work needs to be clearly defined. The CDD manager and other staff need to spend time with consultants to give them background information necessary for effective implementation of the communication component and to ensure that they are following the scope of work.

Task 3

Brief the communication coordinator and make financial arrangements

1. Brief the communication coordinator

The communication coordinator needs to know about:

1. The nature and the importance of diarrhoea as a health problem.
2. The structure of the health system.
3. Health worker training and health education activities.
4. The history of the CDD programme.
5. The official policy and the dominant attitude of the medical community toward the treatment of diarrhoea.
6. Scope of the programme and objectives.
7. Main target audiences.
8. Technology options being considered.
9. Distribution systems being considered.
10. Tentative timetable.

All this information should already be in the CDD Plan of Operations. It is your role to make sure that the communication coordinator has access to it and to discuss it with him.

The coordinator should review this material regularly so that he will understand the basic technical parameters of your programme. He will use this information and his own judgement when planning the communication research (described in PART II, Step 1) and when writing the Communication Plan (Step 2).

You may lack confidence in some data on the assessment of diarrhoea as a health problem. It is widely recognized, for example, that reliable statistics on infant mortality and diarrhoea mortality and morbidity, and information on diarrhoea management practices are difficult to obtain. Therefore, it is helpful to give your communication coordinator a sense of how realistic you believe different estimates are. You can most easily do this by identifying your various sources of information:

- National survey (dates)
- Local/regional survey (dates)
- Official government estimates
- Other research studies
- Widely held opinion.

In some cases you may not have hard data to support your statements. But it is important that you give your best estimate, **indicating where you lack data.**

It is strongly recommended that the communication coordinator be invited to consult with an intersectorial coordinating committee for diarrhoeal disease control. This will enable him to facilitate the involvement of all capable communication institutions and participate in the planning and implementation of the programme.

2. Financing the communication component

Your job as programme manager is to see that the financial and personnel resources needed to carry out the Communication Plan are available.

It may happen that mobilizing resources for the overall CDD programme is done before having recruited a communication coordinator and having drafted a communication plan. Typically communication activities account for 10-20% of the CDD programme budget; that amount could be reserved for communications activities.

This proportion corresponds roughly to what a private firm is willing to spend for the promotion of products. One might say that public health communication need not be that expensive because it does not imply contracting out with private advertising companies or market research firms. This is true since the Ministry of Health may work with less costly public institutions. However, public health communication is concerned with changing far more complex behaviours than changing consumption patterns from one brand to another. While aggressive marketing campaigns aim at shifting a small market share, public health communication efforts need to achieve a dramatic change in use rates to obtain tangible health benefits. Sustained adoption requires continuous exposure to educators and motivators within the communities, and ongoing monitoring activities on a large scale. The required resources to meet this challenge **should not be underestimated**. A breakdown of these costs is presented in Table 5.

Access to funds is critical to programme success. Without an appropriate management system for funding, broadcast, print, and interpersonal channels will not interact according to the plan and timetable to produce an effective combination. Flexible financial control permits paying for services and research which are often outside the normal operating procedures of your ministry. You need a plan for dealing with these special costs and making midcourse corrections. Flexible financial management, when overlooked, may cause delay of certain activities while others continue and result in failure.

Funding will be needed for:

- research (including baseline data on the audience, pretesting, monitoring and evaluation)
- materials and development
- broadcast costs
- printing costs
- distribution costs
- interpersonal communication costs such as training and supervision of service providers in communication
- technical assistance.

