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**WORLD HEALTH ORGANIZATION**

**Prevention of Noncommunicable Diseases Department (PND)**

**Geneva, Switzerland**

**Workbook for**

**Communication Planning**

**for the Prevention of**

**Non-Communicable Diseases

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(Limited Distribution—Being Edited)**

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**PURPOSE AND USE OF THE MANUAL**

This Manual is intended for participants being trained in the use of WHO’s communication planning methodology called “Communication for Behavioural Impact” (COMBI) for designing communication plans for achieving specific behavioural results in the prevention and control of Non-Communicable Diseases (NCDs).

Participants will use this Manual during that part of the training when they are involved in a practicum to design a draft communication plan for presentation on the final day of their training programme.

It is hoped that, by using the Manual during this phase of the training, participants will more readily draw on the Manual as a guide as they develop communication/COMBI plans beyond the training for their NCD programmes.

For those with prior COMBI training, the Manual will serve as a quick reference to the concepts and planning steps used in developing a COMBI Plan.

#### This Manual covers the 10 Steps used in communication planning which would have been introduced step by step in the COMBI training programme. For each step, a series of notes are provided which serve as reminders of what was presented in the training prior to the practicum session. These reminder notes highlight key principles, concepts, and actions pertinent to the Step being presented, and so facilitates completion of the Step.

**Communication Planning:**

**9 Things to Remember**

1. NCD prevention and control depends on people carrying out very specific behaviours: putting less salt in the food one eats, exercising at least three times per week, eating a balanced diet, eating less, checking one’s blood pressure, checking one’s diabetes status, not smoking, and the list goes on.
2. If we fail to get people adopting and carrying out these behaviours, we will fail to make a difference to NCD.
3. We cannot get people adopting and carrying out these behaviours unless we intimately and purposefully engage them in considering the merits of recommended behaviours.
4. We will not be able to have this engagement with people unless we have carefully developed communication plans directed at behavioural outcomes and not just increasing awareness and informing people. And these plans need to engage people in multiple ways over a sustained period of time.
5. The WHO communication planning methodology called “COMBI”, Communication for Behavioural Impact, adopted by WHO since 2000, offers a 10-Step process for developing integrated, synchronised communication plans aimed at getting behavioural outcomes: Since 2000, WHO and UNICEF has applied COMBI successfully to achieving behavioural results in communicable and non-communicable diseases, as well as in other health programmes. COMBI emphasises a sharp focus on achieving specific behavioural outcomes and not only informing and educating the public. Informing/educating people is essential but we know, from 50 years of health communication experience, it is insufficient for getting behavioural responses. It is one thing to KNOW, another to ACT. COMBI focuses on behavioural results and begins with community-based behavioural research and then applies a synchronised, integrated blend of communication actions to the task of engaging people about the merits of recommended behaviours.
6. Well prepared and executed communication plans focused on behavioural results can make a behavioural difference in NCD: See Box #1 for examples.
7. In communication planning, keep in mind the COMBI foundational principle: ***Connect*** to the individual’s need, want, or desire and not focus just on the technical merits of recommended behaviours: Our recommended behaviours may be technically fantastic but unless individuals see these behaviours as connected to what is of value to them, they will remain understood but not adopted.
8. Keep in mind also the other COMBI foundational principle: Be ever mindful of the ***Competitor***, the alternative behaviour or non-behaviour (no action) which ends up having more appeal to the individual than what we are recommending: We need to have a deep understanding of why the competitor is preferable to what is recommended. This enables a more sensitive engagement with people as we offer the value of recommended NCD-related behaviours
9. And finally the COMBI foundational principle: ***Listen*.** Listening to individuals, families and the community tells us whether our behavioural recommendations are realistic and appropriate. It is in listening to people that we learn how they wish to be engaged. It is in listening to people that we learn how to connect. It is in listening people we learn how to offer in a more realistic way what at first seems unrealistic.

Box #1

#### Examples of Communication Plans

#### Making a Behavioural Difference

**Lithgow, New South Wales, Australia:** A COMBI Programme was implemented (by George Institute for Global Health and partners) in this city, population approximately 12,000, to reduce the adult population salt consumption of the city Lithgow, NSW Australia, by approximately one gram over an 18 month study period over an 18-month period from 2011 to 2014. The COMBI effort focused on getting two tools used: (a) “*FoodSwitch”,* a smartphone application which allows users to scan the barcodes of packaged foods, receive colour coded ratings for four key food components (total fat, saturated fat, sugar and salt) and a list of similar foods that are lower salt healthier choices[; (b)](#_ENREF_5) a salt substitute which comprises a salt blend of 136 mg sodium and 176 mg potassium per 0.8g serving, a formula which has 70% less sodium than regular salt. Additionally, families were encouraged to use more spices in their cooking and less salt for taste and to reduce the frequency of eating out. These tools were combined with communication strategies to influence behaviour adoption through the principles of reciprocity/incentives, commitment and consistency, social proof, liking and authority with a synchronised, integrated blend of communication actions. The primary finding was a reduction in population salt intake by -0.8g/day (approximately 9%) over the period of the study. The results indicate that the COMBI intervention favorably changed the behavior of the population towards salt consumption. For further information see: WHO Bulletin, xxxxxxxxxxxxxxxxxxxxx, 2015.

