Health Communication in Pakistan

A Review

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Health Communication in Pakistan: A Review

Authors: Dr Zaeem ul Haq and Masooma Qazilbash

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Foreword

For the last 59 years of independence, health system in Pakistan has been trying to grapple with infectious diseases, malnutrition, maternal and child morbidity and mortality etc. The epidemiological data from the last decade or so shows increasing incidence of disorders previously considered to be problems of a relatively small affluent section of the society. Fortunately, most of these conditions are behavior related and can be addressed by providing appropriate information to the people and enabling them to take care of their own health.

It is high time that health planners in this country started acting on the realization that instead of building high-tech hospitals and training specialists for every kind of disease, it is public health measures like health education, safe drinking water; proper sanitation; good nutrition; healthy life style and basic immunization that can help improve health of the people in Pakistan.

Health education, the topic of this book, is included in public health programs only as a public relations campaign, a flashy cover to the otherwise dull program, a dessert to the main course. Due to this lethargic approach towards health education, population growth rate remained high, the use of immunization services remained static, the Polio cases kept coming up, and despite of being a low prevalence country for HIV-AIDS, Pakistan was to be reported as having highest HIV-AIDS cases resulting due to unsafe injection needles.

Analysis of this dismal situation informs that all the health education/communication or behavior change communication programs in the country are conducting campaigns consisting of communication activities only. Neither there is analysis of the problem, nor an effort to know the impact.

TheNetwork has conducted an extensive literature review of health education/communication initiatives taken up within Pakistan during the last 25 years. Drawing from the lessons learnt from international experiences, this review of the local health education/communication presents what essential steps are necessary for an effective health communication campaign and how much have they been followed by the local campaigns. This is the first review of its kind in our country and by no means a final document. It will be revised from time to time as Health Communication receives more and more attention of the public health programs.

Ayyaz Kiani
Executive Coordinator

List of Acronyms

AFP	Acute Flaccid Paralysis
AIDS	Acquired immunodeficiency syndrome
AV	Audio-visual
BCC	Behavior Change Communication
BMI	Body mass index
CBT	Cognitive Behavior Therapy
CD	Compact disc
CDC	Centers for Disease Control
CM	Community mobilization
CPR	Contraceptive prevalence rate
DGHS	Director General Health Services
DPT	Diphtheria, tetanus and polio
DPWOs	District Population Welfare Officers
EPI	Expanded Program on Immunization
FWCs	Family Welfare Clinics
GATHER	(Greet, Assess needs, Tell information, Help choose, Explain & demonstrate and Return/reinforce/refer)
HBM	Health Belief Model
HIV	Human immunodeficiency virus
IEC	Information, Education and Communication
IEEC	Information, Education and Empowerment for Change
IPC	Interpersonal communication
LHW	Lady Health Worker
MoH	Ministry of Health
MoPW	Ministry of Population Welfare
NACP	National AIDS Control Program
NGO	Non-governmental organization
OBSI	Optimal Birth Spacing Interval
PHC	Primary Health Care
RCT	Randomized Controlled Trial
SBC	Strategic Behavioral Communication
SMART	Specific, measurable, achievable, realistic and time-bound
STIs	Sexually Transmitted Infections
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

01

Health Communication

What is Health Communication?

There is no single definition of Health Communication. Multiple definitions and descriptions used by experts in the field of health communication are available.

According to Clift & Freimuth (1995), "Health communication, like health education, is an approach which attempts to change a set of behaviors in a large-scale target audience regarding a specific problem in a predefined period of time". The Centers for Disease Control and Prevention (CDC 2001) defines health communication as "the study and use of communication strategies to inform and influence individual and community decisions that enhance health."

For the academicians, (Ratzan 1994) it is "the art and technique of informing, influencing and motivating individual, institutional, and public audiences about important health issues" and its scope includes disease prevention, health promotion, health care policy, and business, as well as enhancement of the quality of life and health of individuals within the community.

Various other terms are also used for similar activities. In the modern literature for example, *Behavior Change Communication, Strategic Health Communication,* and *Information; Education; and Empowerment for Change (IEEC)* and *Strategic Behavioral Communication (SBC)* are used. Previously, the terms like *Health Education,* or *Information; Education and Communication (IEC)* were also used. On a closer look, it is found that these terminologies are used interchangeably for similar activities aimed at similar objectives. With minor variations, they all are targeted at the same objective; empowering people with knowledge so that they can take care of their health by themselves.

In this paper, we will be using the terms *Health Communication, Health education,* and *Behavior Change Communication* implying same meanings at different points of discussion as has been used by relevant experts and programs in their papers and concept documents.

“ Health communication, like health education, is an approach which attempts to change a set of behaviors in a large-scale target audience regarding a specific problem in a predefined period of time. ”

Health and Behaviors–The Challenge

"Prevention; consultation; or use of medication; all of these are behaviors. In the world of today, almost all the health problems, one way or the other, are related to such behaviors."

The turn of the 20th century saw great medical progress as better understanding of hygiene, development of vaccines and discovery of antibiotics started contributing a considerable longevity to human life. Encouraged and thrilled by this progress, the world health leaders in 1978 at Alma Ata dreamed of "Health for all by the year 2000". But even 5 years after this deadline, being healthy is still a dream for billions around the globe.

Why is this?

If we look at health as a product, human beings are its biggest producers. It is human beings who adopt preventive measures to avoid sickness. It is them upon whom lies the responsibility of consulting a physician on falling sick, and using the medication as per advice. Prevention; consultation; or use of medication; all of these are behaviors. In the world of today, almost all the health problems, one way or the other, are related to such behaviors.

This behavior-health nexus can be better understood by examining the 10 leading risk factors identified by the World Health Organization (WHO) for preventable death and disease worldwide in 2002. They include: maternal and child underweight; unsafe sex; high blood pressure; tobacco; alcohol; unsafe water, poor sanitation, and hygiene; high cholesterol; indoor smoke from solid fuels; iron deficiency; and high body mass index (BMI), or overweight.

Forty percent of deaths worldwide are due to these 10 behaviors related risk factors alone, according to the WHO.

Table 1: Top Risk Factors Leading to Disease, Disability, or Death

Poorest Countries	Developed Countries
1. Underweight	1. Tobacco
2. Unsafe sex	2. High blood pressure
3. Unsafe water, sanitation & hygiene	3. Alcohol
4. Indoor smoke from solid fuels	4. High cholesterol
5. Zinc deficiency	5. High BMI
6. Iron deficiency	6. Low fruit & vegetable intake
7. Vitamin A deficiency	7. Physical inactivity
8. High blood pressure	8. Tobacco
9. Illicit drugs	9. Unsafe sex
10. High cholesterol	10. Iron deficiency

Source: World Health organization (WHO), *Global Burden of Disease in 2002; Data Source, Methods and Results* (2003).

Pakistan is among those developing countries where many of the preventable diseases take a heavy toll on human health. It has high maternal and infant mortality rates. Malnutrition and infections e.g. diarrhea; respiratory infections including tuberculosis; malaria and intestinal worms lead to a heavy burden of disease. Childhood and infectious diseases are responsible for two thirds of the burden of disease in Pakistan (Hyder &Morrow 2000). The country is also experiencing considerable social change with changing family structures, urbanization and adoption of western lifestyles including unhealthy diet, stress, smoking, increased use of motor vehicles etc. Thus the so called modern or life style diseases like Hypertension, Diabetes, Ischemic Heart Disease, Cancer, Psychiatric problems and Traffic accidents, all behavior induced problems are also on the rise. Pakistan is among the top 10 world nations for high numbers of people with diabetes and a third of Pakistanis aged more than 45 years have hypertension (Ghaffar, Reddy & Singhi 2004).

“Pakistan is among the top 10 world nations for high numbers of people with diabetes and a third of Pakistanis aged more than 45 years have hypertension.”

Meeting the Challenge–Health Communication

Historically, in the post colonial period, when many countries after achieving independence, copied health care system in Europe and America, which had a curative model based on doctors; hospitals and drugs; the health of their people suffered. Among them, countries that realized earlier that promotion of health and prevention of disease do not lie in large hospitals; and made appropriate changes to their system; successfully improved the health of their people.

"Countries that realized earlier that promotion of health and prevention of disease do not lie in large hospitals; and made appropriate changes to their system; successfully improved the health of their people."

Today, USA has the most modern, expensive and technologically advanced health care system in the world. It spends highest per capita annually than any other country (UNDP 2005). Yet the average life expectancy and overall health status of its people is ranked 24th in the world (WHO2000). Countries like Japan are placed higher than the US. The better and longer lives of its citizens are attributed to better health behaviors like eating rice, fish and avoiding dangerous fats (WHO 2000).

Aiming to improve health behaviors, the World Health Assembly at Alma Ata in 1978, declared health education as one of the seven essential activities needed for successful PHC programs in developing countries (WHO 1978). Indeed if Primary Health Care is the backbone of a country's health system, health education and communication is the same for Primary health care. One cannot imagine diarrhea being controlled without adequate washing of hands; prevalence of communicable diseases decreasing without people knowing about the immunization and its schedule, or the challenge of non-communicable diseases being met without proper education on weight loss, exercise and stopping tobacco use.

Sometimes the need of health communication is questioned. For some, people know very well what there need is, and it is only the matter of fulfilling this need which can be done by improving systems. This usually comes from people with a 'clinical mental model'. Cynics on the other hand argue that if health education could work, we would not see the vast epidemic of HIV-AIDS. For them, it is very difficult to change human behaviors and this certainly cannot be done via distant messages. But is this really true?

Public Health experts have generally disagreed to it. According to Dr Hiroshi Nakajima, Director General, World Health Organization 1988, "most of the world's major health problems and premature deaths are

preventable through changes in health behavior and at a low cost. We have the know-how and technology but they have to be transformed into effective action at the community level".

Dr John Hubley (1993) has aptly put it: "The prevention of disease and promotion of health lie not in the hands of the medical profession and doctors but in the lifestyles and social conditions in which people live".

According to Piotrow et al. (1997), today in the field of public health, the issue is no longer whether health communication can influence behavior. Substantial evidence shows that:

- People want to know more about their health;
- People want to talk more about health to friends and family, hear about it through mass media, and discuss it with competent, caring service providers;
- People are willing to change their health behavior; and
- Public health communication programs are helping people make these changes.