Table 6 **Costs for communication activities**

Nature of expense	Costs
1. **Communication Research** including initial audience research, material testing, and monitoring and evaluation is absolutely essential. Resources are needed for staff salaries, travel, per diem costs for at least two months for initial data collection on the audience; and for modest supplies for testing materials and report writing. In some settings, a local university may have a research department, or the Ministry may want to develop its own capacity. Each alternative has different cost implications.	• Staff salaries: interviewers trainers of interviewers supervisors of interviewers data analyst • Transportation • Per diems (field research) • Data processing (computers or manually) • Report writing
2. **Broadcast Cost.** Radio or television requires funds for announcers, actors, scriptwriters, technicians, and programme directors. These services can be contracted, or in some countries cooperation with government stations is desirable. Television is usually considerably more expensive than radio. Costs are higher for both production and airtime.	• Salaries or fees: directors producers technicians actors scriptwriters announcers • Transportation - field programmes • Audio-visual supplies • Studio and/or equipment rental • Copyrights (music) • Airtime
3. **Printing costs** can be high. Government presses are often less expensive than commercial systems, but their reliability is sometimes unpredictable.	• Designer's fees • Layout and prototypes • Mass production
4. **Distribution costs** for flyers, posters and pamphlets can include freight and delivery charges.	• Freight, transport of print materials and delivery
5. **Training and supervision** of health workers and other providers in communication skills. Some of these costs, such as training and transportation, can be shared with the overall programme since the health worker training sessions will cover communication and other skills. Supervisors who will visit to follow up on training will not go to a community for communication activities only. Health workers may need to travel to nearby villages. These costs are often underestimated.	• Complementary training in communication skills: per diem transportation supplies/communication materials • Transportation for community involvement activities • Transportation for supervision activities: means of transportation gas spare parts
6. **Technical assistance**	• Communication coordinator's salary • Fees for other communication resources • Consultants (national or outsiders)

Task 4
Supervise and monitor

Once you have prepared the foundation for the communication component and selected your communication coordinator, then you become a full-time supervisor—delegating the job of developing the communication component to the coordinator but checking on key accomplishments in the process.

Figure 6 is a practical checklist of your supervisory and monitoring responsibilities for the communication component. It is organized by each of the six communication process steps. You can review those steps in the previous sections for more detail on the tasks. Refer to the list often to remind you what to look for as your communication component progresses step by step.

Figure 6 **Checklist for managing communication**

Step One
Investigate

❑ Brief the communication coordinator on the CDD programme and technical issues related to diarrhoeal disease control.

❑ Review the present CDD policy with the communication coordinator and other relevant staff. Identify areas of research necessary to refine the policy in terms of home management to prevent dehydration, treatment of dehydration and dietary management during and after diarrhoea episodes.

❑ Provide technical guidance to the communication coordinator and researchers in the design and implementation of the communication research.

❑ Review results of the communication research and refine the CDD policy based on those results.

❑ Obtain political commitment for the new CDD policy from MOH and other important institutions and decision makers.

Step Two
Plan communication activities

❑ Provide technical guidance on CDD policy and technical issues to the communication coordinator during the writing of the Communication Plan.

❑ Ensure that the Communication Plan is coordinated with service delivery and other activities of the programme.

❑ Assist the communication coordinator to plan monitoring and evaluation of the communication component. This includes the definition of the purpose, indicators, activities and for communication monitoring and evaluation.

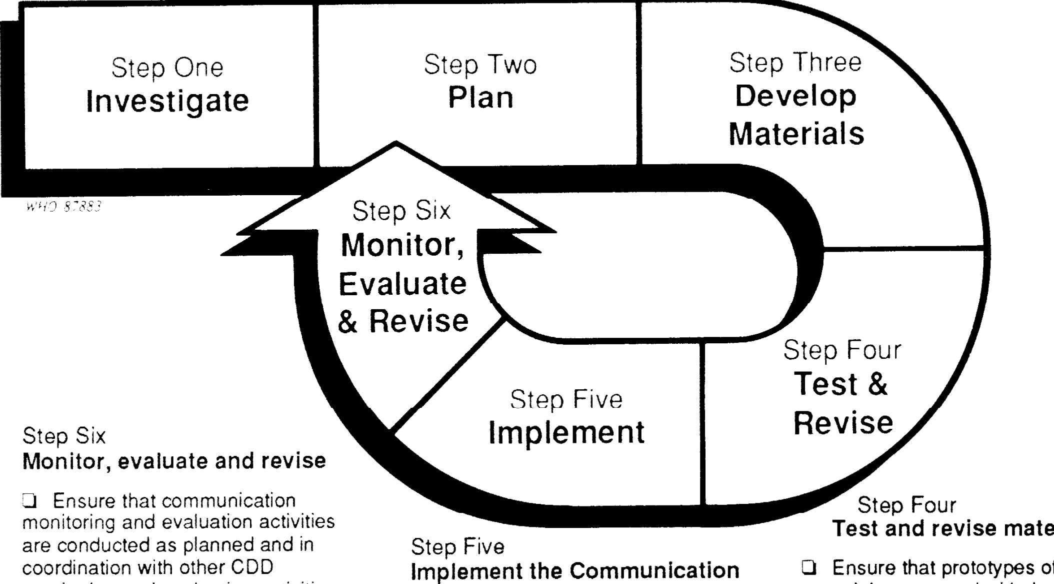
❑ Assist the communication coordinator to define the timetable of the communication component so that it is coordinated with other CDD activities.

