

Health Communication

What is the high-impact practice for creating an enabling family planning environment?

Implement a systematic, evidence-based health communication strategy that includes communication through multiple channels to enable people to make voluntary and informed health care decisions.

“The single biggest problem in communication is the illusion that it has taken place.”

– George Bernard Shaw

Background

Health communication is the use of communication strategies—mass media, community-level activities, and interpersonal communication (IPC)¹—to influence individual and collective behaviors that affect health.² Research shows that theory-driven, interactive communication that follows a proven design and implementation process can increase knowledge, shift attitudes and norms, and produce changes in a wide range of behaviors (Noar et al., 2009).



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In the context of family planning programs, well-designed and -implemented health communication has helped support and strengthen existing services by:

In Cambodia, an NGO worker explains condom use to passengers on the Battambang-Phnom Penh train route using comedy and drama to inform young people about HIV/AIDS. Using such techniques in health communication programs engages people’s emotions while motivating them to make healthy choices.

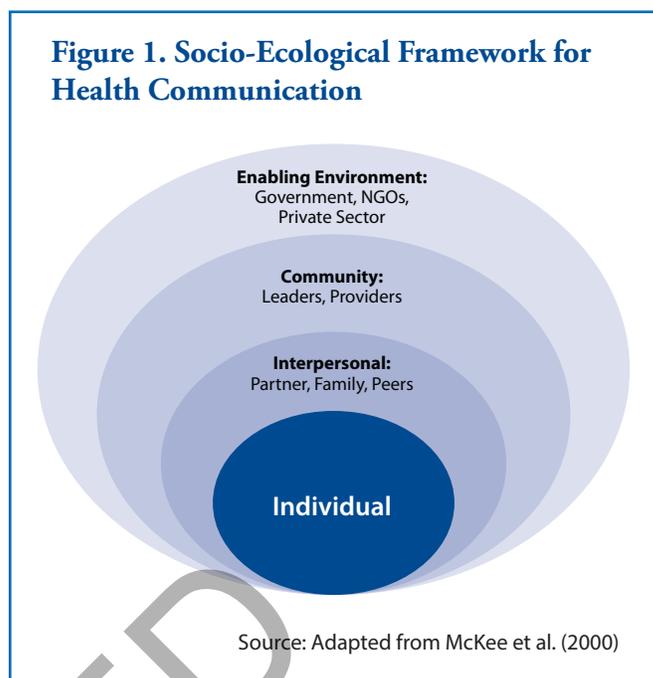
- Creating informed and voluntary demand for family planning products and services.
- Ensuring individuals can use contraceptives correctly and appropriately.
- Helping health care providers and clients interact with each other in an effective manner.
- Addressing behaviors that contribute to ill health or wellbeing.
- Shifting norms that can influence individual and collective behavior.

¹ Advocacy is sometimes included as a fourth category of health communication programming, as it is a necessary prerequisite or component of most behavior change efforts. However, because the evidence base and programmatic processes are somewhat different than for other health communication strategies, advocacy is not treated in this brief. For information about advocacy, please see the HIP brief on Family Planning Policy.

² In this brief, “health communication” is interchangeable with related terms, such as behavior change communication (BCC) or social and behavior change communication (SBCC), and closely linked to the broader, inter-sectoral category of development communication.

The field of health communication has evolved substantially in recent years. Programs have become more diverse in both content and communication approach; more creative and better produced; and more participatory. Many implementers also have begun to situate health communication in a socio-ecological framework, which recognizes that determinants of health and health behavior exist on multiple levels and extend beyond the individual (see Figure 1). Specifically, socio-ecological models acknowledge the influence of interpersonal relationships, community structures, and the broader environment.

Implementing a systematic, evidence-based health communication strategy is one of several “high-impact practices in family planning” (HIPs) identified by a technical advisory group of international experts. When scaled up and institutionalized, HIPs will maximize investments in a comprehensive family planning strategy (USAID, 2011). For more information about other HIPs, see <http://www.fphighimpactpractices.org/overview>.



Why is this practice important?