The real challenge is to better understand the behaviors and develop innovative methods to help people overcome their unhealthy behaviors and replace them with healthier ones.

The case histories presented here establish how communication helped people in changing their health behaviors. These interventions primarily focused on individual and group or community behaviors. At the same time these interventions also addressed the behavior of key officials of the health system, the policymakers, and the other important contextual factors.

“Most of the world's major health problems and premature deaths are preventable through changes in health behavior and at a low cost. We have the know-how and technology but they have to be transformed into effective action at the community level.”

Case History:

Child survival through better feeding practices

Each year, an estimated 10.6 million children in low- and middle-income countries die before they reach their fifth birthday. Seventy percent of these deaths are due to just five preventable and treatable conditions: pneumonia, diarrhea, malaria, measles, and malnutrition. One intervention that could prove effective in prevention of all these childhood diseases is exclusive breastfeeding. The LINKAGES (1997) project developed behavior change strategies to work with policymakers,

health workers, communities, and family members to create a supportive environment for optimal breastfeeding.

It identified six elements common to its interventions in different countries:

- Formative research that analyzed benefits and barriers to change within each relevant segment of the population and identified the specific and desired actions that people were able to adopt
- Targeted, concise, and pre-tested messages to promote the "do-able" actions
- Counseling and communication skills for health and community workers
- Consistent messages and materials across program communication channels to address critical behaviors
- Saturation of specific audiences with messages through appropriate media (electronic, print, interpersonal, event-based, and traditional approaches such as songs and puppet shows)
- Support of the mother and peer group interaction such as mother-to-mother support groups, women's clubs, or other existing groups at the local level.

Results of the efforts were impressive. The rates of timely initiation of breastfeeding almost doubled in Madagascar (from 34 percent to 60 percent) and Ghana (from 32 percent to 62 percent), and rose 25 percent in Bolivia. The rate of exclusive breastfeeding nearly doubled in Madagascar (from 46 percent to 83 percent), increased significantly in Ghana, and showed a slight rise in Bolivia (Murphy 2005).

Case History:

Improving Maternal Health

Approximately 529,000 mothers die worldwide each year. Almost 99 percent of them take place in poor countries. Number of women suffering from pregnancy and delivery related complications is even higher. For every woman who dies, another 30 to 50 women suffer serious and long-term complications. Consequently, pregnancy-related complications are among the leading causes of death and disability for women in developing countries. A major element of success has been the integration of life-saving technologies with the

behavior change strategies needed to make them widely available- and used. The White Ribbon Alliance is an example of this novel combination.

It is a large-scale initiative, a grassroots movement now in 24 countries that initiates awareness-raising campaigns and builds practical, action-oriented alliances among communities, government health workers, and NGOs to prevent needless maternal and neonatal deaths.

These activities have been fruitful in many countries. In Indonesia, for example, 70 percent of women exposed to the campaign used a skilled provider for childbirth, compared with 44 percent who were not exposed; and 41 percent exposed to the campaign knew that bleeding during pregnancy was a danger sign, compared with 16 percent not exposed (Gryboski 2004).

Case History:

Uganda-fighting HIV-AIDS

Uganda was one of the earliest AIDS successes stories. In 1991, the incidence (new infections) and prevalence (total infections) among its population were very high. According to UNAIDS estimates, national prevalence peaked at 15% in that year. The country then experienced a dramatic decline. The falling HIV prevalence was most likely attributable to the nationwide diffusion of an innovation: sexual behavior change. The acronym ABC stood for those primary changes in behavior the population was urged to adopt: Abstinence, or delay of sexual debut; Being faithful, or reducing one's number of partners; or using Condoms. Major components of the social mobilization in fighting against the white plague in the country were:

- Decentralized behavior-change campaigns that reached general populations and key at-risk groups
- Focused Interventions that addressed women and youth, stigma and discrimination
- Religious leaders and faith-based organizations were mobilized to lead AIDS education and care activities
- Control and prevention programs for STIs received increased emphasis fromhigh officials

According to statistics, the national HIV adult prevalence in Uganda fell

"The health system often fails to identify malnutrition or simply ignores it. So a policy level behavior change is required. Gender-inequitable norms of the community result in poor women and girls eating less nourishing foods. This requires a change in group behaviors."

to 5 percent by the late 1990s, and stood at just above 4 percent in 2003 (UNAIDS 2004).

In countries like Pakistan, malnutrition is the condition that has a behavioral link at multiple levels and by taking its example; we can well understand the importance of changing human behaviors to improve public health.

As poverty, gender inequity, and other disparities are underlying causes of poor nutrition, addressing this health problem requires behavior change at all levels.

Decisions made by political and development leaders often create or worsen poverty. In addition, the health system often fails to identify malnutrition or simply ignores it. So a policy level behavior change is required. Gender-inequitable norms of the community result in poor women and girls eating less nourishing foods. This requires a change in group behaviors. Exclusive breastfeeding for the first six months is by far the best source of nutrition and disease prevention for infants, but faces years of declining practice and commercial promotion of infant formula, and has to be vigorously promoted to mothers-a change in individual behaviors.

In this challenging socio-economic and political milieu, the question is: Can we swing the pendulum? Can we influence behavior sufficiently to achieve health for all?

Behavioral science suggests that we can, and offers evidence-based theories of behavior change that can help avoid substantial suffering, exorbitant medical costs and premature mortality.

How behaviors change

Among the public health campaigners, it is a common complaint that the community ignores advice and continues to practice health-damaging behaviors even when they know them to be harmful. The real reason for failure, however, is often that the health education does not take into account the underlying influences on health, contains irrelevant information, promotes unrealistic changes, is directed at the wrong people and uses inappropriate methods (Piotrow et al. 1997).

The communicator must understand that communication is never carried out in a vacuum. It is directed at individuals living in a milieu that is influenced by their inside and the outside. In the process of communicating for behavior change, in many instances the communicator is not just introducing new behaviors; it is trying to substitute a new behavior for an old one. The communicator before developing a communication must ask the question, how did the "old" behavior take hold in the first place? It is necessary to understand this process and think about how health communication can integrate into the culture appropriate values, attitudes and behaviors such that a "health competent society" or culture would emerge. The communicator must also understand that all the old behaviors are not "unhealthy' or "unscientific".

In *Health and Culture: Beyond the Western Paradigm,* Nigerian professor Airhihenbuwa (1995) advises health educators not to assume that culture always represents an obstacle. He divides cultural traditions into three categories: positive, neutral, and negative. Cultural traditions such as breastfeeding and transmission of important messages through song and dance are positive building blocks for health education. Beads tied around a child's wrist to ward off evil spirits offer no threat to health. Gender inequity, female circumcision, and withholding fluids during diarrheal episodes have negative consequences. He recommends building on the strengths of the culture to reinforce the positive and gently undermine the negative.

Health Communication in its early days was conceptualized as a simple one-way transmission of messages from a source to a receiver with the intention of producing some effect (Rogers 1973). Under this, large volume approach was adopted in which attention was given to production of materials rather than to their content; to

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technical quality rather than to how different audience members would interpret the meaning of the content within their particular social context. Communication in this way sometimes even had effects on the audience contrary to those intended. One of the main lessons learned over the last 25 years is that effective communication begins with the audience, the client, or the consumer and continues over time as a process of mutual adjustment and convergence (Piotrow et al. 1997).

With increasing focus on the audience, health communication started turning to theories of behavior change of individuals and groups of individuals. These theories help explain the process that individuals go through as they exchange information and as they interpret and react to different messages.

Today, experts believe that theories and models provide a basis for predicting behavior change and maintenance, developing interventions to achieve changes in health-promoting and disease-preventing behaviors, and evaluating the outcomes of the interventions. The variety of theories and models available provide insights into the different factors affecting health-promoting behaviors, with no single model being all-encompassing (Ockene 1998).

Behavior Change - Models and theories

Following are the important theories and models of health behavior change.

Health belief Model

The Health Belief Model (HBM) was developed in the early 1950s by a group of social psychologists at the U.S public Health services. HBM suggests that beliefs about health develop in a certain steps and can be altered if those steps are followed. The steps include: *Perceived Susceptibility*, one's subjective perception of the risk of contracting some disease; *Perceived Severity*, perception about the seriousness of that disease; *Perceived Benefits* of adoption; *Perceived Barriers* to adoption; and *Cues to Action,* the stimuli to trigger the action.

HBM is a well researched model and a lot of evidence is available in its support, its main weak point is its emphasis on individual's reaction to environment and completely ignoring the environmental actions. Clark and Becker (1998) argue that many other factors influence health actions as well; for example: many health-related behaviors are undertaken for non health-related reasons e.g. dieting to appear more attractive, stopping smoking or jogging to attain social approval. Similarly economic or environmental factors may prevent the individual from undertaking a preferred course of action e.g. a worker in a hazardous environment; a resident in a city with high levels of air pollution.

“Stages of change theory identifies psychological processes that people undergo and stages they reach as they adopt new behavior.”

Stage/Step theories

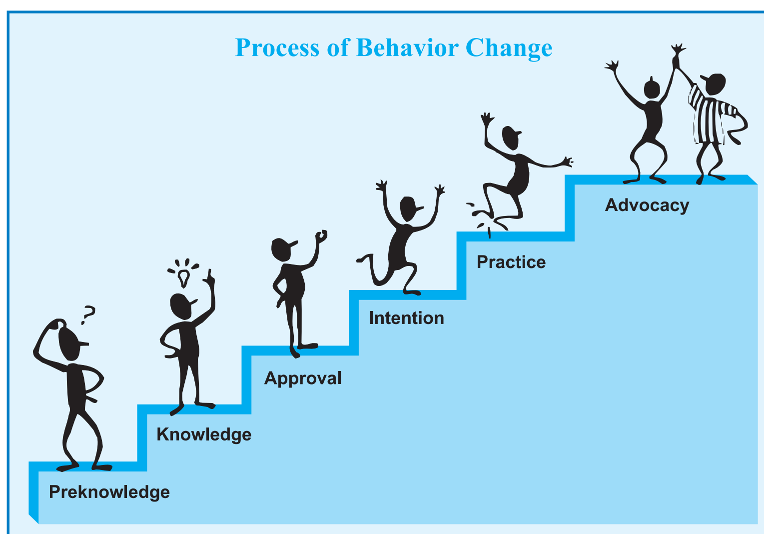
This includes *Diffusion of innovation theory* (Rogers 1983) that traces the process by which a new idea or practice is communicated through certain channels over time among members of a social system. The model describes factors that influence people's thoughts and actions and the process of adopting a new technology or idea.