❑ Obtain approval and financial resources for the Communication Plan from relevant authorities.

Step Three
Development of communication materials

❑ As necessary, assist the communication coordinator to select and contract communication experts to design products, mass media and print materials. Ensure that the steps of adequate field testing and revision of draft materials are included in the contract. Approve the scope of work and production schedule.

❑ Review materials and products to ensure that they are technically correct and that they are coordinated with each other and with other CDD activities.



Step Four
Test and revise materials

❑ Ensure that prototypes of materials are tested with the target audience(s) in a timely manner.

❑ Ensure that improvements are made in materials based on these tests.

❑ Review new drafts of materials to ensure that they are still technically correct and coordinated with each other and with other CDD activities.

❑ Facilitate funding for production of materials.

Step Five
Implement the Communication Plan

❑ Coordinate funds for all activities

❑ Check monthly to ensure that distribution of materials, mass media broadcasts, and other communication activities are being conducted as scheduled and in coordination with other CDD activities.

Step Six
Monitor, evaluate and revise

❑ Ensure that communication monitoring and evaluation activities are conducted as planned and in coordination with other CDD monitoring and evaluation activities.

❑ Provide technical guidance in the analysis of the monitoring/evaluation and the re-planning of the communication component and related CDD activities.

Glossary

Access

(to a product or service)
The opportunity to obtain or use a product or service. For example, people who have access to a health service must live near enough to use it.

(to a channel)
Having physical and technological means to receive a message through a given medium. For example, an individual has access to radio through his radio receiver but may not have access to the national radio programme because he lives in an area that is too far away to receive that radio station.

Adoption

Continuous and appropriate use of a product, service, or behaviour.

Anthropology

The scientific study of the culture, organization, and behaviour of human groups.

Audience analysis

The analysis of general and specific characteristics of the target audiences based on the result of communication research. The target audiences include the users and people who influence them.

Audience segment

A homogeneous subset of the target audience. Examining an audience segment enables planners to better describe and understand a segment, predict behaviour, and formulate tailored messages and programmes to meet specific needs. Target audiences may be segmented demographically (e.g., age, sex, education), geographically (e.g., urban, rural, northern, southern), economically (e.g., income level), and by a variety of characteristics (e.g., personality, lifestyle, services use patterns, risk factors, benefits sought).

Behavioural analysis

Analysis of events that condition, change and maintain behaviour.

Change approach

A set of financial or social incentives to reinforce behaviour change. For example, distribute a free container with the packet. The change approach sets the tone of the communication strategy.

Channel (of communication)

The way by which a message is transmitted. For example, word of mouth, letter, radio, telephone.

Communication

Social process of sharing or exchanging information between two or more persons by interpersonal (face-to-face) interaction or other media such as newspapers, radio or television broadcasts, brochures or posters, words and symbols (pictures, visuals, sounds).

Communication coordinator

A communication specialist in charge of planning and managing the communication component of the programme, based on communication research. He acts as team leader of the specialists in charge of research, materials development, and implementation according to the communication plan.