**Cambodia:** In January 2009 Cambodia (the National Center for Health Promotion with UNICEF/Cambodia) launched a COMBI programme to support Ante Natal Care (ANC) services. The COMBI programme was an integrated, synchronised blend of communication actions, with a mix of door-to-door family communication, mass media, and community mobilisation. The 12 month behavioural objective was to increase the percentage of women seeking ANC within the first 8 weeks of pregnancy from 5 per cent to 25 per cent in the seven demonstration provinces. In turn this would enable them to receive a set of ANC services including confirmation of the pregnancy and related medical check-ups, vaccination against tetanus, iron-folate tablets, and education on birth planning and proper health and nutrition during pregnancy. An external evaluation of the project and the ANC campaign in 2011 documented that the communication objective was met well beyond expectations: Already within the first 12 month of the ANC campaign, 36 per cent of potentially pregnant women came in for their first ANC visit within the first 8 weeks of pregnancy. This represented a 700% increase. Source: UNICEF ICON New and Noteworthy, 21 August 2012; “Antenatal Care Behaviour Change Campaign Assessment in Cambodia”, UNICEF/Cambodia, 2010**.**

**United States of America:** Legacy, formally the American Legacy Foundation®, is a Washington, D.C.-based national public health organization devoted to tobacco-use prevention and education. Nearly 80 percent of smokers in the United States begin using tobacco before the age of 18. Legacy began a multi-year communication campaign called “Truth”, targeting youth between the ages of 12 and 17, in an effort to keep teens from ever trying that first cigarette. To form its strategies, the Truth campaign

used research with teen audiences, marketing and social science research, as well

as evidence from other successful campaigns. In its first ten years, truth utilized

many different forms of media and evolved its tactics to ensure it reached the teen

audience most effectively. A study published in the May 2009 issue of the American Journal of Preventive Medicine (AJPM) found that truth was responsible for keeping approximately 450,000 teens from starting to smoke during its first four years, from 2000 to 2004. Source: American Journal of Preventive Medicine (AJPM) – May 2009

#### The 10 Steps for Designing

**NCD Communication Plans**

#### Following are the 10 Steps in developing a communication plan focused on achieving specific NCD-related behavioural outcomes. These are the 10 Steps of the WHO COMBI planning method which were presented during the training workshop on COMBI for NCD .

#### These 10 Steps do not pretend to cover all the intricacies of developing COMBI plans; part of this process is intuitive and creative. But they do immerse us in the often confounding exercise of communication planning for specific behavioural outcomes in health.

While we set out a ten-step process, it is not intended to be followed religiously in a linear fashion. One will find that in the actual design process one moves back and forth among the various steps as new insights emerge in one step or the other.

The Ten Step Process focuses on *designing* a COMBI Plan and will point to various issues related to implementation of the plan. But it does not address in detail the tasks involved in actually *implementing* the plan. For example, the COMBI Plan may be designed with an advertising component including details on the advertising schedule being suggested and the tone of the advertisements. But this workbook will not discuss issues related to the process of selecting an advertising agency and working with one.

It might be helpful, as one proceeds through the Ten Steps, to refer from time to time to the sample COMBI Plan distributed in the course of the training workshop. The sample COMBI Plan will show how the 10 steps emerge in an actual document and the language used. While the tools used in COMBI Planning have their own unique terminology, they are rarely used in the actual plan document which will be read by others who have not participated in a COMBI training exercise and for whom the terminology will make no sense. So the tools are used but necessarily the language in the final document.

The 10-Steps are presented in a short form at the end of this workbook.

**STEP #1**

1. **State The Overall Goal**

**Providing the Context – Setting the Stage**

Stating an overall long-term goal provides the context within which the specific COMBI Plan is to be developed. This allows one to see the connection between the COMBI Plan for a specific behavioural objective and the mission of the overall goal. The overall long-term goal is usually related to some key health problem. A background statement describing this problem grounds the overall goal. Basically, one presents the over-riding challenge and some background information that would help elucidate the importance of the behavioural objective upcoming in Step 2.