Stages of change theory (Prochaska, DiClemente and Norcross 1992) identifies psychological processes that people undergo and stages they reach as they adopt new behavior. Changes in behavior result when the psyche moves through several iterations of a spiral process: from pre-contemplation through contemplation, prepara-

tion, and action, to maintenance of the new behavior. What we adopt does not happen all of a sudden but brain follows a logical process before final adoption.

This theory enables to design a step wise communication by doing sensitization initially and suggesting action points later. It also explains that in a community, different people will be at different stages of knowledge and behavior adoption.

Based on these theories, Piotrow et al (1997) developed a theoretical framework for communication programs called *Steps to Behavior Change* or *Process of Behavior Change*. It consists of five major stages of change: knowledge, approval, intention, practice, and advocacy. These five stages have been subdivided into sixteen steps.



Source: 2003 A field Guide to Designing Health Communication Strategy, JHU/PCS

Cognitive theories

Theory of reasoned action by Fishbein & Ajzen (1975) explains that what we act is first thought by our brain. This thought or intention can be divided into two; one the person's attitudes towards performing that behavior, and two his/her belief that it will be acceptable to society (subjective norm).

According to Learning theory, (Clanz & Rimer 1995) even a simple

behavior is actually complex and person learns it in steps. Therefore, the desired change should also be designed in steps.

This theory also suggests that the new behavior should suggest some replacement also if the old behavior was a relaxing one. A person, who keeps sitting and watching TV for hours if asked to start walking, might not do that unless some pleasure replacement is also suggested.

Social cognitive (learning) theory (Bandura 1977; 1986) has a rich background dating back to the late 1800's. According to this, a person's behavior is affected by the environment. Dr Bandura further developed this idea and explained that three factors worked around this individual-environment nexus. They include: environmental influences, personal characteristics and; attributes of the behavior. A person will jog only if according to his mind jogging in his community is acceptable; his age and physical fitness allow him to run and; he is convinced that running will improve his quality of life.

Self efficacy is an important pillar in this theory. A person will consider himself capable only when possesses a strong will and will draw attributes from the environment according to his mind set. Psychologists have suggested many ways to improve self efficacy. Providing clear instructions, providing opportunities or training for skill development are some of the ways to develop self efficacy.

“Relapse prevention model suggests that the new or better behavior which is adopted consciously needs a strong will and supporting environment to continue with it.”

Relapse prevention model

This model suggests that the new or better behavior which is adopted consciously needs a strong will and supporting environment to continue with it. If a person quits smoking and after some time goes down emotionally, or the peers keep pressurizing him to smoke, there are chances of his reverting back to the smoking habit. This is called a relapse (Marlatt & Gordon 1980, 1985).

To prevent a relapse, high risk situations should be recognized and properly addressed. Identifying an emotionally vulnerable person, and working to develop his/her mental strength so that he does not go back to smoking in emotional situations or copes well with the peer pressure is the relapse prevention model.

Health Communication- theories and approaches

> *"Entertainment containing highly emotional content would be more likely to influence behavior than one having low emotional content."*

Along side the psychologists and social scientists, the marketing and communication experts have been working on communication models. The subject of behavior change through communications has thus evolved over time. Prior to the modern era of health communication where it is designed and conducted in a more participatory and strategic manner, health communication in the 1960s was predominantly clinical oriented and was conducted in a one sided lecturing mode. Doctors were considered as know-it-all and their health sermons were considered enough to make people adopt healthy behaviors. In the 1970s it was realized that one sided lecturing did not work very well and the need to think beyond the clinical top down approach was felt.

Thus health education went out into the "field" and the monologue turned into a dialogue phase. In the 1980s, in an attempt to learn from the private commercial sector, the promotional approaches from the advertising industry were incorporated into the health education and a new term "social marketing" was introduced. From 1990s to the present, Health Communication has evolved into what may be called as strategic health communication. This is the form of communication in which both the sender and receiver create the messages together for a vision that is shared by the both.

Following are the theories and approaches that spell out the basis on which communications can be built in order to bring a social change.

Emotional Response Theories

Theories of emotional response (Clark 1992; Zajonc1984) propose that emotional response precedes and conditions cognitive and attitudinal effects. That is, entertainment containing highly emotional content would be more likely to influence behavior than one having low emotional content.

Mass Media Theories

Cultivation theory of mass media (Gerbner1973) proposed that repeated, intense exposure to deviant definitions of reality in the mass media leads to perception of that reality as normal. The result

is a social legitimization of then reality depicted in the mass media, which can influence behavior.

Community Mobilization

Community mobilization (CM) brings together community members, leaders and institutions at various levels to work together to identify and solve problems. Research has proven that changes in behaviors can be far more sustainable when working through and with groups than focusing on individuals alone. In addition, since behaviors are often linked to social and cultural contexts, and bound to particular networks, it can be more cost effective to address behaviors in groups than through interventions that focus on individuals and their behaviors since ultimately it is the group that needs to change and not just the individuals. Though community mobilization processes take time, their rewards are often greater, since the communities themselves take a leadership role in the process. While BCC activities may increase knowledge and desired actions, community mobilization can motivate people and empower change within community norms. Together community mobilization and BCC efforts create more sustainable changes.

Advocacy

Advocacy is about winning support of key constituencies in order to influence policies and spending, and bring about social change. Advocacy is an organized effort to change governmental, public or organizational policies; to redefine norms and procedures; and/or to support protocols for the ultimate benefit of groups of the people. Advocacy includes getting important people to speak up, drawing attention to important issues, defending new ideas or policies before those needing to hear about them and directing decision makers toward solutions. Effective advocacy contributes to the creation of an enabling environment for cumulative change of policies, norms and regulations affecting the behavior of individuals and communities.

Two terms are used in regard to advocacy and at times cause confusion. *Public Policy Advocacy* is the effort to influence public policy through various forms of persuasive communication. Public policy includes statements, policies, or prevailing practices imposed by those in authority to guide or control institutional, community, and sometimes individual behavior. *Media Advocacy* is the strategic use of mass media to advance a social or political policy initiative.

“Advocacy is about winning support of key constituencies in order to influence policies and spending, and bring about social change.”

"Almost all the behavior change and communication theories emphasized change in only the individuals. It was gradually realized that only the individual's change is not enough and there has to be an enabling environment for which the ecological change is necessary."

Ecological approach

Almost all the behavior change and communication theories emphasized change in only the individuals. It was gradually realized that only the individual's change is not enough and there has to be an enabling environment for which the ecological change is necessary. For this, it was proposed that the interventions should be carried out on multiple levels. These approaches place the creation of enabling environment on a par with the development of personal skills.

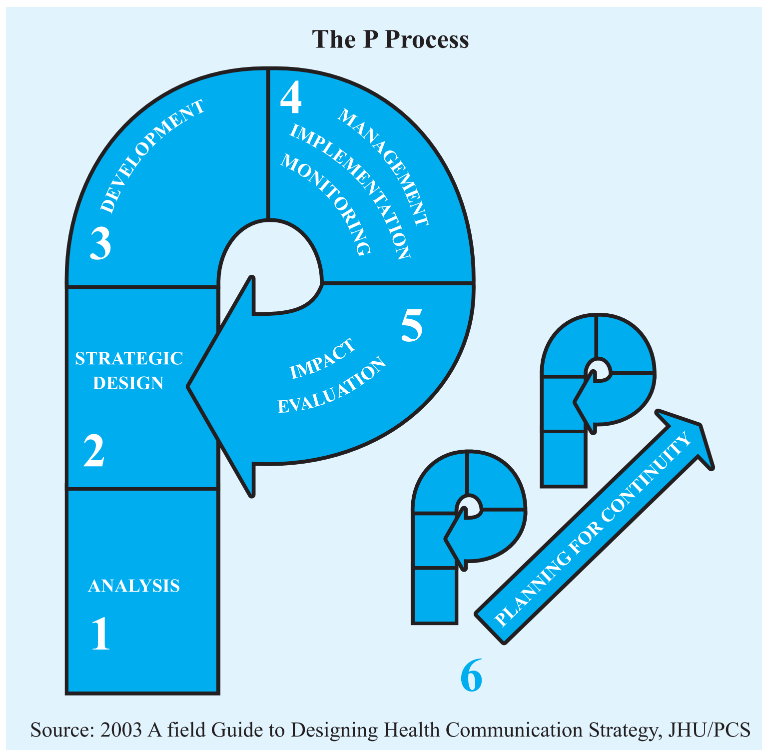
A model (Glanz, Lewis & Rimer 1997) has been proposed that suggests several levels of influences on behaviors and it includes intrapersonal factors, interpersonal and group factors, institutional factors, community factors and public policy.

Steps to effective Health Communication

Different organizations, institutions and experts have elucidated the steps towards effective communication. There is a 12 step approach to strategic behavioral communication (SBC) developed by Family Health International (2005) which includes establishing program goals; conducting situational analysis and baseline studies, involving stakeholders and other key people, identifying beneficiary populations, designing the SBC strategy and implementing; monitoring; and evaluating etc. Similar steps have been suggested by various other experts and organizations involved in designing strategic communications.

The most time tested and widely practiced so far is the one developed by Johns Hopkins Population Communication Services project called *The Processes and Principles for Health Communication Projects* known as the P Process (O' Sullivan 2003).

The P Process



Source: 2003 A field Guide to Designing Health Communication Strategy, JHU/PCS

The P Process (in which P stands for project or program) is valuable because it is i) systematic and rational, ii) iterative with regard to

research findings and data, iii) practical for field applications at all levels, and iv) strategic in setting and pursuing long term objectives.

Ever since, it has continued to provide a solid framework for strategy development, project implementation, technical assistance, institution building and trainings.

The P Process consists of six steps that are followed in sequence to develop and implement effective national communication strategies, programs, or any organized communication activity. These steps provide a sound basis for evaluations of Health Communication interventions and will be used in this paper as a reference for reviewing the program interventions.

