Chapter 2

Conceptual Frameworks for Strategic Communication

EXPANDING THE ROLE OF COMMUNICATION

One of the biggest obstacles to the effective use of communication in early family planning programs was thinking about communication in too narrow a manner. Communication was originally conceptualized as a simple one-way transmission of messages from a source to a receiver with the intention of producing some effect (Rogers, 1973). The intended effect was usually limited to making the receiver aware of some point of view, new product, or course of action. Neither the social process of communication nor the influence of communication on behavior received enough consideration. This was the concept underlying the "large volume" approach that was common to family planning communication programs before the 1980s (see Chapter 1). Attention was given to the production of materials rather than to their content; to technical quality rather than to how different audience members would interpret the meaning of the content within their particular social context.

Just as family planning communication has changed in response to the evolution of family planning programs (see Chapter 1), so also family planning communication has changed as the concept of communication has evolved. By the 1990s, the conceptual framework for communication had expanded dramatically. The key program elements of strategic communication identified in Chapter 1 —audience participation, recognition of behavior change as both a social and an individual process, use of mass media, and development of entertainment for

educational purposes—are rooted in new conceptual frameworks of communication and behavior change.

AUDIENCE PARTICIPATION

The first step in this reconceptualization began in the late 1970s, when communication was defined as a two-way, interactive process involving two or more individuals or groups in which all participants both encode (create and share) and decode (perceive and interpret) information until the goals of each are adequately achieved. In other words, the definition and practice of communication shifted from *monologue* to *dialogue*. A convergence model of communication was developed by D. Lawrence Kincaid to capture this new participatory orientation (1979).

Thus communication was redefined as "a process in which the participants create and share information with one another in order to reach a mutual understanding" (Kincaid, 1979; Rogers & Kincaid, 1981). Mutual understanding builds the foundation for mutual agreement, which in turn makes collective action possible. In the convergence model of communication, the emphasis shifts to the iterative process of information sharing over time, to the ways in which participants interpret and understand that information, and to the dynamic process of feedback and adaptive behavior. In the process, there is convergence of both the ideas and the behavior of the participants. The distinction between sender and receiver disappears because all participants have the opportunity to be both senders and receivers.

The practical implications of this shift in thinking about communication are readily apparent. Program officials who attempt to bypass or shortcut this process by simply sending out whatever messages make sense or appeal to them should expect to have limited (and unknown) impact on their audience. Communication in this way sometimes even has 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.*

Audiences have different ways of thinking, different vocabulary, even different ways of interpreting drawings and photographs from those of the experts and officials who initiate communication programs. The attitudes and predispositions—even the thought processes—of potential audiences need to be taken into account when communication is designed to address them. Messages need to be (1) based on information obtained from audience members themselves and (2) pretested with them to make sure they were correctly designed. Only then can program managers have any degree of confidence that audience members will interpret family planning messages in the way that they were intended.

Small group discussions or in-depth interviews give audience members the opportunity to express themselves to program officials first, before communication programs are designed. Effective program managers pay attention to this valuable experience when designing their messages and then return to other members of the

same audience to pretest their messages to see if they have been produced correctly. If this communication design process is followed, then the probability that family planning communication will be effective greatly increases. This is the communication theory underlying market research and such formative research techniques as focus-group discussions, audience surveys, and message pretesting. In other words, communication research is a systematic dialogue with members of the intended audience.

SOCIAL MARKETING THEORY AND PRACTICE

At approximately the same time that the concept of communication was being expanded to recognize more interaction with the audience, a new and similar concept was introduced from the field of commerce and advertising—social marketing. First proposed by Kotler and Zaltman in 1971, social marketing was defined by Kotler as "the design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product, planning, pricing, communication, distribution, and marketing research" (Kotler & Zaltman, 1971, p. 5).