***Example (in brief)***:

*Background:* The situation with regard to the health burden accounted for by diabetes in Jamaica is as follows and is taken from the document titled **NATIONAL STRATEGIC AND ACTION PLAN for the PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES (NCDS)** **in JAMAICA 2013 – 2018, MINISTRY OF HEALTH, 2013**. Prevalence of diabetes mellitus in Jamaica is now estimated as 7.9% among persons 15-74 years old (35) with prevalence being higher among women compared to men (9.3% vs. 6.4%), reflecting higher levels of overweight and obesity in women. The estimated prevalence of diabetes mellitus in the 2000 -2001 Lifestyle Survey was 7.2% suggesting that the prevalence may be increasing.

Diabetes is a major cause of morbidity and mortality in Jamaica and was ranked as the leading cause of death among women and the third leading cause of death men for 2009. In addition it has been estimated that the cost of treatment for diabetes in 2001 was 221 million US dollars representing 2.7% of GDP (45).

It is widely believed that obesity is a major factor fuelling the chronic disease epidemic. Data from the two national surveys suggest that the prevalence of obesity in Jamaica is increasing. In the 2000-2001 Lifestyle survey approximately 20% of the population was obese while the estimated prevalence in 2007-2008 was 25%. In addition to the obese persons, approximately 27% of the population was overweight in 2007-2008, resulting in a prevalence of 52% for overweight and obese combined. The situation is markedly more severe among women with 38% being obese and 27% overweight for a combined prevalence of 65%. There has been a 10% increase in diabetes in the 8 year period.

The Government of Jamaica/MOH has set out in its National NCD Strategic Action Plan five priority action areas and has listed, among others, the following goals under ***Priority Area #1:*** ***Risk Factor Reduction and Health Promotion.***

*Overall Goal:* To reduce the prevalence of diabetes mellitus in adults aged 18+ years by 5% by 2018 by reducing the proportion of persons engaging in insufficient physical activity by 5% by

2018 and reducing the prevalence of obesity in adults aged 18+ years and adolescents by 5% by 2018.

**STEP #2**

1. **State Tentative Specific Behavioural Objective(s ) (SBOs)**

Set out the preliminary, tentative, Specific Behavioural Objective(s) (SBOs) which will focus the design of the COMBI Plan. One is urged to go no further until this is done.

SBO Example #1: To get, within a period of 12 months from the start of this COMBI programme, 30% (about 105,000) of all individuals responsible for preparing meals (Meal Preparers – MPs) in families (estimated to be a total of 350,000 in Phu Tho Province/Vietnam) to use half as much salt as they now use in the cooking of all daily meals. This will be referred to as “Cooking With Half Less Salt” behaviour (CLS½ ). *(Note: This SBO presumes all families use too much salt in their cooking of meals currently.)*

SBO Example #2: To have within a period of 12 months from the start of this COMBI programme, 50% of individuals age 10-65 in selected countries of the South Pacific [approximate number to be calculated per each WHO South Pacific country carrying out this COMBI Plan, e.g. in Fiji, it would be about 150,000] walking “briskly”(with “briskly” being defined by each individual), to be referred to as “BMW” meaning “Brisk Meditative Walking” (BMW) every day for 30 minutes (*BMW 30*) or an accumulated 30 minutes (meaning two 15-minute sessions or three 10- minute sessions, or one 30-minute session) for a continuous period of 100 days (*BMW 30x100*) within the last four months of the COMBI Plan one year period, leading to a --% increase in the proportion of these individuals who do the BMW, calculated in relation to a baseline figure for this behaviour to be determined by a baseline survey**.**

The entire COMBI Plan turns on this specification of expected behavioural outcomes. It is also central to the eventual task of evaluating behavioural achievement. The more precise and specific the behavioural objective, the better the impact assessment exercise described later on. The following notes will be helpful in guiding us through this step.

**Note 2.1 COMBI Planning Mantra #1:**

**“Do nothing….make no posters, no t-shirts, no pamphlets, no**

**videos, no caps, no ball point pens…do nothing until one has set out precise, specific, behavioural objectives (SBOs)..”**

 Step #2 is premised on a fundamental principle: the control and prevention of non-communicable diseases rests ultimately with the achievement of specific behavioural results. Someone has to Do something; it is not enough be aware, or motivated, or persuaded. Someone must act. To achieve the overall goal earlier stated calls for specific behavioural responses. It is the health behaviours that people adopt or fail to adopt which will have an impact on their health status. The COMBI Plan must be absolutely informed by this behavioural imperative. Hence the COMBI Mantra #1: Do nothing…make no posters, no T-shirts, no pamphlets, no video…do nothing, until one has set out specific, precise behavioural objectives. Living by this mantra prevents the headlong rush into the production of “IEC” (information-education-communication) materials such as T-shirts and posters and pamphlets, without first thinking through the relevance of these materials to the behavioural outcome desired. These materials may or may not be needed; but this decision turns on how these items serve the behavioural objective(s). And that calls for a clear statement of expected behavioural results at the very start.