“The P Process consists of six steps that are followed in sequence to develop and implement effective national communication strategies, programs, or any organized communication activity.”

The steps are:

1. Analysis – Understand the nature of the health issue and barriers to change: Before embarking upon the intervention aspect, analysis of the overall problem and role of knowledge and behaviors in that problem is important. The communication component of a health program should listen to potential audiences; assess existing program policies, resources, strengths, and weaknesses; and analyze communication resources.

2. Strategic Design – Working within the overall program objectives, the communication component must come up with distinct and clearly spelled out communication objectives. Besides objectives, the program should identify audience segments, position the concept for the audience, clarify the behavior change model to be used, select channels of communication, plan for interpersonal discussion, draw up an action plan, and design for evaluation.

3. Development, Pretesting, Revision, and Production – Based on a thorough analysis of the problem and the target audience including their information seeking behaviors, the program should develop message concepts, pretest with audience members and gatekeepers, revise and produce messages and materials, and retest new and existing materials before finally disseminating them.

4. Management, Implementation, and Monitoring – While implementing according to the plans, the program should mobilize key organizations relevant to the program; create a positive organizational cli-

mate; implement the action plan; and monitor dissemination, transmission, and reception of program outputs.

5. Impact Evaluation – Knowing whether the program managed to achieve what it wanted, if yes; how much and if not; why not is extremely important for a communication program. This evaluation only comes if it was carefully planned right from the beginning. Not only it gives satisfaction to the program, it also brings home a body of knowledge on how to improve future projects.

6. Planning for Continuity – Communication is a process that goes on. Despite a thorough analysis and careful planning, communication programs might face situations that had not been envisaged while planning. The programs should learn from these experiences, adjust to changing conditions, and plan for continuity and self-sufficiency.

“Knowing whether the program managed to achieve what it wanted, if yes; how much and if not; why not is extremely important for a communication program.”

International Learning

Large-scale public health communication programs create special problems in trying to make claims for effects (Hornik 2002). However, the experience with evaluations of public health communication programs provides some new perspectives. In addition, there are modified notions about the various mechanisms through which public health communication may affect behavior. Some of the lessons learned from the international experiences (Piotrow et al. 2003) are as follows:

" Comprehensive programs using mass media as well as community activities are more effective than small-scale efforts. "

1. Health communication programs can be effective.

Multiple research reports and two authoritative meta-analyses of 48 US and 39 international programs indicate people often change their behavior as a result of strategic communication campaigns and programs. An effect or influence of 9-10 percentage points in the desired health behavior can occur as a result of large-scale communication campaigns (Snyder & Hamilton 2002; Snyder et al. 2003; Hornik, 2002).

2. The larger the program reach, the greater the impact.

Comprehensive programs using mass media as well as community activities are more effective than small-scale efforts. While on an individual basis, one-to-one personal contact may be most persuasive, from a public health perspective, the reach (that is, the number of people exposed or involved) is a major determinant of success. Moreover, programs based on a coherent national strategy can go to scale to achieve national impact (Hornik, 2002; Piotrow et al.1997; Snyder et al.2003).

3. Entertainment-education is a powerful tool to reach large numbers of people and engage hard-to-reach audiences.

No one enjoys being lectured to but everyone enjoys and often learns from entertainment, whether broadcast through radio or television, or performed in person. Young people, men and women, at home and at work, rural families, and even busy health care providers can identify with actors as role models and understand the dramatic consequences of wise or foolish health behavior. They can also participate in music, dance, and sports events (Singhal & Rogers, 1999).

4. The more participatory the program, the more readily it can lead to sustained individual and social change.

When communities are engaged in designing, carrying out, and monitoring communication programs, they are more likely to change and to maintain those changes than when programs are designed or imposed by outsiders. Community action takes time to organize and needs continuing support, but the effects can be long lasting (Gumucio Dagron, 2001).

“When communities are engaged in designing, carrying out, and monitoring communication programs, they are more likely to change and to maintain those changes than when programs are designed or imposed by outsiders.”

5. Every program has three main constituencies" each one of which must be satisfied.

These are 1) intended beneficiaries, audiences or participants, without whose behavior change no improvements will occur; 2) local team members and implementers, without whose skills and commitment, programs will not get off the ground; and 3) sponsors and donors, without whose support little can be accomplished. Continuity of support from all three elements is essential to an effective program.

02

Health Communication in Pakistan

State of Health Communication in Pakistan

Health communication has had a poor share of attention in the health sector of Pakistan. During the 1960s, through the technical and financial help and guidance of international agencies, public sector health education activities were initiated. Malaria control program and Small pox eradication program were the first that had public health messages.

Today, there is a health education wing at the federal ministry of health comprising of only a health education advisor. Different vertical health programs also have a health education or BCC component and small number of staff dedicated to it. Similarly, in the provinces, a health education wing exists usually situated at the office of DGHS. Provincial BCC staff for different vertical programs is also in place.

Though the health communication staff has been in place for sometime now, capacity in this field has always been an issue. There is a dearth of institutions, scholars and true practitioners in this field. Ministry Of Population Welfare's strategy has aptly described the situation that the staff lacked specialized training and guidance to make effective strategies. Training institutions responsible for designing these training programs themselves suffered from an inadequacy of funds and specialized staff to do the job. According to an evaluation of the non-technical training component of Population Welfare Program, none of the teaching staff in Population Welfare Training Institutes had attended an advanced course in communication (Hakim & Bhatti 2000).

"Health communication has had a poor share of attention in the health sector of Pakistan."

According to the National Program Review of Health Education in Pakistan (1999), health education services have been putting a dismal performance. The public health sector though has an education arm; it has been suffering from some basic anomalies like lack of consensus on a definition of health education, lack of a unified job description of health education personnel in the country, lack of professional supervision of the health education personnel and lack of consensus on objectives of health education.

The most important reason of this dismal situation as mentioned in this report has been lack of hierarchical interest and dwindling funds. Lately, the public sector health programs realized its importance and started putting some resources towards health communi-

cation. According to the Director General Health annual report (DGH2000-2001), out of the total health budget of Rs. 24, 281 million, 77.24 million rupees were spent on health education during that period. This does not include the amounts spent on health education activities of National Tuberculosis Program, Role Back Malaria Program and Women Health Project. Considering the importance of Primary Health Care and the impact that health communication can have on it, the amounts appear to be meager but the question is; were these expenditures albeit small, able to achieve their objectives? The report is silent on this.

" Sporadic Health education/communication activities are seen from the national and international NGOs working on health issues in Pakistan. Generally, the audience of these interventions is limited and impacts on behaviors remain largely unknown. "

Private sector contribution to the field of Health Communication has been understandably negligible as it mostly caters to only the curative side. Sporadic Health education/communication activities are seen from the national and international NGOs working on health issues in Pakistan. Generally, the audience of these interventions is limited and impacts on behaviors remain largely unknown.

Impact assessment is an essential component of health education activities. It helps in knowing whether a message was successful in bringing about the desired change. In other words, it informs whether the spending on communication was justified and should be enhanced, or fell flat and a change in approach is required. There is dearth of information both from the public and private sector on the impacts that health communication created on the knowledge and behaviors of the people in Pakistan.

One reason of not doing the impact evaluation of communication campaigns is that it is considered to be not easy. When conceptualized as a means-end relationship to health status, the complexity of health communication is brought to light. Because it is not only the health messages but many other factors including the government health care policy (strategic plans, laws, fiscal commitment, judicial enforcement), healthcare structure (geographical distribution and access to care, professional education and training, and research priorities), health care process (distribution of services, information and its dissemination venues, targeted patient education campaigns, and interpersonal and inter-group encounters) and ethno social-realities that influence healthcare utilization, satisfaction, compliance and public health status at the national and community levels (Calderon 2004).

The other reason is that impact evaluation only comes with a systematically planned communication intervention. According to Piotrow et al (1997), evaluation is easy to ignore until a project nears the end but impossible to carry out effectively unless it is planned from the start. Parallel with the P process itself, evaluation in fact begins along with the preliminary analysis that provides background information and baseline data. It takes further shape in the strategic design phase, where specific, measurable objectives and supporting sub objectives are established.

Thus it is clear that communication based on thorough analysis of the problem, the audience and the program is likely to show change in behaviors provided there is an evaluative part to it. Our attempt to know the impact of different health communication interventions in Pakistan led us to the following question:

Do Health Communications in Pakistan follow some standard steps to an effective intervention?

By the help of this review, we tried to answer the question.

"Evaluation is easy to ignore until a project nears the end but impossible to carry out effectively unless it is planned from the start."

Methodology

We reviewed all interventions both from public and private sector that aimed to induce a health behavior change. All those interventions that had a title of Health Education, Health Communication or Behavior Change Communication were included.

A systematic search was conducted employing the electronic, web and manual resources to find such interventions during the last 25 years. Public Health Experts from all the program areas were requested via letters, e-mails and phone calls to help us in providing any materials or data that they had. The period of 25 years was decided to cover the time that had gone by since the introduction of the concept of *Health for All* through the Alma Ata declaration of which health education was an important component.

What we expected were reports and articles describing the health communication interventions on public health issues with details of the methodology employed and impacts created. But only a few documents fulfilled the criteria. All the others were either the documents that explained the prospective communication strategy of respective program; or evaluation reports. Since these documents did not provide the

results of the interventions, we focused our attention on whether they made an effort to look for these results and whether these programs followed the steps that are essential to have a result orientation communication. In all, 12 documents were included for the review and were subdivided into two categories and evaluated accordingly.

The categories included:

- Program strategies /interventions
- Research interventions

Health Communication in Pakistan

Program Strategies / Interventions

Program strategies/interventions

The field of program evaluation is steadily evolving to answer fundamental questions regarding the effectiveness of communication programs, as well as related issues of program design and implementation. Experts have agreed on three primary types of evaluation that span the life of a program: formative, process, and summative(Rossi Lipsey &Freeman 2004). Small non-governmental organizations (NGOs) with limited resources may opt to perform only one of these types of evaluation, whereas a major communication program with national scope would be remiss to exclude any of them(Bertarand2005).

Considering the status of the relative infancy of Health Communication that our country is in, we limited ourselves to appraising programs with reference to whether they followed the basic steps of designing a campaign and whether they demarcated at least two data points or sets; before and after. This was done on the basis of six steps of the P process described in the first chapter.