Communication research

An investigation of the factors and situations that will affect the communication component including the characteristics of the audiences, the communication networks available, resources available, the feasibility and desirability of the behaviours being promoted, and the effectiveness of given strategies and materials. It is the basis of planning and implementing effective communication activities.

Effective case management in the health facility

Correct assessment of the patient, correct selection of treatment, correct rehydration therapy (oral or IV), correct use of antibiotics if indicated, correct advice on effective case management at home:

- feeding
- continued ORT
- when to seek further treatment.

Effective case management in the home

Timely ORT, using correctly prepared fluid in adequate volumes, continued feeding in adequate quantity, correct knowledge of when to seek treatment outside the home.

Epidemiology

A branch of medical science that deals with the incidence, distribution and control of disease in a population.

Ethnography

The systematic recording of the cultural, organizational, and behavioural characteristics of social groups.

Evaluation

The process of assessing a programme's status, achievements, and impact in order to detect and solve problems and plan future programme emphases.

Exposure

Being in contact with (hearing or seeing) a message.

Flyers

Pamphlets or leaflets.

Focus group discussion

An interview conducted with a group of 6 - 10 people, specially selected and brought together to represent a target population which a programme is interested in learning about. A trained interviewer uses a prepared list of probing questions on a selected topic to encourage participants to speak freely among themselves.

Folk media
Traditional communication channels such as drama, song, dance, puppetry, and story telling. Sometimes called traditional media.

Home fluid
Fluid for preventing dehydration in the home.

Home therapy
ORT and continued feeding at home.

Household survey
A method of data collection in which surveyors visit houses to ask a series of standard questions at each.

In-depth interview
A form of qualitative research consisting of intensive interviews to find out how people think and feel about a given topic.

Informant
Members of a community that are selected by an anthropologist to get thorough in-depth information on the community's cultural values and beliefs. Selection is based on their willingness and ability to participate and their knowledge of the community.

Intercept interview
Interviews conducted with respondents who are stopped at a location that is highly populated and frequented by individuals typical of the desired target audience.

Interpersonal communication
Direct communication between two or more people in which immediate feedback (two-way communication) is possible.

K.A.P. study (knowledge, attitude and practices study)
Study of the audience's knowledge, attitude, and practices related to a specific product, service, or behaviour. This type of study has typically examined individual variables through quantitative methods (surveys). The influence of social factors and communication networks must also be explored.

Logo
An identifying mark, statement, or symbol.

Market research
A piece of research that aims at understanding the intended users' preferences, needs, and constraints to adopting a given product or service in order to plan ways to maintain or increase the number of adopters.

Media study
Study of the accessibility, acceptability, and usage patterns of various media for the purpose of selecting the best combination of media to reach the target audience.

Mass media
Systems or instruments of communication, such as radio, television, newspapers, intended to reach anonymous, heterogeneous, and geographically dispersed audiences with uniform messages.

Medium
Synonymous with channel.

Mock-up
An initial or preliminary design or model to be tested before full production.

Monitoring
Regularly checking to see that programme activities are being done as planned for purpose of finding problems and prompt solutions.

Oral rehydration salts
A mixture of glucose and salts conforming to the WHO recommended formula (in grams per litre): sodium chloride 3.5; trisodium citrate, dihydrate 2.9 or sodium bicarbonate 2.5; potassium chloride 1.5; and glucose 20.0.

ORS solution
A solution of Oral Rehydration Salts in water which is recommended for treatment of dehydration from diarrhoea and can be used to prevent dehydration.

ORT
Oral rehydration therapy using ORS solution or a recommended home fluid to treat or prevent dehydration.

Pretesting
Measuring the reaction of a representative sample of the target audience to a communication message or material prior to widespread diffusion in order to make the material more effective.

Primary audience
A term used in audience segmentation. Generally considered to be those people who are expected to perform the desired behaviour, such as using the products or services of a programme. In CDD the primary audience would include parents and other caretakers of children.

Provider-oriented
Based on the interests, needs, and concerns of the provider of the product or service of the programme.