**Note 2.2 Avoid being seduced by the “Educational Sensibility.”**

 The “education sensibility” suggest that all we need to do is to make people aware of a

 recommended health behaviour, and informed and educated about it, in order to prompt

adoption of the suggested behaviour. As a consequence, this sensibility seduces one into formulating objetives which speak to “increasing awareness and improving knowledge” but with little or no explicit focus on expected behavioural results. While awareness and knowledge are essential steps in the process towards healthy behaviour practice, they provide an insufficient basis for prompting behavioural responses. Knowing what to do and actually doing it are quite different things.

Step #2 urges that from the outset objectives should be stated in behavioural terms and not from the perspective of increasing awareness and knowledge. With some behaviours there may be no need to pursue the tasks of increasing awareness and knowledge; people may already be informed and even persuaded of the recommended behaviour. A communication effort may need instead to address other factors which constrain the desired behavioural response. But to make this determination, one needs to begin with a clear statement of the desired behavioural result.

The “educational sensibility” also contributes to that rush into the production of IEC materials which serve to “inform and educate” but with no effective linkage to our ultimate goal of behavioural impact. Step #2 steers one away from this direction.

**Note 2.3 Be wary of one’s “social development conscience”; aim for a limited number of behavioural outcomes, one to three at the most.**

The overall goal we would have presented in Step #1 most likely would have to be achieved by a variety of behavioural results. One’s “social development conscience” tempts one to tackle all or many of them But this would be an operational error. While we feel obliged to take on every behavioural objective to get to the overall goal, we need to curtail this urge and restrict ourselves to a limited few at a time.

In tackling too many desired behavioural outcomes, we may very well end up, like butterflies, flitting from one flower to the next, but not accomplishing very much by the end of a year. We would have worked hard and have been well intentioned but in attempting to do too much, we achieve little.

It would be best to limit our focus and restrict oneself to one fundamental behavioural objective at a time which would make a significant difference. At most, we urge no more than three related behavioural goals at a time. Consumer communication research over the years have shown that people have enormous difficulty in recalling more than three themes/messages from a communication presentation. In selecting behavioural objectives, we urge a tight, limited focus.

 *Example A: South Pacific (excerpted from a draft COMBI Plan)*

*The work of WHO/WPRO/South Pacific in the NCD area is awash with a multitude of desired behavioural outcomes. A very preliminary exploration of what specific behaviours we would like people to adopt with regard to reducing risks to NCD suggest we may be talking about 20 very specific behaviours, if not more. There are a number of behaviours linked to diet: achieving energy balance and a healthy weight; limiting energy intake from total fats; shifting from saturated fats to unsaturated fats; eliminating trans-fatty acids in one’s diet; increasing consumption of fruits; increasing consumption of vegetables; increasing consumption of legumes, whole grains, and nuts; limiting the intake of free sugars; limiting salt/sodium consumption. And in the area of physical activity, we have a range of recommendations, from begin any kind of physical activity if currently sedentary, reduce sedentary activities, be active every day in as many ways as you can, do at least 30 minutes of moderate-intensity physical activity on most days of the week/5 days a week/every day of the week, and carry out some kind of regular vigorous-intensity activity (if you can).*

*Each behaviour listed above or hinted at has its own unique rationale and actions. Reducing salt is quite different from eating more fruits. Gardening as physical activity is quite a different behaviour from regularly walking briskly for 30 minutes every day or walking to church rather than driving to it, or playing rugby three times per week. The communication strategy for each will need to be different. But one can’t arrive at a communication strategy unless one has a clear sense of exactly what behaviour to request and one understands that recommended behaviour from the perspective of the consumer.*

*If we go to consumers all at once with, say, six of the recommended NCD behaviours, we will simply overwhelm them and they are likely to turn away from any attempt to engage them. One also recognises that people can recall at the most only three messages from any single presentation. To present consumers with six behaviours and their rationale is to court disaster.*

*It is not wise (and in any case not possible) to have a single COMBI programme directed at a wide and wild variety of behavioural results. Were one to do so, one would end up like a butterfly, flitting from one flower to another, being very busy, but not accomplishing a lot in terms of behavioural impact. The COMBI technical advice is to limit one’s focus over a specific period of time with a South Pacific COMBI Plan focusing on a single behaviour which could focus the attention and resources of the individual Pacific countries within WHO/WPRO.*

*This COMBI Plan focuses on one behavioural objective as the basis for a South Pacific-wide NCD risk-reduction effort. To engage the South Pacific community with a multiplicity of NCD risk-reduction behaviours would confound the public, as already explained. We need to have a singular behavioural objective around which, individuals, families, schools, and the community can come together for joint action. In discussion with WHO/WPRO/South Pacific, it was decided that it would be extremely difficult to arrive at a set of regional dietary behaviours recommendations, given the wide array of culturally-dictated dietary practices from country to country. In dealing with dietary issues, one would have to proceed country by country with regard to their unique dietary practices which increase NCD risks.*