“Experts have agreed on three primary types of evaluation that span the life of a program: formative, process, and summative evaluation.”

First and foremost in P process is analysis. Before getting involved on to the intervention phase, the overall health issue needs to be explored and scope of knowledge and behavior in improving that problem estimated. The communication component of a health program should then hear from the potential audiences (formative research), assess existing program policies, strengths and weaknesses (to make informed strategic decisions); and weigh the available communication resources. We evaluated analysis part of the reports/strategies according to these four components.

Second step in the P process is working out a strategic design of the communication. Components of a strategic design that we selected for evaluation were: clearly spelled out communication objectives within the framework of the overall program objectives; clearly identified audience segments that will be addressed; appropriately selected communication channels; and the selected behavior change model. Though drawing up an action plan and design for evaluation are also part of a strategic design; they were not included in this step as they are better placed at step 4 and 5 respectively.

Third step is development of communication on which because of various attractions, usually there is a tendency to jump too quickly. This is the most creative and fun part but it can be equally tedious. One has to process the communication by pre-testing the message concept with intended audience

and gate keepers. In the light of feed back in pre-testing, the creative agencies make necessary changes and sometimes this process has to be repeated two or three times. Message concept; pre-testing; revisions; and final production were the four steps taken as evaluation criteria of this step.

Step number four in the P process is implementation and monitoring of the communication. While implementing, the program should monitor and be iterative in the process so that if there is a need to review the communication or the strategy, it is done without wasting time and resources. Monitoring of dissemination, transmission, and reception of the program outputs is crucial. This component was evaluated with reference to implementation, monitoring and incorporation of the feedback into the program.

Knowing the impact of a communication campaign is the fifth and the most crucial step. For programs that have a sound analysis, appropriate design and healthy monitoring, this is the time to rejoice. This moment only comes if it was carefully planned right from the beginning and has at least two data sets. These two data points; the pre and post were considered as the evaluation criteria for this step.

Last step according to the P process is planning for continuity. Despite a thorough analysis and careful planning, communication programs might face situations that had not been envisaged. These should not be seen as failures. The programs should learn from these experiences, adjust to changing conditions, share the findings with all the relevant, and reinvest for continuity and self-sufficiency.

Findings

Analysis is the foundation on which a communication is built. There must have been some degree of analysis gone in before all these interventions were executed. The question is was enough analysis done before jumping on to the intervention? Objective evaluation of these documents informs that only two considered it important to explore the health problem they were addressing; and scope of knowledge and behaviors in bringing a positive change with respect to this problem. Similarly the program policies and its strengths and weaknesses were also not considered while planning for the communication component by three out of six programs. Four of them carefully analyzed their audience and available communication resources for them.

Clearly spelled out communication objectives are the corner stone of a strategic design. On the one hand, they inform about the change in level

of knowledge and intention that they will be able to bring in, and on the other, they also delineate the limitations of communication with respect to behavior change. Two programs out of six had communication objectives as part of their strategy. Five appeared well oriented on the audience segments that they targeted. Three programs clearly described communication channels that they would use while none of the six mentioned the behavior change model that it followed or would follow.

"Clearly spelled out communication objectives are the corner stone of a strategic design. On the one hand, they inform about the change in level of knowledge and intention that they will be able to bring in, and on the other, they also delineate the limitations of communication with respect to behavior change."

Communication development is the part where art and science become submerged with each other. No communication campaign can be conducted without communication materials, and all the reviewed programs did develop their communication tools, yet very few of them fulfilled even the basics of developing a communication. Three out of six programs pre-tested their concept and only one revised and retested it or had the intention of doing so. All the others just developed and went on to implementation.

Implementation phase of a program is equivalent to a toddler's growth. One has to look after it and take care of the corrections/ revisions required. Though all the programs had the implementation phase and five had monitoring as well, only one availed the true benefit of monitoring by continuous review and revision.

Trying to know whether the intended results have been achieved is the evaluation part. A communication component should be very alert on its effects because a behavior change program needs other crucial elements beside communication to achieve the desired change. Knowledge, intention and behavior indicators should be carefully developed and evaluated. Among the programs under review, only three collected information at two different points in time to establish the difference that they created.

Reinvesting for continuity is the step that keeps the communication cycle going. There is no stopping if the communication achieved its objective. It should share its strategy and findings with others involved in similar projects. If it failed to achieve its desired results, even then it has a lot of learning that can be beneficial for the program itself as well as the others. Programs reviewed here are totally remiss on this point and none of them had any plans to share the learning and reinvest its resource for continuity of the process.

Our appraisal of six strategies/interventions is being presented here in tabulated form, followed by a qualitative assessment of the individual programs.

Table 2: Methodologies/ Strategies

No.	Steps for a Program Intervention	Number of interventions that followed the steps
1	Analysis	
	Problem	2
	Audience	4
	Program	3
	Communication resources	4
2	Strategic Design	
	Clearly spelled out communication objectives	2
	Audience segmentation	5
	Behavior change model to be used	0
	Appropriate channels of communication	3
3	Development of communication	
	Draft messages	3
	Pretest with intended audience	2
	Revise and reproduce	1
	Retest and finalize	1
4	Implementation & Monitoring	
	Implement	6
	Monitor and get the feedback	5
	Review in the light of feedback	1
	Make necessary changes	1
5	Evaluation	
	Baseline data	3
	Post intervention data	3
6	Reinvesting for continuity	
	Share the findings	0
	Reinvest	0

Overall, while all the programs appeared oriented on the segmentation of their target audience, not all had undertaken a thorough analysis of the problem behaviors and their determinants. Without a thorough analysis, focusing on the overall problem and the knowledge and behavior part of it becomes difficult. For example, the message "smoking is injurious to health" can make a difference in behaviors of only those who didn't know this danger and for all the others, "why they indulge in the behavior of cigarette smoking?" will have to be explored first before developing any communication.

Some programs conducted a proper situation analysis, identified right audience, adopted right kind of communication approach, but faltered when it came to implementation. The flashy television screen took most of their attraction and resources while in the planning phase, interpersonal communication had been chosen by them as a more appropriate medium. The lesson learnt is that even the best plans are useless if they are not adhered to during implementation.

> *"The lesson learnt is that even the best plans are useless if they are not adhered to during implementation."*

Evaluation part generally needed improvement in all the program strategies. None of the programs selected a behavior change model that it would follow. Selection of a model makes evaluation of the intervention easy. Programs that developed some indicators did not really delineate communication (Knowledge and intention) indicators from the overall program indicators. Communication part of any health program is only complementary to the program. It can only raise knowledge and intention level. The change in behavior needs supply side to be on the same level so that the intention meets an enabling environment and a new or changed behavior occurs. While striving for the overall program goals, communication part of the program should have clear communication objectives that would help in assessing what the communication achieved by measuring the change in the knowledge or intention level of the audience.

Overall, none of the health communication programs followed all the steps that would entail into an effective communication.

A brief qualitative review of these programs is given below.

Individual programs

Expanded Program on Immunization (EPI 2005) in Pakistan that aims to achieve universal immunization coverage in the country has a health

education component also. This component uses different communication tools to enhance its outreach.

Immunization is an important area of public health strongly influenced by human behaviors. If parents do not have a behavior of getting their child immunized on seven EPI diseases, despite of abundant dosages, it will be difficult for our country to achieve universal coverage against these deadly and crippling diseases. EPI communication activities 2005 consisted of involving General Practitioners, Tabibs and District Nazims through conventions and conferences. They were informed about the EPI activities and requested to extend support. This approach could bring excellent results if a thorough situation analysis was also conducted.

“To improve the coverage, it is important to know where the uncovered population lives and what level of literacy and media access they have?”

Presently, EPI coverage in Pakistan is quite low. It was 54% in 1999 as reported by EPI Cell. According to UNICEF (2005), 82% of 1 year old Pakistani children were vaccinated for Tuberculosis, 67% for DPT, 69% for Polio, 61% for Measles while only 57% pregnant women were immunized against Tetanus in the year 2003. To improve the coverage, it is important to know where the uncovered population lives and what level of literacy and media access they have? This information can be obtained by gathering data from the field and analyzing it. Critical appraisal of EPI Health Education activities 2005 reveals that these activities were not backed up by a thorough analysis.

In the absence of analysis of the problem, the audience, and the program; strategic decision making in development and implementation of communications becomes imprecise. This is reflected in EPI health education activities suggested for 2005. The program intends to increase awareness through posters, brochures, stickers, hoardings, vinyl sheets on buses, give aways, special painting of 500 pharmacy shops, advocacy kit including a CD, and radio; TV; and Newspaper messages. What if the uncovered population mostly belongs to villages where people are illiterate and have low media access? They would not benefit from any of these communications and the country might well be reported again to have the same low EPI coverage in the coming years.

The social mobilization, advocacy and program communication is an important component of *Polio Eradication Initiative* (2002) in Pakistan. An overview of this component of the initiative shows that it has been strategic in its approach. In the year 2002, because of the stagnating

progress, door to door vaccination was started instead of fixed site vaccination centers. Communication component also changed its approach and started using interpersonal communication (IPC) to mobilize people. In 2002, with the new program approach, as the number of Polio cases reduced and Polio virus became limited to a few districts, the target audience for mobilization and communication were also narrowed down. This decision was possible only after a thorough analysis of the problem, a strong point of its communication component.

Similarly, the initiative is very clear on the levels of communication that it needs to adopt. They are: mass awareness of campaign dates, focused social mobilization for high risk groups and areas, motivation for team members, and promotion of surveillance for suspected cases of Polio. What the component lacks is clear communication objectives. These objectives help in assessing what the communication part achieved by measuring the change in the knowledge or intention level of the audience.

The audience has not been included in the process of development of messages. While consensus about the messages was sought among communication experts of MoH, UNICEF, WHO and other partners; there was no involvement of the recipients of these messages; people whom the program wanted to adopt certain behaviors.

No assessment of the impacts of this communication or plans to do so has been mentioned. Even in the way forward, while the initiative plans for the President and Governors to launch National Immunization Days and issue messages, and describes the plans to have more meetings, EPI cells and more advocacies; there appears to be no intention of gauging what has been changed through all these efforts.