Limited knowledge of contraceptive methods may prevent women and couples from effectively managing their childbearing. A review of DHS data from 36 countries suggested that lack of knowledge of family planning methods remains an important barrier to contraceptive use, particularly in sub-Saharan Africa (Sedgh et al., 2007). In the seven African countries in which knowledge of family planning was lowest, 10% to 15% of married women cited this as their primary reason for not using contraception. Lack of knowledge may play a more important role with regard to some methods (such as long-acting reversible and permanent methods) or among certain population groups (such as young, rural, or less educated women). Health communication can create informed demand for family planning by increasing knowledge and awareness of suitable methods, their availability, and how to access them (Mwaikambo et al., 2011).

Fears and health concerns related to contraceptive methods and their side effects persist. Even when awareness of family planning is high, myths, misconceptions, and misinformation can limit demand (Sedgh et al., 2007; Campbell et al., 2006). In 26 of 36 countries with DHS data, 20% to 50% of married women at risk of unintended pregnancy cited side effects or health concerns as the main reason for not using family planning (Sedgh et al., 2007). Such barriers appear to be particularly common in countries of South Asia, Southeast Asia, and sub-Saharan Africa. Health communication programs can dispel myths about contraceptive methods, correct misconceptions related to their use and side effects, and increase client participation in contraceptive counseling (Kim et al., 2006-2007).

Social and gender norms that oppose family planning can limit contraceptive use. Fear of social disapproval or of opposition to contraceptive use by a partner or other influential person can limit use. DHS data from 53 countries between 1995-2000 indicated that about 12% of married women outside sub-Saharan Africa and 23% of married women within sub-Saharan Africa cited opposition to family planning (by the woman herself, a spouse, or other personal contact) as the main reason for not using contraception (Sedgh et

al., 2007). Health communication can help establish or strengthen family planning as a social norm among partners, family, and peers by promoting discussion about the benefits of family planning, birth spacing, smaller family size, and people's right to make choices in life.

Provider attitudes and practices can influence family planning demand and method choice. Health communication interventions can address provider bias against contraception and improve providers' ability to counsel clients. Studies across multiple countries demonstrate that provider bias can negatively impact access to family planning (Campbell et al., 2006; Abdel-Tawab and Roter, 2002). Improved client-provider interactions can create more satisfied and empowered clients, who can then make more informed and effective family planning choices (Campbell et al., 2006; Abdel-Tawab and Roter, 2002; Ramchandran, 2007).

What is the impact?

There is substantial evidence that well-designed and -implemented health communication programs can influence norms and behaviors, fostering the enabling environment required for delivery of health services at scale (Noar et al., 2009; Mwakaimbo et al., 2011; JHU CCP, 2009; Snyder et al., 2003; Storey et al., 2011; Westoff et al., 2011). A systematic review of 63 evaluations of family planning interventions³ indicated that 46 of these studies demonstrated increased contraceptive use, while 54 studies showed improved knowledge, attitudes, discussion, and intentions to use contraception (Mwaikambo et al., 2011). Another similar meta-analysis of 52 studies demonstrated positive behavioral impact in 15 family planning campaigns (Snyder et al., 2003). In these 15 campaigns, an average of 31% of respondents reported modern contraceptive use before the intervention, compared with 37% after the intervention. (See Table 1 for selected examples of studies included in these reviews.)

In addition to these main areas of impact, program evaluations also suggest the following:

- Direct or indirect⁴ exposure to health communication programs contributes to increased family planning use, in some cases by more than 150% (Boulay et al., 2002).
- Integrated, multi-channel programs typically produce greater impact than those that employ a single channel (Noar et al., 2009; JHU CCP, 2009).
- Mass media programming typically produces a dose-response effect, in which higher exposure to messaging results in increased positive behavioral change (Van Rossem and Meekers, 2007).
- Health communication is cost effective, with costs as low as US\$1.57 per contraceptive adopter in mass media programs (JHU CCP, 2009).