*The focus then became “physical activity”. Studies from a number of Pacific countries show that between 40%-60% of the population are physically inactive. The challenge is what behavioural recommendation to make: start some kind of physical activity, do anything; be active in as many ways as you can every day; do at least 30 minutes of moderate intensity physical activity on 5 or more days a week; carry out some kind of vigorous-intensity activity a few times a week. These behavioural options are taken from a WHO/WPRO/South Pacific document on “Pacific Physical Activity Guidelines for Adults: Framework for Accelerating the Communication of Physical Activity Guidelines.” To present this array of options to the public would be to overwhelm them.*

*In looking at the various options, there is one which stands out as having clear, documented evidence of reducing risks of cardiovascular diseases, hypertension, some cancers, and Type 2 diabetes. It is the recommendation to carry out 30 minutes of moderate-intensity physical activity on five days or more per week. There is also evidence that such activity makes a difference to the health status of the obese/overweight even if there is no weight loss. In addition, such exercise contributes to emotional well-being. But this behaviour is best presented to the public if there is more clarity and specificity as to exactly what is being recommended. Each individual can then incorporate the recommended behaviour within his or her life with appropriate modifications.*

*After much consideration, the behavioural objective recommended became that of trying to get individuals between the ages of 10 and 65 to do 30 minutes of Brisk Meditative Walking (BMW), either in one 30-minute session or in any sequence for the accumulation of the 30 minutes (e.g. two 15 minute session or three 10-minute sessions). According to WHO advice, the physical benefits are about the same regardless of the sequence of accumulating the recommended 30 minutes. In addition, at the end of the first year of the COMBI Plan, when this behaviour is measured, the individual should have been carrying out this activity everyday for the past 100 days.* [The draft COMBI Plan then proceeded to discuss further the rationale for BMW]

**Note 2.4 Our first shot at stating specific behavioural objectives will**

 **not be our last; we will return to it with modifications**

Our first attempt at stating specific, precise behavioural outcomes will be based on our initial understanding of the disease, its causes, people’s behaviours and perception about the disease, and what the disease experts have surmised as the desired behaviours for controlling the disease. But as we proceed to Step #3 below (conducting the Situational Market Analysis for Communication Keys- SMACK), we will be prompted to return time and again to our initial delineation of behavioural results expected for further modifications. As was the case in the South Pacific, we thought of having a regional set of dietary recommendations. But our field work pointed out the wide variety of dietary customs and preference, thus making an initial statement of an SBO related to diet un realistic.

**Note 2.5 Review specific behavioural objectives vis-à-vis**

**the 4+1 Ws and the “SMART” criteria and STEP #3**

In setting out our behavioural objectives, it is useful to review them for completeness in relation to the **4+1Ws** questions: Who, What, When, Where, and Why. A clear statement of an expected behavioural result would specify exactly **Who** (in quantitative terms) is expected do precisely **What**, **When** (during what time frame), and specifically **Where**. The SBO statement need not be that exact order but the four Ws should be covered, E.g. SBO Example #1 previously presented: To get, within a period of 12 months **(When)** from the start of this COMBI programme, 30% (about 105,000) of all individuals responsible for preparing meals (Meal Preparers – MPs) in families (estimated to be a total of 350,000 in Phu Tho Province/Vietnam) **(Who)** to use half as much salt as they now use in the cooking of all daily meals **(What)**. This will be referred to as “Cooking With Half Less Salt” behaviour (CLS½ ).

One should check that these essential **4 W** questions are responded to in the behavioural objective. The more detailed the SBO, the better the communication planning to achieve. For example, having a sense of the actual numbers of people with respect to the “Who” immediately has one thinking of the scope of the challenge and the communication reach to that many people. The last **W (Why)** reminds us to verify a substantial link between the behavioural result desired and achievement of the overall goal. As mentioned earlier, one most likely will need to pick a limited number of desired behavioural outcomes from a longer list. In making this selection, one needs to ensure that what is selected will make a critical difference to achieving the overall goal earlier stated.

Sometimes it is helpful to conclude the SBO statement with a sentence indicating the proportional increase in the behaviour from some baseline measure, e.g. from a 20% current level of practice of the behaviour to 30% in a year. For policy makers deciding on funding, such an indication of proportionate increase can win support.