Optimal Birth Spacing Initiative (OBSI 2004) had a strong communication component. The strength of this intervention was the analysis of problem that it conducted through Focus Group Discussions. These discussions showed that on the one hand, women/men were able to identify correctly some of the potential benefits of practicing optimal birth spacing while on the other, they did not know the potential risks on woman's and baby's health if OBS was not practiced. These discussions also informed that men were the main decision makers as to when to have sex regardless of the women's desire, there was no conscious dialogue among couples on when to have pregnancy, and pregnancy was viewed as the proof of man's virility etc.

Despite a thorough analysis that showed husbands as the most important decision maker, the program decided that women, husbands, family members and community leaders, all will be its target audience. Thus audience selection for a very sensitive issue tended to be rather generalized which would make the communication less focused. The main communication activity conducted through radio was not focused on husbands. Rather it was organized in such a way that most of the programs could be heard by women while doing their domestic chores with the husband away for work.

The program based its communication on the assumption that most efficient way to reach a large number of the OBS intervention clients was through the use of mass media. Without independently assessing the reach of various media components, it assumed that most popular medium in Pakistan was radio and conducted almost the whole campaign on the basis of this assumption. Changing behaviors on an issue like birth spacing that involves so many sensitivities is difficult and using mass media can only add to the complications. To complement the radio messages, the program also developed posters, counseling cards, calendars etc. for different audiences. The evaluation component of this initiative had only the knowledge indicators and no behavior indicators.

“ The change in behavior needs supply side to be on the same level so that the intention meets an enabling environment and a new or changed behavior occurs. ”

Women Health Project, an initiative of the Ministry of Health, being implemented in 20 districts, aims to improve women's health through expanding basic women's health interventions, developing women friendly district health systems and strengthening institutional and human resources capacity to improve women's health. Designed to benefit about 15 million rural women and children, the project specially aims to reduce the number of maternal and neonatal deaths.

One of the main strengths of the BCC strategic document (2003) of this project is its analysis of all the constituents of the problem for which both formative and evaluative research was conducted. The project listed the problem behaviors that affect the maternal and neonatal health and through formative research also looked into the determinants of these behaviors.

The project adopted a comprehensive approach by addressing women issues at all levels through health promotion, community mobilization,

advocacy and capacity building. The project was strategic as considering its geographical and programmatic limitations it decided to keep interpersonal communication (IPC) as the main communication channel to be complemented by mass media, alternative media and IEC materials.

The communication objectives were clearly spelled out and distinct from the overall program objectives; a potential weakness common to all the programs.

The project did not select a behavior change model that it would follow; a loose end common to almost all the health programs. Adopting a behavior change model makes the process evaluation easy which is of utmost importance in an iterative program.

It is surprising that while the project decided to have IPC as its main mode of communication, it did not put enough effort on introducing effective means of IPC/Counseling. Instead, it included and relied heavily on the seminars and meetings by local NGOs; and the support group meetings conducted by LHWs. The weak capacity of NGOs to conduct BCC activities for a health program has been mentioned by the project itself in its conceptual document while the need of knowledge and skill building of LHWs has been pointed out in the evaluations of the National Program of Family Planning and Primary Healthcare (Oxford Policy Management, Evaluation Report 2002).

In this situation, the project needed to back up its decision of using IPC with some effective enhancement of counseling/IPC skills of NGOs and LHWs. GATHER (Greet, Assess needs, Tell information, Help choose, Explain & demonstrate and Return/reinforce/refer) which is a counseling approach for family planning (Rinehart1998), Participatory Hygiene and Sanitation Transformation (PHAST) which is a set of pictures to start community conservations (WHO1996) and Visualization in Participatory Planning (VIPP) which uses cards and games to ensure more equal participation among groups (UNICEF1993) are some of the examples that could be considered.

The project invested heavily on its media component. Overall on mass media, a component originally planned to be a support to the IPC, an amount of 73 million rupees was spent. It included TV talk shows, TV magazine show, Newspaper supplement etc.

"Communication campaigns in the past have relied heavily on television for creating awareness on family planning not taking into account the fact that exposure to electronic media is not universal in Pakistan."

Whether a common man or woman's participation was ensured while developing these TV programs is not mentioned. It would be interesting to know from the evaluation of these media programs, how much these media interventions were able to achieve as compared to the costs incurred on them.

The BCC indicators mentioned in the concept paper are media coverage and number of BCC events. Change in level of awareness in the community and degree of utilization of women health services could have replaced them.

The BCC component of the *National AIDS Control Program* (NACP 2002) describes the BCC and advocacy segment of the program. These documents are more of a program document describing how the BCC activities will be carried out rather than providing insight into the BCC strategies of NACP.

Clear and elaborate details are available on implementation of the BCC activities, allocation of responsibilities regarding the implementation and their monitoring. BCC indicators that will be observed are also provided. There is a clear segmentation of the target audience into Youth, Labor, Police etc. to plan focused interventions for each.

However the concept lacks the basic step of analysis. There is very less information provided in the BCC concept on the fact that in a country like Pakistan, where HIV-AIDS has a very low prevalence, what really was the problem behavior that NACP thought to change?

Pakistan is one of the top three countries that have the highest prevalence of unsafe injections in the world (Simonsen et al 1999); a risk factor for spread of HIV-AIDS, yet this issue does not come as part of the problem any where. Perhaps it was the lack of attention on this important public health issue that unsafe injections did not come up on the agenda of behavior change of even the health providers- a segment of audience declared important by the Program in its own document.

It is interesting that a program that aims to maintain Pakistan's population status of "low-prevalence low-risk", and expects maintenance of behaviors, calls its communication component, a behavior change.

Perhaps it was the absence of baseline data that among the list of impor-

tant influentials, it misses on the religious leaders and among the target audience; the Commercial Sex Workers. Perhaps for the same reason, it does not mention the use of safe injections as the most important preventive measure for HIV-AIDS in our country.

Population Welfare Program is being run under Ministry of Population Welfare (MOPW) since mid 1960s. The goals of its communication component since its inception have been to increase public awareness about the adverse consequences of unchecked population growth, generate demand and satisfy unmet need for family planning services, and create an environment conducive to achieve the overall program goals.

This program has always maintained a communication campaign to service delivery efforts. This is the only program that has been evaluating its communication components to gauge their affectivity and to make strategic changes if required. The program decided to revise its communication and advocacy strategy in 2002 to address the questions that it faced after years of awareness raising. Thus it came out with *communication and advocacy strategy for family planning and sustainable population* (MOPW 2002) that aimed to be 'people centered' communication program that will be well supported by effective interpersonal counseling.

"Weak capacity prevailing in our country in the field of health communication is an important factor that has resulted in weak performances."

The strategy describes almost all the necessary steps that a communication program should follow to induce a behavior change through communications. It lays its foundations by admitting the mistakes that its communications have done in the past. It clearly states that focus of its communication programs remained weak towards the information needs of rural people that comprise about 67% of the total population.

It also states that communication campaigns in the past have relied heavily on television for creating awareness on family planning not taking into account the fact that exposure to electronic media is not universal in Pakistan. It is also aware that contraceptive prevalence rate (CPR) is higher in educated families as compared to the illiterate.

A striking feature of the implementation part of the strategy is its emphasis on capacity building of MOPW and concerned departments in the area of health communication. Weak capacity prevailing in our country in the field of health communication is an important factor that has resulted in weak performances. No program can achieve desired results

even if its strategy is excellent on paper but is not supported by skilled human resource.

The implementation part about different segments of the audience is very elaborate. The audience, its messages, appropriate medium of communication, detailed activities that will be carried out and monitoring & evaluation part, all is well described. However there is no mention of involving the communities in the development of messages.

"If the target audience is not involved in development of messages, there is a risk of having culturally in-appropriate messages or messages that are too vague and generalized, confusing and not suggesting clear action points to the audience."

Family planning is a sensitive issue and working with rural populations can be even more sensitive. If the target audience is not involved in development of messages, there is a risk of having culturally in-appropriate messages or messages that are too vague and generalized, confusing and not suggesting clear action points to the audience. Numerous experiences are available from around the world on how the disconnect between the "well designed" message and its intended audience existed resulting in little change.

For example in India, the planners and health educators were worried that the growing population was using up available resources. In their messages, they emphasized national priorities and the cost of food, clothing and school fees etc. These issues were important to the planners and health educators who usually came from urban middle-class backgrounds. However the community viewed it differently. For poor people, having more children made sense: extra children were more hands to help in the home and fields as well as sources of care and support in their old age. They also knew from their past experience that some of their children would probably die of childhood diseases so they need to have extra children to ensure survival of a good number till adulthood (Hubley 1993).

Evaluation part of the strategy needs to be more robust. MOPW has been getting its communication campaigns evaluated previously and published reports of these evaluations are also available. These reports are based on only the end-line data. The knowledge level at the time of evaluation cannot be attributed solely to the intervention when the pre intervention data and other confounding factors are not known.

Program Interventions: evaluation reports

Some health programs also evaluated the communication part of their interventions. We could find six such evaluations.

Evaluating any social program is difficult (Piotrow et al 1997). Communication programs pose special problems for evaluators. It is a daunting task to demonstrate that communication programs themselves make a difference to health behavior. The reasons are: one, communication is not only an independent function but also a part of other program functions; two, most communication have both short term and long term effects; and three, communication may have both intended and unintended effects.

In this background, the eight criteria developed by evaluation experts (Bertrand & Kincaid 1996) are helpful. These are:

- Measurement of a change or difference in the population of interest
- Correlation between exposure to the program and the intended outcome
- Evidence that exposure to the program occurred before the observed change in the outcome
- Control of the effects of the confounding variables that might also influence the outcome
- Observation of an abrupt, large impact in the absence of other major influences
- A direct and close causal connection specified by theory between a program and its outcome
- Impact that increases in proportion to the level or duration of communication exposure
- Consistency with the evidence from previous communication program evaluations

"A detailed look at the reports from Pakistan indicates that the evaluation component of the communications needs a lot more to be done."

It is difficult to satisfy all eight criteria in a single study but not all are required in order to make a valid conclusion about impact. However, the more that apply, the greater the confidence in the conclusion. A detailed look at the reports from Pakistan indicates that the evaluation component of the communications needs a lot more to be done as most of the above mentioned criteria are missing.