Qualitative research
Means of obtaining in-depth information on a group under observation. The researchers frequently immerse themselves in the activities being studied. The information gathered usually cannot be quantified in numerical terms, and generalizations should not be made based on it.

Quantitative research
Research designed to gather information objectively from representative, random samples of respondents; results are expressed in numerical terms (e.g., 35 percent are aware of X and 65 percent are not). Quantitative data are used to make generalizations about the target audience.

Reach and frequency

The potential coverage of the broadcast facility, i.e., the number of people that can be exposed to a message at a given time; the number of times a given audience is being exposed to a given message during a period of time. For example, the radio can reach 80% of the total population. The frequency of the radio broadcast is 10 times a day for a week.

Secondary audience

A term used in audience segmentation. Generally considered those who influence the "primary audience" and whose informed involvement is also necessary; can be used to teach and support them in behaviour change. In CDD, the secondary audience would include health staff.

Self-reporting

Answer given by a respondent to interview questions about the respondent's own knowledge, attitude, or practice. Accuracy is limited by the willingness and ability of the respondent to answer accurately (for example, he may forget).

Stage

The emphasis or focus of a programme over a period of time. For example, when a CDD programme focuses on replacing poor diarrhoea treatment at major health facilities with correct case management, this could constitute the first stage. A focus on extensive promotion of home therapy through various media as well as the health system would be a later stage.

Strategy

A method of solving or controlling a problem. In a CDD programme the strategies usually include improving case management of diarrhoea, nutritional practices, use of safe water, good personal and domestic hygiene, and measles immunization.

Target audience

The segments of the audience to whom messages and materials are directed.

Two-way communication

A flow of information between the source of the message and the receiver in which there is a dialogue, i.e. an opportunity for the receiver to send feedback to the source and transform into a source of new messages. The receiver has the opportunity to send immediate and individual feedback to the source, for example, in a conversation.

User-oriented

Based on the user's interests, needs, and concerns.

List of photographs and illustrations

Photographs

Egypt - page 3
A nurse teaches mothers how to use ORS.
UNICEF photo by Sylvie I. Cohen

Honduras - page 4
A mother gives her child ORS.
Academy for Educational Development
Photo by Elizabeth N. Booth

The Philippines - page 5
A mother giving ORS at home
Photo by Ministry of Health

Thailand - page 8
At a health centre a health worker shows a mother how to mix ORS with water.
UNICEF photo by Amnat Nikromrat

Burma - page 45
Oral rehydration demonstration at a nutrition rehabilitation centre.
UNICEF photo by Steve Mains

Honduras - page 46
Poster from the Ministry of Public Health.
Division of Education/PROCOMSI

The Gambia - page 47
Radio broadcasts and mixing flyers reinforce interpersonal communication
WHO Photo

Indonesia - page 49
A simple and attractive message from the West Java ORT Project
"A healthy child for a happy family"

Illustrations

Figure 1 - page 13
The increasing numbers of mothers to be reached with communication
WHO Graphics

Figure 2 - page 17
Six steps towards effective communication
WHO Graphics

Figure 3 - page 30
Target audiences
WHO Graphics

Figure 4 - page 41
Hints for appraising communication materials
WHO Graphics

Figure 5 - page 43
How testing improves a logo
Preliminary drafts and final logo
Egypt NCDDP

Figure 6 - page 71
Checklist for managing communication
WHO Graphics

Cover and book design
WHO Graphics

Acknowledgements

This manual has been prepared by the WHO Diarrhoeal Diseases Control Programme in collaboration with UNICEF.

Acknowledgement is made to the following individuals and organizations for their contributions: Dr William Smith and Elizabeth Mills Booth, Academy of Educational Development, USA; Cecilia C. Verzosa, Kabalikat, Philippines; Dr Farag Elkamel, Center for Development Communication, Egypt; Patricia H. Whitesell, ACT International, USA. Acknowledgement is also due to many other experts both in and outside WHO for their helpful criticisms and comments.