Social marketing focused primarily on influencing consumer behavior by emphasizing the "four Ps"—product, price, place, and promotion. Initially, in the field of family planning, this meant promoting and selling over-the-counter contraceptive products, such as condoms, at subsidized prices that were affordable to a defined population (Altman & Piotrow, 1980). But each of the four elements gradually expanded. Thus social marketing could promote not only a specific product such as a condom but also a practice such as breastfeeding or nonsmoking. Price could mean the psychological cost of adopting a practice that others frowned upon. Place could refer to any distribution channels, commercial or otherwise, that would reach the intended client or consumer. And promotion could range from point-of-purchase information in pharmacies to billboards, mass media, or any form of advertising and even community entertainment events (Kotler & Roberto, 1989; Lefebre & Flora, 1988; Manoff, 1985). In fact, by 1995 the definition of social marketing had expanded to include not only most voluntary public health programs but also many other social issues. Thus, in the words of Alan Andreason, social marketing is broadly defined as "the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society" (Andreason, 1995, p. 7). As a result, while communication experts saw social marketing as one component of communication, social marketers began to see health communication as one component of social marketing, sparking a controversy that still flourishes (Buchanan, Reddy, & Hossain, 1994; Hastings & Haywood, 1991).

Social marketing programs expanded rapidly during the 1980s and early 1990s. In fact, one might even call that period "the social marketing era" in family planning. Largely under the aegis of Population Services International and of the

Social Marketing for Change (SOMARC) program of the Futures Group social marketing organizations sell condoms, and, sometimes in addition, oral contraceptives, IUDs, injectable contraceptives, oral rehydration salts, and even mosquito nets. As the threat of AIDS spread worldwide, social marketing became a major strategy in developing countries for selling condoms to men, who were rarely reached by clinical or field services. By the mid-1990s, 54 social marketing programs were under way in 50 countries, providing 13.9 million couple-years of contraceptive protection and serving 9 percent of couples of reproductive age in developing countries (Harvey, 1996).

Social marketing has brought a useful discipline and focus to family planning programs and to the communication component of these programs. Emphasis on audience research, audience segmentation into identified markets, and the establishment of a market niche for specific methods reinforced the new emphasis on addressing the concerns and unmet needs of the audience. Moreover, calling on the professional skills of the commercial communication industry, such as market research firms, advertising agencies, and public relations organizations, stimulated creativity in health communication.

But social marketing, although a useful addition to clinics and field outreach, does not meet everyone's family planning needs. Some clients cannot pay even subsidized prices; some may substitute social marketing products for commercial brands; many will need advice and counseling from health professionals; and some methods—particularly voluntary female sterilization and vasectomy—do not lend themselves well to social marketing. Nor does social marketing theory satisfy the growing need for a strategic approach to health communication at all levels, that is, for a national strategy of health communication in each country. Thus the present era, in which clinic, field, and marketing approaches all play a role in national health strategies, can best be described as "the strategic communication era," both for programs and for communication.

BEHAVIOR CHANGE AS A PROCESS

With increasing attention focused on the audience, as individuals, as clients, and as customers, and on the exchanges between providers and clients, health communicators began turning to theories of communication and behavior change that emphasize process. These theories help to explain the process that individuals go through as they exchange information and as they interpret and react to different messages.

Various models for this process developed in different fields. In the late 1940s Hovland and colleagues developed the first mass communication impact model that described the communication process as a hierarchy, leading from cognition to affective response (like or dislike, attitude) to behavior or action (Hovland, Lumsdain & Sheffield, 1949). In the field of marketing and advertising, the model specified four stages in an individual's change: attention, interest, desire, and action (AIDA). This was soon expanded to six steps: attention, interest, comprehension,

impact, attitude, and sales (Palda, 1966). This evolving model closely resembled the classic model of the diffusion of innovations developed in rural sociology during the 1940s and 1950s (Ryan & Gross, 1943; Rogers, 1962) and which now includes five stages: knowledge, persuasion, decision, implementation, and confirmation (Rogers, 1983 & 1995).

In addressing communication as a process, models in different fields identified specific pathways to behavior change. The convergence concept of communication used in the revised diffusion model specifies five individual steps in the process—perception, interpretation, understanding, agreement, and action—but it adds three social outcomes: mutual understanding, mutual agreement, and collective action (Kincaid, 1987; Rogers & Kincaid, 1981). Also, a 12-step input-output communication/persuasion model was developed by social psychologists to describe the persuasion process (McGuire, 1989). The most recent model of health behavior change comes from the field of psychotherapy. It consists of five stages of personal change: precontemplation, contemplation, preparation, action, and maintenance of new behavior (Prochaska, DiClemente, & Norcross, 1992). This model has been applied to individual and group counseling for alcohol and drug addiction. The striking similarity of these models across such diverse scientific and applied disciplines suggests that a "stage" model is also appropriate for family planning communication.