The report on *effectiveness of media messages in promoting family planning in Pakistan* (Hakim & Tanweer 2000) is about the status of knowledge and practices of people regarding family planning. During the seventh five year plan (1988-93), IEC activities of MOPW were enhanced. Electronic media was used more as there was an upsurge in better and

effective use of mass media. The program assessed the peoples' access to electronic and print media, their exposure to family planning messages, the impact of IEC component and also the specific reasons of non-use of contraceptives.

According to the report, exposure to T.V was higher than radio. It was observed that television, radio and newspapers contributed to the knowledge about contraceptives. Fixed and other printed materials did not appear to have played much role and need greater attention to become more effective. Women who watched television were more likely to use them. The evaluation reported 83% of respondents having knowledge of specific method.

It is obvious that many of the evaluation criteria including the control of confounding factors have not been accounted for. There was no media specific data prior to these interventions, and report did not firmly establish that the impact was entirely because of the interventions of Ministry of Population Welfare.

As part of the continuous evaluations of Population Welfare Program, a study *Evaluation of Interpersonal Communication at Family Welfare Clinics of Population Welfare Programme* (Hakim & Bhatti 2000) was conducted in March 1996. This study looked into the impacts created by the IPC part of the overall IEC campaign. Interviews were conducted with married women of child bearing age living within the vicinity of Family Welfare Clinics (FWCs).

Overall, this evaluation was well designed and fulfilled most of the criteria mentioned above. This could have been an interesting study as some of the evaluations from other health programs reported IPC as a more effective medium than electronic media. However, the evaluation instead of documenting the clearly attributable impacts, had to report poor performance on part of the staff of FWCs. The highest percentage of the respondents (42%) was informed about the existence of FWCs by friends or relatives. Only 21% currently married women had been visited by a Family Welfare Worker.

As a component to the communications of the Population Welfare Program, audio-visual vans were also used. Film shows were

arranged by District Population Welfare Officers (DPWOs) using these vans. Evaluation of Audio-visual vans (Hakim & Zahir 2000) was conducted in 1996-96. DPWs, Projectionists of AV vans and men residing in these villages where films were shown were interviewed. In addition to assessing the functional status of these vans and their impact on the knowledge and behaviors of the villagers, the evaluation also tried to get information on other electronic media resources available in the area.

" 68% of the individuals overall come to know about health interventions through interpersonal communication channels. "

While DPWs, the Van staff and three quarters of the beneficiaries of these shows showed their satisfaction about this component, the evaluation also noted that people attending film shows were more interested in feature film than family planning documentaries.

UNICEF (2005) conducted a study to estimate the impact of communication interventions in the Pakistan Polio Eradication Initiative. This cross sectional survey conducted in 12 districts compared high risk intervention groups versus non-intervention groups. 93% of individuals recognized Polio as an important health problem in the intervention group compared to 86% in the non intervention group.

This well designed evaluation followed most of the evaluation points that have been suggested for health programs. It also came up with an interesting finding that 68% of the individuals overall come to know about health interventions through interpersonal communication channels.

Health Communication in Pakistan

Research Interventions

Research Interventions

"Research interventions are carried out to experiment with the innovations so that if found beneficial, they may be replicated by the others."

In order to ensure that the prominent research interventions are taken account of and incorporated in the review, various organizations including NGOs, donor agencies, prominent universities and community health departments of leading medical colleges all over Pakistan were informed of the review and asked to share their contribution if any in this field. In all, six research documents were received. All the articles dealing predominantly with a health education/communication intervention and describing the evaluation of the intervention were included for review.

Research interventions are carried out to experiment with the innovations so that if found beneficial, they may be replicated by the others. The gold standard for research interventions is Randomized Controlled Trials (RCT). Some experts have discussed the difficulties of employing a control in the communication research. Piotrow et al (1997) argue that randomized control group design has limited value for communication program evaluation because it is usually not feasible and because by itself it does not provide information about the underlying processes of change. According to them, as most of the communication programs now use mass media to try to reach the entire population, the most rigorous design is the one-group, before-after longitudinal design with multivariate statistical controls.

According to Hornik (2002), randomized experimental designs that are entirely appropriate when a well-defined treatment (e.g., a new surgical procedure or a new medication) is at issue may be misleading when applied to public health communication interventions, which are messy efforts. These communication interventions are constantly evolving, highly opportunistic in exploiting any channel available to reach the audience and reinforce a message. They affect individuals directly and indirectly through social norm and institutional changes. The most successful may operate in a national media environment where newspapers and televised news and talk shows and other media as well as professional channels are discussing the issue.

Loevinsohn (1990) however has other views. According to him it is important to improve the methodological quality of health education research. This can be done by using controlled, preferably randomized designs, ensuring adequate sample size, examining only objective changes in behavior or better yet, changes in morbidity or mortality.

Research reports should describe in detail the educational intervention employed and the target audience.

We think that in countries like Pakistan where people have limited access to mass media, communication interventions involving mass media can be tested in a controlled design. Interventions that employ interpersonal communication can also be tested by adopting RCT as the research design. In addition to design selection, proper explanation of the process of developing the intervention and details of the audience should also be explained in the study by the researcher.

“In countries like Pakistan where people have limited access to mass media, communication interventions involving mass media can be tested in a controlled design.”

In this background, and observing the criteria explained by Loevinsohn B P, we evaluated six research interventions that were collected for this review. Prior to the review it was agreed between the reviewers that health communication interventions could be considered reliable if:

- A randomized controlled design was used employing adequate number of individuals or clusters of individuals
- Adequate description of the target audience was provided so that others could decide about the populations they were dealing with
- A description of the communication intervention was given so that replication by others would be possible
- The outcome was either the desired change in behavior or at least in the intention to adopt that change

Our findings are presented here in table 3 followed by a narrative commentary.

Table: 3 Research interventions

Characteristic	Number of interventions that displayed the characteristic
Randomized controlled design	0
Adequate description of the audience provided	3.5
Details of intervention	3.5
Measured outcome before and after the intervention	4.5

Six interventions is in fact a very small sample and limits the generalization of results. However, Cumulative look at these six studies shows that none of these interventions used randomized control trial as their design. Majority of them described the educational level of the audience. Same number of reports explained their intervention by defining how the communications material was developed, pre-tested etc. Only two out of six interventions conducted both pre and post evaluation while the rest of them conducted some form of post evaluation alone. The interventions that did not clearly specify if they carried out these steps but some inferences could be drawn supporting it in the description of the study were attributed half of the credit.

"The spirit that public health initiatives can not compete with strong commercial interests for valuable air and print media space, and cost effective methods for communicating health messages should be explored is valuable."

The spirit that public health initiatives can not compete with strong commercial interests for valuable air and print media space, and cost effective methods for communicating health messages should be explored is valuable. With this objective in mind, Heartfile, a non governmental organization conducted the study *Newspaper Articles as a tool for cardiovascular prevention programs in a develop*ing country (Nishtar S. et al 2004). This study was the first health education intervention in the country that attempted to demonstrate the effectiveness of health education through newspapers in a low resource setting.

The study gave detailed description of the intervention that in this case were newspaper articles. However there is no information on whether and how the audience participation in material development was ensured. The study also lacked the true experimental design and comparison groups. Neither randomized control trial method was adopted nor baseline data collected. The survey relied on self reported changes in knowledge and behavior as described on telephone.

The audience of this study was readers of an English newspaper; not a representative sample in Pakistani context. The number of people reading English newspapers in Pakistan is very limited. These are people with high literacy as compared to the general population, more access to knowledge, and greater inclination to gain knowledge and apply it in their daily life. This leaves small chances for the generalization or replication of this study.

A Pilot Intervention to Improve Injection Practices in the Informal Private Sector in Karachi, Pakistan (Agbotwalla M n.d) was the

second research intervention that came under review. It was one of the few studies in our country that engaged private healthcare providers; a segment of healthcare system that provides treatment facilities to 70% of the population.

The study demonstrated the effectiveness of Interactive Group Discussions (IGDs) in reducing unnecessary injections by employing a case control design without randomization. It measured number of injections prescribed and disposable syringes used as the outcome before and after the intervention.

Health providers in Pakistan are usually very busy and not ready to engage in discussions with the general public. Technique of conducting IGDs and how the research team managed to bring patients and prescribers on the discussion table has not been explained. However notes on how the discussion unfolded injection issues are there. The study also mentions using IEC materials including posters and small booklets to raise patients' and health providers' awareness on injection hazards. At what point in the IGDs and how these IEC materials were used has not been detailed. Patients' and Providers' detailed profile also has not been described.

Husband-Wife Communication and Family Planning: Impact of a National TV Drama (Lozare 1993), an Enter-educate electronic media intervention came as part of a campaign by Johns Hopkins University in collaboration with Ministry of Population Welfare. This study followed most of the prescribed steps desirable in an experimental design except for the randomized control trial technique. It looked for key audience indicators in the existing literature and undertook some additional research studies to probe the reasons for the high unmet demand for family planning.

In this study two separate surveys (the step seen missing in most of the other initiatives) were conducted - a baseline survey and a post-campaign survey. Project evaluation questionnaires were developed and all questions were pre-tested using target audience groups to determine their validity. The lesson learnt in this study is not simply that a successful communication campaign can influence behavior since that has been amply demonstrated in programs worldwide. Instead this study also focused on one of the particular ways in which family planning communication could influence behavior change.

Long-term improvement in unsafe injection practices following community intervention was another health education study that was conducted after it was identified that frequent unsafe injections were the cause of widespread hepatitis C virus infection in Hafizabad, Pakistan (Luby S et al 2005). It was a simple and low cost community education program.

Case and control settings were used to assess impact of the intervention on the audience but adequate details of the audience have not been provided. The tools/channels for communications used in this study were educational materials on hepatitis C, health education meetings, and announcements in mosques and via pamphlets. The researchers have not mentioned involving the community in the development or pre-testing of the materials before their actual implementation.

It appears that print materials were used with IPC channels like group meetings and announcements from mosque providing the back up to these print materials. This is a practical and replicable approach to spread specific messages in a focused geographical area.