Another approach to reviewing the completeness of a stated behavioural objective is to examine it in relation to self-explanatory questions prompted by the “**SMART”** acronym: Is it **S**pecific; Is it **M**easurable? Is it **A**ppropriate? Is it **R**ealistic? Is it **T**ime-bound? In particular, asking whether a recommended behaviour is Appropriate may raise implementation issues about the recommended behaviour being counter to current social and cultural practices. This does not mean that one should not pursue the SBO but instead acknowledges major hurdles and competitors ahead. Asking whether the SBO is Realistic forces us to confront the possibility that we may be chasing unrealistic expectations.

**Step #3** (presented next) of the 10 Step COMBI Planning process also enables further tweaking and modifications to the SBO, sometimes leading to the decision that the proposed SBO be dumped and another one pursued.

**STEP #3**

1. **Conduct A Situational "Market" Analysis**

**for the Communication Keys (SMACK) vis-à-vis Preliminary Specific Behavioural Objectives (SBOs).**

The Situational “Market” Analysis (SMA) for the Communication Keys (CK), referred to as the SMACK or SMACKing exercise, is a critical step in acquiring an understanding of the desired behavioural result from the perspective of the “consumer.” It is only with this understanding that one can proceed to engage the consumer via various communication means in considering a recommended behaviour.

The term “market” is purposefully used here. It draws on the over 150 years of experience in market research and consumer communication. It locates the individual within their “market” environment (even in the poorest of communities) where they make “consumer” decisions ranging from whether to buy rice today or visit a health clinic to get a persistent cough checked out, or put less salt in their food, or engage in physical activity. The word “consumer” will be used hereon in reference to the individual to whom we are making a behavioural recommendation. The word “consumer” prompts us to see the individual as making a consumer decision when weighing the merits of the recommended behaviour.

SMACKing can be a delightfully frustrating experience. It will consume most of one’s time in COMBI planning. But when done well, subsequent Steps #4 and #5 become relatively easy as a communication strategy and action plan emerge out of the SMACKing.

One should recognise, however, that the SMACKing may lead to the conclusion that the “market situation” is so bleak that it would be pointless to embark on an effort to offer and recommend the particular healthy behaviour. This should lead to considering other behavioural options or approaches to controlling or preventing the particular disease.

The following notes will help in carrying out Step #3.

**Note 3.1 COMBI Mantra #2:**

**“Do nothing…. make no posters, no t-shirts, no pamphlets, no**

**videos…do nothing until one has carried out a Situational “Market” Analysis for Communication Keys (SMACK) in relation to preliminary specific behavioural objectives (SBOs).**

As with COMBI Mantra #1, Mantra #2 evolved out of the recognition that the SMACK is an essential early step in COMBI design way before contemplating the selection of messages and media and the production of IEC materials. While there is that constant push from others to get on with the production of materials, Mantra #2 guides one into resisting that urge until the SMACK is done.

TWEAKING COMBI Mantra #2:

Why the Situational Market Analysis (SMA)? It is done, in part, to discover the Communication Keys (CK) which would enable engaged communication with the “consumer” to facilitate consideration of the suggested behaviour. Hence the combination of SMA with CK leading to “SMACK”. MANTRA #2 becomes: Do nothing….make no posters, no T-shirts, no pamphlets, etc…until we ‘SMACK’ THE BEHAVIOUR around…

**To “SMACK” the proposed behavioural objective is to take the suggested behaviour to the “consumer”, smack it around as if in tennis between you and the consumer, and explore what are those facilitating/constraining factors with regard to the possible practice of the behaviour. The basic marketing principles here is: *Listen to the consumer*. There is an old marketing phrase which says: One can do nothing for the consumer until you have listened to the consumer. In the process, communication keys which may make a difference in considering and carrying out the behaviour will emerge.**

We will elaborate below what are some of the tools to be used in carrying out a SMACK-ing exercise. For example, part of an SMACK will prompt one to examine those reasons why people do not accept a recommended health behaviour or why they do. In many cases the reasons go beyond “awareness and knowledge” issues. It would be presumptuous for us to embark on producing an information leaflet without first eliciting from a SMACK what those factors are which facilitate the adoption of a health behaviour or constrains its adoption. Hence we urge the chanting of COMBI Mantra #2.

 **Note 3.2 Getting the data base for conducting the SMACK**

The SMACK is usually based on existing research data available from various surveys and studies done on a particular disease in a country. Sometimes these are not readily available. Often research studies are tucked away and rarely used in planning communication programmes. Local universities or research institutes may have completed studies but have not yet formally published the results. In the absence of such studies, one may need to commission specific research. But if time and or finances are constraints, one may have to resort to self-conducted research by walking around and chatting with community members and knowledgeable personnel in the health system, especially those at the field level.

Various research methods can be used to gather data. For NCD, there is the WHO STEPS studies. Demographic Health Surveys (DHS) and KAP (Knowledge-Attitudes-Practice) studies can also be good sources of information. In addition there are studies that can be carried out involving Focus Group research and in-depth interviews. Both may provide relevant qualitative insights to supplement findings from quantitative studies such as the WHO STEPS Surveys and the DHS.