Updated research is needed, particularly on multi-channel family planning communication programs. In addition, understanding the contribution of health communication programs to population-level health outcomes, such as HIV incidence or total fertility rate, will require rigorous research that assesses field programs over several years and includes both process and outcome evaluations to measure behavior change (Mwaikambo et al., 2011).

³ Of the 63 family planning interventions, 47 were health communication interventions (mass media, IPC, and provider/client communication) and approximately 7 included health communication as a component of a broader intervention.

⁴ Indirect exposure to health communication programs occurs when someone is influenced by the program's message through someone who has been directly exposed to the message.

Table 1. Impact of Health Communication Programs on Family Planning Outcomes, Selected Studies

| Channel | Key Findings |
|--|--|
| Increased knowledge of contraceptive methods | |
| Multi | <p>Promotion of Youth Responsibility Project, Zimbabwe (Kim et al., 2001)</p> <ul style="list-style-type: none"> Description: 6-month multimedia campaign in 5 pilot sites promoting sexual responsibility and reproductive health among young people Results: Youth exposed to the program were 2 to 4 times more likely to know of most contraceptive methods than their peers and about 8 times more likely to know about female condoms |
| Multi | <p>Quiché Birth Spacing Project, Guatemala (Bertrand et al., 1999)</p> <ul style="list-style-type: none"> Description: Comprehensive intervention including improved access to services, IPC, mass media, and community-level advocacy to improve attitudes toward birth spacing and increase knowledge and use of contraceptives among a hard-to-reach population Results: Increased knowledge of contraceptives (from 42% to 95%) among Mayan women |
| Increased discussion of family planning between spouses, family members, or friends | |
| Mass media | <p>Fakube Jarra Project, Gambia (Valente et al., 1994)</p> <ul style="list-style-type: none"> Description: Training for family planning (FP) providers, distribution of information booklets to clients of FP services, radio spots, a radio drama, and listening groups to respond to fears and concerns about modern contraceptive methods among rural women and improve FP discussion between spouses Results: Women who heard the radio drama were significantly more likely than those not exposed to have discussed FP with their spouses (36% vs. 16%) and their friends (26% vs. 15%) after 2 years |
| IPC | <p>Senga Institution Study, Uganda (Muyinda et al., 2003)</p> <ul style="list-style-type: none"> Description: Community-based events and IPC about sexual and reproductive matters through the senga—a traditional channel of communication about sexual and reproductive matters—targeted at adolescent girls in rural Uganda Results: Increased communication about sexual matters with partners from baseline to 12 months (from 46% to 54%), as well as with other people (from 23% to 31%) |
| Increased positive attitudes toward family planning | |
| Mass media | <p>Twende na Wakati Project, Tanzania (Rogers et al., 1999)</p> <ul style="list-style-type: none"> Description: National radio soap opera promoting FP, broadcast from 1992-1997 Results: Increased positive attitudes toward FP as measured by: ideal number of children (4.9 to 4.4); ideal age at marriage for women (18.1 years to 19.3 years); and approval of FP (80% to 85%) |
| Increased provider support for family planning | |
| Multi | <p>Radio Communication Project (RCP), Nepal (Storey et al., 1999)</p> <ul style="list-style-type: none"> Description: Multimedia national reproductive health campaign (1994-1997) including 2 entertainment-education radio serials targeting the general public and health workers to improve FP services, especially counseling skills of health workers. Results: Improved provider knowledge (7%), FP attitudes of providers (2%), and IPC skills (8%). |
| Increased report of equitable gender norms | |
| Multi | <p>African Transformation Project (AT), Uganda (Underwood et al., 2011)</p> <ul style="list-style-type: none"> Description: Community development program (2005-2006) in 4 rural areas of the Central Region to measure if participation in community dialogues about gender issues would influence participants' self-efficacy, gender norms, and agencies Results: Participants were significantly more likely to report gender-equitable attitudes than their unexposed peers: 65% vs. 60% for men and 60% vs. 56% for women |
| Increased use of modern FP | |
| Mass media | <p>DHS Data Analysis, Kenya (Westoff and Rodriguez, 1995)</p> <ul style="list-style-type: none"> Description: Analyses of data from the 1989 Kenya DHS Results: Strong statistical association between women's reports of having heard or seen mass media messages about FP and use of contraceptives, even after controlling for a variety of life-cycle, residential, and socio-economic controls. 15% of women who had neither seen nor heard FP messages were using a method; increased to 25% among women who had heard radio messages; to 40% among women exposed to both radio and print messages; and to 50% among those exposed to radio, print, and TV messages |
| Mass media | <p>Twende na Wakati Project, Tanzania (Rogers et al., 1999)</p> <ul style="list-style-type: none"> Description: See above Results: Increased use of modern FP from 29% to 39% over a 2-year period for those who were in areas exposed to the intervention. Analysis of Tanzania DHS data also showed that exposure to the soap opera was associated with increased use of modern contraception |