There is scarce information on use of theater as a medium of health education. Aahung, a resource centre on sexual health from Karachi filled this void. *Sexual and Reproductive Health Promotion at the Grassroots; Theatre for development - a case study* (Afsar & Gill 2004) established how theatre played an instrumental role in the field. The case study pointed towards the strengths of using innovative methods for community mobilization, health promotion of sensitive topics like sexual and reproductive health and male involvement in issues like reproductive health.

The use of participatory approach was the major strength of the study. There was no pre set notion as to what the theatre should be about. The community was involved in suggesting the topic, the problems of the community and got to a point where the community came up with a solution of these problems. The messages thus incorporated a participatory method.

For a culturally sensitive issue like sexual health, it is evident that simple health messages on electronic media or pamphlets distributed at the health centre may not be very effective interventions by themselves. The study establishes that theatre because of its participatory

> *"The study establishes that theatre because of its participatory note, lack of dependence on technology or literacy and its ability to exploit indigenous forms, is one form which is most able to respond to the need."*

note, lack of dependence on technology or literacy and its ability to exploit indigenous forms, is one form which is most able to respond to the need to be context specific when dealing with grass root self development. Impact of the intervention however could not be scientifically assessed since no formal pre and post intervention data was collected nor was it a controlled trial.

"In countries like Pakistan where literacy rates are low, information dissemination potential of print materials has to be carefully weighed."

Heartfile conducted a study Posters as a Tool for Disseminating Health related Information in a Developing Country: a pilot experience to investigate the effectiveness of a tool that is commonly used (Nishtar S et al. 2004). The study assessed the understandability of print materials like posters and the impact they can have on the knowledge and attitude of the people. In countries like Pakistan where literacy rates are low, information dissemination potential of print materials has to be carefully weighed. However in a low resource setting, the cost advantage of print materials over expensive electronic media is another factor that should also be kept in mind.

While testing their posters, the research team piloted the color, font and graphics of the poster for clear visibility. The two major limitations of the study were the lack of a comparison group and absence of pre intervention information on knowledge about blood pressure in the study population. In the absence of control group and pre-intervention data, it is difficult to attribute the results to the intervention. Taking the same line, the study also suggests that this experience can serve as a pilot for a larger prospective study to assess poster as a tool for prompting people to adopt a new health behavior.

Discussion

The present review on initiatives from Pakistan informs that Health Communication has to go a long way in our country. Traditionally, this field has been seen as an activity and not as a whole program. There is a culture of using expensive mass media to disseminate health messages without really establishing the local evidence of its effectiveness. Similarly IEC materials are printed without real knowledge of their benefits. Distribution of these materials and proper training on how to use them has been a far cry. There have been cases where IEC materials were distributed when the project period was about to finish or had already finished. Among the electronic media, every television and radio channel relays health programs but none has a behavior change philosophy and methodology behind it. Celebrities are chosen as ambassador to a health cause without putting an effort to establish their relevance.

According to Stiles (1995), during early 90's Ministry of Health, Government of Pakistan and International donors produced tens of thousands of posters and calendars featuring Imran Khan, a national sports hero who promoted immunization on television. After field testing the spots on 120 rural mothers with children under the age of 5, it turned out that 72% of them did not recognize the cricket champion. A nation wide media survey at that time also confirmed this opinion indicating that in rural households only 18% watched TV regularly, only 14% listened to radio regularly, and only 2% read newspapers.

Mass media definitely has a broader outreach, but while using it, cost effectiveness should also be kept in mind. Interpersonal communication has been reported to be more reliable when it comes to health. The sample of these rural women received the best advice on child health from doctors, paramedics, and family members (Stiles 1995).

Communication is not simply message repetition, but includes the development of an environment for community involvement to espouse common values of humankind. Involvement of community in health communication efforts has been rare. This has been leading to ineffective communication. Only with effective communication, health literacy can become a reality and only with health literacy, the dream *Health for all* can be fulfilled.

"Only with effective communication, health literacy can become a reality and only with health literacy, the dream Health for all can be fulfilled."

> *"Looking at the health communication activities gives this feeling also that Pakistan has not been able to come out of the one-way lecturing mode."*

Communication campaigns in Pakistan have been relying heavily on television for creating mass awareness about different health issues. Media, especially television, definitely plays an important role in achieving the goal of mass awareness but it should be used with a proper knowledge of the access of intended audience to this medium. There have been sporadic studies on the media reach that indicate an increase in the television ownership as compared to radio. In 1991, radio and television were owned by 35% and 27% of families respectively (NIPS 1991). In 2000, the possession increased with 35% of the population reported to be having a radio while 46% had a TV (Hakim & Tanweer 2000). Does the intended audience of a health program fall into the category having access to media is an important question that the program should explore before deciding about the medium that they want to use.

Health communication sector in Pakistan suffers lack of objectivity and clarity and this has been underscored by the evaluation of National Program of Health Education. Current branding adopted by Expanded Program on Immunization is another example of the case in point. Pakistan has one of the highest prevalence of unnecessary and unsafe injections in the world (Simonsen et al 1999). Diseases like Hepatitis B and C that are transmitted through unsafe injections and are difficult to treat are creating havoc in our country. In this scenario, decisions like using injection as a branding to persuade parents on getting their children immunized need to be rethought.

Looking at the health communication activities gives this feeling also that Pakistan has not been able to come out of the one-way lecturing mode. There seems to be less intention of empowering the people with knowledge. People are taken as the objects of change by the educators rather than becoming the agents of their own change. Interventions aim to persuade people to do something, rather than seeing them negotiate the best way forward in a partnership process.

The biggest question in this context is *why is it that Pakistan still has a long way to go?* Is it due to lack of importance given to health communication, lack of skills and expertise or lack of resourcefulness? Perhaps the answer lies in the self evaluations of National Program of Health Education and the Population Welfare Program

according to which all the three are responsible for this situation. There has been less commitment from the policy makers at different levels because effectiveness of health communication could not be established in the absence of sound impact analyses and this in turn was due to lack of capacity.

A careful look at the communication institutions, scholars and practitioners in the country reveals a dearth of resource in this area in both the public and private sectors. The subject of Health Communication is neither taught in the mass communication departments, nor at the medical college and public health institutes. In addition to the scarce human resource at the federal and provincial Health Education programs, National programs on Tuberculosis, HIV-AIDS, Lady Health Workers Program and EPI also have scanty Health Communication or BCC positions mostly occupied by informally trained persons.

The only worth mentioning contribution comes from MOPW that along with UNFPA have been conducting a two-weeks long health communication workshop in collaboration with Center for Communication Programs (CCP) of the Johns Hopkins University. Recently, this workshop was organized by Pakistan Initiative for Mothers and Newborns (PAIMAN) in collaboration with CCP and it intends to do so in the remaining project period as well. Graduates of these workshops can become a critical mass for the progress in future.

“ A careful look at the communication institutions, scholars and practitioners in the country reveals a dearth of resource in this area in both the public and private sectors. ”

Recommendations

The scope of health communication today is limitless. Internationally, health communication professionals are helping the planners in battling with problems as diverse as HIV-AIDS in Africa and obesity in the U.S.A. At the national level, Pakistan has the daunting task of beating killers like under-nutrition, tuberculosis, diarrhea, pneumonias, problems related to pregnancy and childbirth, lifestyle diseases etc. In this situation, it is imperative for health communication professionals to work scientifically in a variety of settings including schools, workplaces, voluntary organizations, communities and media etc., in addition to health facilities.

"An element of impact assessment should always be included in the health communication plans."

Across the world, the amount of research in the field of health behavior and health communication has significantly increased in the last two to three decades. Health communication is recognized now as a major tool to achieve public health objectives. The challenges and opportunities for health communication professionals have never been as gargantuan as they are today. In this backdrop, for countries like Pakistan, building communications on the evidence available from all over the world is crucial.

While the health communication sector in Pakistan must build upon the body of knowledge and experiences that international experiences provide, it goes without saying that only local solutions can solve the local problems. Conducting communication on methodologically sound basis, with rigorous evaluation will enable the health educator in Pakistan to decide what works in our setting and what not. Health educator in Pakistan should apply the international learning by adapting them within our cultural contexts, evaluate and then disseminate them.

The developed world appears to have moved on to mass media interventions. With easy availability of television sets and many private channels coming to household through cable T.V, Pakistan is rapidly catching up. Yet, the experts agree that interpersonal communication appears to be an important catalyst of community programs, and its inclusion should be emphasized to obtain higher impact with community programs (Korhonen et al 1998). The only significant tool of IPC for health in our country is the LHWs of national program. There is a need to conduct more research so as to enhance the IPC skills of these LHWs. More tools should also be explored and evidence created by conducting research on

them. Seminaries for men, lady teachers for women and school children for parents can be some potential ideas.

The challenge of understanding and improving health behavior is a central challenge for health policy. A coordinated and focused effort will be essential to resolve many of the health issues that haunt our population today. The integration of best available knowledge from theory, research, and health promotion practices and experiences can help advance the agenda in the future.

Planning health communication interventions according to some standard methodology is crucial. An element of impact assessment should always be included in the health communication plans. Planning the evaluation right from the beginning prepares the eyes on seeing what it wants to see. As health communication has suffered less attention from policy makers and has been facing dearth of resources, one of the few ways of getting more funds may be to provide planners and other government officials with convincing studies demonstrating the effectiveness of health communication. Douglas Noel Adams said in 1990, the most misleading assumptions are the ones you don't even know you're making. Health communication in Pakistan should stop working on assumptions in the new millennium.

Better planned, well organized and result oriented communication campaigns need skilful human resource. Efforts should be made to improve the capacity of this crucial element. Both public and private sectors should work hand in hand to improve the critical mass of health communication experts. Mass communication departments should include the subject of health communication in their curriculum. Public health institutes and medical colleges should have classes on health communication while teaching community health. Public sector programs, NGOs and development organizations should carry out their health communication campaigns according to standard methodologies; and then share their learning.

Communication has an important role to play not only in health but the overall development. Communication professionals should realize the significance of their role in the present and future of this country. The kind of tomorrow our children will have depends more on communication professionals of today than any body else. To give better prospects to our children, they will have to rise from where they are today.

“Public health institutes and medical colleges should have classes on health communication while teaching community health. Public sector programs, NGOs and development organizations should carry out their health communication campaigns according to standard methodologies; and then share their learning.”

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