Sometimes research by “walking around” and interviewing members of households or people in their work places or in schools or in the market squares can also be instructive.

**Note 3.3 Areas to explore in conducting the SMACK**

Listed below are the main areas to be explored in conducting the SMACK. One need not be limited to these. Each of them is further elaborated on in subsequent Notes and particular tools are offered in the process. Sometimes the tools seem repetitive; we have found that, though similar, different tools generate different factors to be considered.

* *Current situation* of the disease with respect to extent of health burden, knowledge levels, attitudes, perception of risk, current behaviours, behaviour trends. (See Note #3.5 below and reference to HIC-DARM)
* *Market segmentation:* what “beneficiary” groups are to be involved, what are the priority market segments. (See Note # 3.6 )
* *Context and Behavioural Influences:* what existing “forces” serve as constraints and/or supporting factors to the adoption of recommended health behaviours for the focus disease (from the perspective of the individual); what in the situation (from the perspective of the implementing agency)serve as “strengths, weaknesses, opportunities, and threats” which would influence the recommended behavioural response. (See Note #3.7, and 3.8)
* *Perceptions of the recommended behaviour in relation to marketing concepts of “****C****onsumer” need/want/desire,* ***C****ost to the consumer, and* ***C****onvenience to the consumer:* what consumer need/want/desire is being addressed and how is this perceived; what is the perception of the “costs” (money, time and effort) involved in carrying out the recommended behaviour in relation to the value promised if the behaviour is carried out; what is the perception of how convenient and accessible the recommended behaviour is to consumers. (See Note #3.9, 3.10)
* *Positioning --Existing and desired perceptions of behaviour:* how is the recommended behaviour perceived now (current “position” in consumer’s mind) and what would be the desired perception and, therefore, how should the behaviour be “re-positioned” in the consumer’s mind. (See Note #3.11 )
* *Competitors:* what alternative behaviours serve as competitors to the recommended behaviour; to what extent and why is inaction (“doing nothing”) or taking a chance (TAC) competing with the recommended behaviour. (See Note #3.12)
* *Communication situation:* what media/channels of communication are most popular and most influential; what traditional media are used; who would be credible sources of information; what media would provide useful triggers and prompts to action; what are the current patterns of social communication; what are the current methods for consumer communication, etc. (See Note #3.13)
* *Further research:* what aspects of the recommended behaviour and social communication warrant further research to facilitate better COMBI design. (See Note #3.14)
* *COMBI Pre-requisites:* what should be identified as pre-requisites (such as services and drugs being in place) prior to embarking on a COMBI programme. (See Note #3.15)

#### Note 3.4 Keep track of issues amenable and not amenable to

####  communication solutions as the SMACKing is carried out

While doing the SMACK, it is useful to keep track of those issues that are not amenable to communication solutions and those that are. Obviously, not every constraint to behaviour adoption is necessarily one that can be affected by “communication” action. For example, if clinic doors are shut at 4.00 P.M. sharp and most people in that area can only come after 4.00 P.M. for a blood pressure or diabetes check, this is a factor for which there is no “consumer communication” solution. However, senior health management should be alerted to this constraint with the added suggestion that a COMBI effort may be pointless unless this issue is resolved. The SMA can be helpful for both COMBI design and overall management of the disease programme.

For those factors that do seem amenable to communication intervention, note the communication implications for strategy and actions later on in Steps #4 (Strategy for achieving behavioural results), #5 (COMBI Plan of Action), #6 (Management), #7 (Monitoring) and #8 (Evaluation).

On the following page, a worksheet is offered which may help organise the gathered information. The items listed under the column for the SMACK will become more meaningful after first reading all of Step #3.

**Worksheet for Communication Implications of the SMA or SMACK-ING:**

**Listening to the Consumer**

|  |  |  |  |
| --- | --- | --- | --- |
| **SITUATIONAL****MARKET****ANALYSIS** | **Emerging issues NOT amenable to communication solutions** | **Emerging issues amenable to communication solutions** | **Communication implications**  |
| (1) Current situation : Current knowledge, behaviours, and behaviour trends. |  |  |  |
| (2) Market segmentation:Priority market segments  |  |  |  |
| (3) Force field /SWOT analysis: Forces/factors in field which constrain/support behaviour adoption |  |  |  |
| (4) Consumer need/desire/want being responded to with a solution – the recommended behaviour |  |  |  |
| (5) Cost in terms of pricing, effort, time, other ‘cost’ factors, and cost/value calculations |  |  |  |
| (6). Convenience in terms of accessibility, availability |  |  |  |
| (7) Perceptions and Positioning : How current perceptions position the offered behaviour in the consumer’s mind; how can it be re-positioned in relation to best desired perceptions. |  |  |  |
| (8) Competitors: alternative behaviours, Do-Nothing and Take-A-Chance |  |  |  |
| (9) Communication Situation |  |  |  |

**NOTE 3.5 : Conduct a *HIC-DARM* Analysis of current situation - knowledge levels, attitudes, current behaviours, behavioural trends**.