Other behavioral change models emphasize different stimuli for behavior change but are compatible with the concept of a gradual, step-by-step process. Social comparison and influence theories, for example, emphasize the effect of social interaction on individual behavior (Festinger, 1954; Latane, 1981; Moscovici, 1976). Network analysis illustrates how communication networks can provide a source of new ideas and a stimulus for behavior change (Rogers & Kincaid, 1981; Valente, 1995). Some theories, such as Fishbein and Ajzen's theory of reasoned action, emphasize the role of cognitive factors in behavior change (Fishbein & Ajzen, 1975). Still other theories have explored the power of emotion to influence behavior (Zajonc, 1984). Each of these theories offers insights that can be relevant to individuals or societies as they shift behavior patterns and to public health programs as they deliberately try to influence health behavior. (See Box 2.1 for a summary of relevant theories relating to communication effects on behavior.)

THE STEPS TO BEHAVIOR CHANGE FRAMEWORK

To design strategic communication programs that are appropriate for family planning and reproductive health, Population Communication Services developed a theoretical framework termed the Steps to Behavior Change (SBC). This framework is an adaptation of diffusion of innovations theory and the input/output persuasion model, enriched by social marketing experience and flexible enough to use other theories within each of the steps, or stages, as appropriate. It consists of five major stages of change: knowledge, approval, intention, practice, and advocacy. These five stages and sixteen steps are shown in Box 2.2.

Box 2.1
Theories of Communication Impacts on Behavior

Over the last 50 years social scientists have advanced various theories of how communication can influence human behavior. These theories and models provide family planning communicators with indicators and examples of what influences behavior, in what ways, and under what conditions and offer foundations for planning, executing, and evaluating communication projects. Theories particularly relevant to health communication include:

Stage/Step Theories *Diffusion of innovations theory*, by B. Ryan and N. Gross, 1943, 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 the factors that influence people's thoughts and actions and the process of adopting a new technology or idea (Rogers, 1962 & 1983; Ryan & Gross, 1943 & 1950; Valente, 1995). *The input/output persuasion model*, by W. J. McGuire, 1969, emphasizes the *hierarchy of communication effects* and considers how various aspects of communication, such as message design, source, and channel, as well as audience characteristics, influence the behavioral outcome of communication (McGuire, 1969 & 1989). *Stages of change theory*, by psychologists J. O. Prochaska, C. C. DiClemente, and J. C. 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 precontemplation through contemplation, preparation, and action, to maintenance of the new behavior (Prochaska et al., 1992).

Cognitive Theories *Theory of reasoned action*, by M. Fishbein and I. Ajzen, specifies that adoption of a behavior is a function of intent, which is determined by a person's attitude (beliefs and expected values) toward performing the behavior and by perceived social norms (importance and perception that others expect the behavior) (Fishbein & Ajzen, 1975). *Social cognitive (learning) theory*, by A. Bandura, specifies that audience members identify with attractive characters in the mass media who demonstrate behavior, engage emotions, and facilitate mental rehearsal and modeling of new behavior. The behavior of models in the mass media also offers vicarious reinforcement to motivate audience members' adoption of the behavior (Bandura, 1977 & 1986).

Social Process Theories *Social influence*, *social comparison*, and *convergence theories* specify that one's perception and behavior are influenced by the perceptions and behavior of members of groups to which one belongs and by members of one's personal networks. People rely on the opinions of others, especially when a situation is highly uncertain or ambiguous and no objective evidence is readily available. Social influence can have vicarious effects on audiences by depicting in television and radio programs the process of change and eventual conversion of behavior (Festinger, 1954; Kincaid, 1987 & 1988; Latane, 1981; Moscovici, 1976; Rogers & Kincaid, 1981; Suls, 1977).