How to do it: Tips from implementation experience

The following list highlights some key elements of successful health communication interventions. Note that not all the elements are necessarily required simultaneously for a successful intervention.

- **Follow a systematic approach.** Health communication interventions should be designed, implemented, and evaluated based on a systematic and proven process. Following such a process helps ensure that complex interventions are evidence-based, organized, and cost-effective, and it supports active engagement of audience members and other stakeholders. Typical processes include a series of steps such as:
 - situation and audience analysis,
 - strategic design, including objective-setting and channel selection,
 - development and pretesting of communication outputs,
 - implementation and monitoring, and
 - evaluating and re-planning.

For more details, see descriptions of “C-Planning” at <http://www.c-changeproject.org/> or the “P Process” at www.jhuccp.org.

- **Base program design and evaluation on theory.** Behavioral theories such as the Health Belief Model (Rosenstock et al., 1988), Stages of Change (Prochaska and DiClemente, 1992), and Social Learning Theory (Bandura, 1977) describe many factors that may influence behavior, including knowledge, self-efficacy, attitudes, risk perception, social norms, and access to products and services. Understanding how to measure and address these factors in both messages and methods is central to effective health communication.
- **Plan for and use research, monitoring, and evaluation.** Regular and actionable research, monitoring, and evaluation ensure that health communication is designed and implemented to the highest standard possible—which helps increase intervention impact. Research (either primary or secondary) helps implementers understand their target audience when designing a health communication intervention, which enables them to develop relevant, compelling messages and select appropriate channels. Process evaluation, as is the case with monitoring, helps to improve the quality of implementation, which is particularly essential in IPC and community-level activities. Periodic, small-scale qualitative activities or concept testing helps refine program content and inject new or evolving themes into a program. Impact evaluation—preferably with the ability to demonstrate the relative effect of activities in different channels—is essential to generate lessons learned that can be applied to other programs.
- **Consider and address the cultural and social context, including gender issues.** Health communication has historically focused on shifting intentions and behaviors at the individual level. However, there is now consensus that health communication must also address—and in some cases shift—prevailing social norms in order to achieve lasting behavior change at the population level. Formative research should consider not only the knowledge, attitudes, and practices of primary and secondary audiences but also the social and environmental context in which programs are implemented.
- **Segment audiences.** Audience segmentation—the process of identifying subgroups of people based on such characteristics as age, sex, place of residence, ethnicity, religion, marital status, or profession for purposes of customizing messages—is an essential component of effective health communication. The factors that influence the behavior of one group of people are not always the same as those that influence another group; for this reason, communication interventions should be tailored to meet the needs of particular subgroups.