Emotional Response Theories *Theories of emotional response* propose that emotional response precedes and conditions cognitive and attitudinal effects. This implies that highly emotional messages in entertainment (see Chapter 4) would be more likely to influence behavior than messages low in emotional content (Clark, 1992; Zajonc, 1984; Zajonc, Murphy, & Inglehart, 1989).

Mass Media Theories *Cultivation theory of mass media*, proposed by George Gerbner, specifies 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 the "reality" depicted in the mass media, which can influence behavior (Gerbner, 1973 & 1977; Gerbner et al., 1980).

Box 2.2
Steps to Behavior Change

Knowledge
1. Recalls family planning messages.
2. Understands what family planning means.
3. Can name family planning method(s) and/or source of supply.

Approval
4. Responds favorably to family planning messages.
5. Discusses family planning with personal networks (family, friends).
6. Thinks family, friends, and community approve of family planning.
7. Approves of family planning.

Intention
8. Recognizes that family planning can meet a personal need.
9. Intends to consult a provider.
10. Intends to practice family planning at some time.

Practice
11. Goes to a provider of information/supplies/services.
12. Chooses a method and begins family planning use.
13. Continues family planning use.

Advocacy
14. Experiences and acknowledges personal benefits of family planning.
15. Advocates practice to others.
16. Supports programs in the community.

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

This SBC framework has been refined by advances in theory and by practical experience in implementing communication programs. These modifications recognize the following:

- Not all individuals go through each step of the process in the same order, at the same speed, or at the same time. For example, some women recognize a personal need to limit family size before they ever hear of family planning methods. Other women learn about and approve of family planning but wait a long time before they begin to practice it. Most women and men increase their knowledge of family planning gradually, not all in one step, as they are exposed to different sources of information, and as they try one method, learn about its advantages and disadvantages in practice, discontinue, and then try another.
- As knowledge and approval reach high levels in more advanced programs, emphasis shifts to later steps, such as identifying effective cues to action, maximizing access to

and quality of services, identifying and removing barriers to change, reinforcing current users, and creating opportunities for advocacy.

- Social norms and public policies influence individual behavior change. Therefore political leaders, policy-makers, and local people of influence are part of the audience for most mass media communication, most community mobilization activities, and much interpersonal communication.
- Advocacy for behavior change, through public acknowledgment, promotion by satisfied users, and support for programs, is the final stage of behavior change. Once the benefits of family planning or any other health practice are confirmed by experience, a person's public advocacy of the practice to others cements conviction and sustains the new behavior. Advocacy also helps other people move through the steps by offering them a behavioral model and confirming community norms. Advocacy is positive feedback to the process of behavior change.

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

MEETING THE AUDIENCE'S COMMUNICATION NEEDS WITH THE SBC FRAMEWORK

How does the communication expert apply this theoretical framework about behavior change to operational programs? Survey research can identify different segments of the population in terms of their current stage of change. For example, a certain percentage may still never have heard of family planning, while others are already using some method. The rest of the audience will fall somewhere between these two points in certain proportions. For example, some women will approve of contraceptive use, have positive attitudes, and desire to avoid pregnancy but will not have taken any action yet. These women have what is called "an unmet need" for family planning (see Chapter 3) (Robey, Ross, & Bhushan, 1996; Westoff & Bankole, 1995). The reasons for this unmet need vary, but often an unmet need for family planning can be traced to an unmet need for communication.

Building on the behavior change models and theories discussed above, practical guides have been developed that make it easier to develop communication programs that are participatory and effective. One such practical guide used in Johns Hopkins programs is termed the Seven Cs of Effective Communication (J. R. Williams, 1992) (see Chapter 5, Lesson 1). Corresponding to specific steps to behavior change, the Seven Cs suggest the type of information most needed at each stage of change.

MASS MEDIA, ENTERTAINMENT, AND MEDIA ADVOCACY

Even without any modern communication media, people communicate, exchange ideas, and alter their behavior. But the unprecedented growth of mass media—first print, then radio, now television and computer communication—has raised new possibilities for rapid global communication and thus new theories about how people may react and change as a result of mass media.