- **Establish realistic timelines and budgets.** Implementers should set communication objectives that are realistic, measurable, and specific, with clear linkages between short-term objectives and long-term behavior change goals that often require significant time and resources to achieve. In some cases, long-term, cyclical initiatives may offer greater cost-effectiveness, flexibility, and impact than more traditional campaign models. Budgets should account for expenses associated with design (including formative research and pretesting); implementation; and monitoring and evaluation. These expenses may vary substantially by country and communication channel and should be informed by careful market research.
- **Harmonize messages across a combination of channels.** Research shows that communicating complementary messages through multiple channels enhances the impact of health communication. This requires coordination of efforts across implementers. Implementers should apply the same processes and level of rigor in designing and implementing activities in all channels.
- **Promote audience engagement and interaction.** Engaging audiences and provoking discussion are not only expected in today's communication environment, they are essential to achieving normative change. Interventions should plan to engage their audiences in design (identifying priority issues and locally appropriate solutions to inform messaging); implementation (ensuring continued audience engagement and feedback); and monitoring and evaluation (feeding back results to generate new content).
- **Align supply and demand.** Health communication is most effective when closely linked to provision of products and services. Implementers should coordinate with those offering social marketing or health services to ensure effective calibration of supply and demand. Such coordination may include development of joint communication strategies or harmonization of messages; staging of communication and supply-side activities to ensure that demand is adequate and corresponds to available commodities and services; or development and management of service brands, among other activities.
- **Foster synergies across health areas and development sectors.** All high-quality health and development communication interventions share certain characteristics and similar processes. Health communication implementers should create opportunities for exchange with their counterparts in other areas of health and development, as well as with private-sector communication experts, in the interest of improved innovation and establishment of economies of scale.

Innovations and Emerging Trends in Health Communication

Interventions must respond to the evolving context of communication and behavior change, incorporating not only new communication channels and formats, but also promising approaches to behavior change drawn from a variety of fields. Many implementers are increasingly turning to disciplines such as marketing, behavioral economics, and human-centered design for new ideas and strategies that can enhance the impact of health communication.

Practices that may hold promise include—but are by no means limited to:

- systematic use of mobile and digital media
- application of social network principles
- improved branding and creative design
- innovative and immersive research methods
- increased dialogue and audience engagement
- storytelling
- crowd-sourcing
- data visualization

Tools and Resources

A Field Guide to Designing a Health Communication Strategy https://www.k4health.org/sites/default/files/A%20Field%20Guide%20to%20Designing%20Health%20Comm%20Strategy_0.pdf

C-Capacity Online Resource Center <http://www.cominit.com/c-change-orc>

Tools for Behavior Change Communication, In: INFO Reports, No. 16 <http://www.k4health.org/toolkits/info-publications/tools-behavior-change-communication>

- **The Communication Initiative** <http://www.cominit.com/>

For additional information pertaining to social and behavior change, please also see the HIP briefs on Policy, Community Health Workers, and Social Marketing.

For more information about High-Impact Practices in Family Planning (HIPs), please contact the HIP team at USAID at fphp@k4health.org.

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Suggested citation:

High-Impact Practices in Family Planning (HIP). Health communication: enabling voluntary and informed decision-making. Washington, DC: USAID; 2012 Oct. Available from: <http://www.fphighimpactpractices.org/briefs/health-communication>

Acknowledgments: This document was originally drafted by Geeta Nanda, Hope Hempstone, and Zarnaz Fouladi. Critical review and helpful comments were provided by Arzum Ciloglu, Gloria Coe, Selam Desta, Peggy D'Adamo, Mario Festin, Sandra Jordan, Azza Karam, Shawn Malarcher, Alice Payne Merritt, Juncal Plazaola-Castaño, Suzanne Reier, Ruwaida Salem, Jeff Spieler, Nandita Thatte, and John Townsend.

This HIP brief is endorsed by: Abt Associates, Chemonics, EngenderHealth, FHI 360, Futures Group, Georgetown University/Institute for Reproductive Health, International Planned Parenthood Federation, IntraHealth International, Jhpiego, John Snow, Inc., Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, Management Sciences for Health, Marie Stopes International, Pathfinder International, Population Council, Population Reference Bureau, Population Services International, University Research Co., LLC, United Nations Population Fund, the U.S. Agency for International Development, and Venture Strategies Innovations.

The World Health Organization/Department of Reproductive Health and Research has contributed to the development of the technical content of this document, which is viewed as a summary of evidence and field experience. It is intended that this brief be used in conjunction with WHO Family Planning Tools and Guidelines: http://www.who.int/topics/family_planning/en/.

Access the current information about this HIP: <https://www.fphighimpactpractices.org/briefs/sbc-overview/>