By the early 1970s expectations that mass media could have a direct effect on mass behavior had faded. In fact, a "limited effects" view of mass media was dominant in the United States (Klapper, 1960; McQuail, 1994). Klapper (1960) concluded that mass media by themselves—apart from reinforcing the status quo—do not act as the sole cause of audience effects but rather as a contributory agent through a set of mediating factors and influences. Research in the United States was showing that important individual differences in gender, age, education, and psychological predisposition led to selective exposure, attention, retention, and perception of mass media messages (Klapper, 1960). The notion of a homogeneous "mass" audience was being replaced by the notion of a heterogeneous audience comprised of different types of individuals and different subcultures, each with different ways of looking at the world. Thus the concept of audience segmentation emerged, consistent with theories of behavior change and marketing that could guide political, consumer, and other types of mass media campaigns and focus resources where the potential for change was the greatest.

Research on a U.S. presidential campaign in the 1940s led to the "two-step flow" hypothesis of mass media effects: that the media had direct effects on opinion leaders, who then had indirect effects on other members of the audience by means of interpersonal communication (Katz & Lazarsfeld, 1955). By the end of the 1970s the accepted view of mass media was that they were effective for increasing awareness but that only interpersonal communication could persuade or motivate action (Rogers, 1983).

One of the first theories to propose that mass media may have more powerful effects was Noelle-Neumann's (1993) "spiral of silence" theory of opinion formation. Her research on political campaigns in Germany in the 1960s and 1970s concluded that the more frequently the dominant or majority opinion is disseminated by the mass media, the more likely it is that individuals with contrary opinions will remain silent, thus accelerating the effects of the media (in a spiraling process). The theory assumes that individuals have a fear of isolation and hence try to identify with and express the majority opinion or perceived consensus. The theory implies that, for a new, minority opinion to become accepted, the ideal condition would be for the majority to remain silent while the minority opinion receives more public expression via the mass media. This leads the audience to perceive that the minority opinion may actually be the majority position (social norm). If the majority remains relatively silent, the minority opinion could eventually prevail. This outcome is similar to what Gerbner's (1973) cultivation theory of mass media would predict: even if the message is distinctive and deviates from "reality," its persistent exposure

on television can lead to its adoption (perception) as the consensual view of society. This is sometimes called the "legitimizing effect" of the mass media.

At about this same time Katz, Blumler, and Gurevitch (1974; Blumler & Katz, 1974) were proposing a "uses and gratifications" approach to mass media, which treated audience members as active selectors of media content rather than as passive receivers. Entertainment was considered to be one of the main functions of mass media, along with surveillance (news), correlation (interpretation of reality), and cultural transmission (values and norms).

Then Ball-Rokeach and Defleur (1976) developed a dependency theory of mass media that specified a three-way interaction among audiences, media, and the larger social system. A group's (or audience segment's) dependency on a medium such as television or radio for information increases when (1) that medium supplies information that is central to the needs of that group and (2) when social change, conflict, and social instability increase uncertainty and ambiguity. Increased dependency on mass media for information increases the impact of mass media on knowledge, attitudes, and behavior.

EVALUATING BEHAVIOR CHANGE AS A PROCESS

When communication is recognized as a process that affects different people in different ways at different times, it becomes clear that evaluation of the impact of communication programs also must grow out of this conceptual framework. As the Steps to Behavior Change model indicates, individuals or couples respond to family planning communication in different but related ways depending on where they stand in the process: switching from being undecided to no longer wanting another child; gaining knowledge of modern contraceptives; beginning to talk with other women who support family planning practice; shifting from disagreement to agreement with one's spouse about using a contraceptive; and so forth. They may move one step at a time, or they may take several steps at once. When the intermediate steps of knowledge and attitudes, as well as behavior, change within the time period of the program, this multiple response increases confidence that a communication program has influenced the changes. At the same time, if knowledge and attitudes are observed to change within the period under study, the likelihood that behavior eventually will change, too, is increased.

Statistical analyses of these influences on several hundred or several thousand respondents before and after a communication campaign—including multivariate, regression, and path analysis, for example—can also show how exposure to a campaign is related to the subobjectives or steps to behavioral change, such as an increase in discussion and agreement between spouses or an increase in the belief that modern contraceptives are healthy (see Chapter 7). Such findings suggest that communication not only has a direct impact on behavior in conjunction with other factors, but also that it has an indirect impact because it operates at each step in the process as well. These intermediate steps (intervening variables) can be specified in advance as intended subobjectives of the intervention. Measurement of these intermediate steps (links in the causal chain) greatly increases confidence in

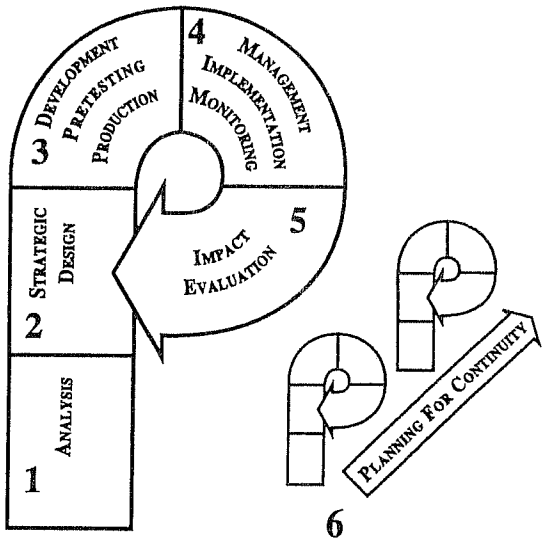
attributing outcomes to interventions, because these outcomes are implied by the theories of communication and behavior change used to design the interventions.

A Systematic Process for Developing Strategic Communication Programs

Not only the content and evaluation of communication programs but also the development of these programs is now increasingly systematic and strategic. The design, implementation, monitoring, and evaluation of Johns Hopkins communication projects follow "The Processes and Principles for Health Communication Projects," known as the P Process (see Figure 2.1).

The P Process (in which P can stand for project or program) is valuable because it is (1) systematic and rational, (2) continually responsive to research findings and data, (3) practical for field applications at all levels, and (4) strategic in setting and pursuing long-term objectives. The P Process consists of six s teps that are followed in sequence to develop and implement effective national communication strategies, programs, or, indeed, any organized communication activity:

Figure 2.1
The P Process



- **Analysis**—Listen to potential audiences; assess existing programs, policies, resources, strengths and weaknesses; and analyze communication resources.
- **Strategic design**—Decide on objectives, identify audience segments, position the concept for the audience, clarify behavior change model, select channels of communication, plan for interpersonal discussion, draw up an action plan, and design evaluation.
- **Development, pretesting and revision, and production**—Develop message concepts, pretest with audience members and gatekeepers, revise and produce messages and materials, retest new and existing materials.
- **Management, implementation, and monitoring**—Mobilize key organizations, create a positive organizational climate, implement the action plan, and monitor the process of dissemination, transmission, and reception of program outputs.
- **Impact evaluation**—Measure impact on audiences and determine how to improve future projects.
- **Planning for continuity**—Adjust to changing conditions; plan for continuity and self-sufficiency.

The P Process was developed in 1983 by the first Population Communication Services project team, which included the Academy for Educational Development; Porter, Novelli and Associates; and the Program for Appropriate Technology in Health. It has continued to provide a solid framework for strategy development, project implementation, technical assistance, institution-building, and training for more than a decade. Somewhat similar processes have been developed by other individuals and organizations to guide their work (Graeff, Elder, & Booth, 1993; L. W. Green & Kreuter, 1991; National Institutes of Health [NIH], 1992). Due to international training programs and technical assistance provided by PCS, many family planning communication programs throughout the developing world have adopted, applied, and institutionalized the P Process over the last decade.

The remainder of the book is organized according to this P Process for program planning and implementation. The experience gained over the last 15 years at each step of a communication program is described in Chapters 3 through 8. The book concludes with a discussion of the challenges facing family planning and health communication in the future. The emphasis throughout is on expanding the role that communication plays in health programs, institutionalizing a systematic approach to developing communication programs, and stimulating the level of creativity needed to make communication effective.