One cannot act on a suggested health behaviour if one is not aware of and knowledgeable about it, and if one is not engaged in a full and fair appraisal of its merits in relation to the cost and effort involved in putting it into practice. For effective COMBI planning, therefore, one needs to begin with a good sense of the current situation with regard to people’s knowledge and understanding of the recommended behaviour in the context of their awareness of the disease health burden, their attitudes to the recommended behaviour, their current behavioural response, and projections of future response. We call this a HIC-DARM Analysis.

**“HIC-DARM”** is a simple model for describing the process of adopting new or recommended behaviours. It is based on traditional behaviour adoption theory and consumer behavioural analysis.

First, we **H** ear about the new behaviour

then, we become **I**  nformed about it

and later **C**  onvinced that it is worthwhile.

--------------------------------------------------------------------------------

In time,

we make the **D** ecision to do something about our conviction

and later we take **A** ction on the new behaviour.

We await next **R** e-confirmation that our action was a good one. If all is well,

we **M** aintain the behaviour

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In this model, a line separates the HIC from the DARM, to illustrate a typical gap between informing-convincing someone (HIC) and prompting the next steps towards behavioural impact (DARM). Many health programmes manage to inform and convince (HIC), but often stall there, failing to prompt people to take the steps towards adopting and maintain new health behaviours (DARM). Relatively speaking, it is easy to inform, educate and convince individuals of what needs to be done. It is quite another challenge to prompt the leap into action and to sustain the action.

One reiterates here the earlier caution about being seduced by the education sensibility with the consequence that one is stuck on the HIC of the HICDARM process. COMBI, utilising with care the principles of Integrated Marketing Communication (IMC), facilitates the process through DARM (Decision, Action, Re-confirmation and Maintenance).

To do a HIC-DARM Analysis is to acquire and analyse the data and information (from existing or commissioned “market” research) which would enable one to view the market, the community, in relation to each dimension of HICDARM. For example, from the data available one determines how many people have *Heard* about the recommended behaviour and what they have heard; how many seemed more substantially *Informed* and what is it they know and/or do not know; how many seemed *Convinced* or not convinced of the merits of the recommended behaviour and what is the basis of this conviction or lack of; what proportion seem to have arrived at a point of making a Decision – what is the decision and how was it arrived at; how many have actually taken the steps to Act (or not to) on the behavioural recommendation; if they have acted, what triggered the action and what was the experience like; in the case of no action, what contributed to this inaction; to what extent were people satisfied with the experience of taking action and had the benefits and value of the recommended behaviour *Re-confirmed* ; what proportion of people are currently *Maintaining* the practice of the behaviour and what facilitates this maintenance.

Each dimension of HIC-DARM calls for an appropriate communication intervention. The HIC-DARM Analysis explores the current situation and prompts consideration of communication approaches to facilitate people’s tumble through HIC-DARM. In general, what one says for the HIC phase is usually quite different from what one needs to say for the DARM phase. Often we see the attempt to tackle the DARM phase with the same tired messages used with the HIC component.

If most people are through the HIC phase and have expressed an inclination to Act but have not yet done so, a HIC-DARM analysis allows for exploring why people are reluctant to act. This in turn provides the basis for engaging them in re-examining their reluctance together with offering a variety of triggers which may help them overcome their reluctance. A HIC-DARM analysis alerts us to the somewhat obvious: the message to an individual that creates awareness of a suggested behaviour (regardless of the medium used) has to be different from what would prompt a decision to act and still different from what would actually help trigger action.

The data for a HIC-DARM analysis is sometimes available in completed KAP (Knowledge-Attitudes-Practice) Surveys or in other similar studies such as Demographic Health Surveys (DHS), or WHO STEPS studies. Often there is much good research lying around but unused. Sometimes a local university department or faculty member has produced some unpublished studies of relevance. In the absence of completed studies, and provided there is adequate time, one may need to commission a specific research study (surveys or focus-group studies) in relation to a HIC-DARM analysis. Another source of good information is health staff at the field level whose direct community experience can provide very useful HIC-DARM insights. One would urge, in any case, a HIC-DARM exploration by “walking around”: stepping into community life and chatting directly with members of the community about the particular health issue and the recommended healthy behaviour, with HIC-DARM elements prompting the conversation. While conclusions from these informal sessions cannot be generalised to the larger population, they can provide fascinating HIC-DARM snapshots.

An important function of a HIC-DARM Analysis is to explore the bewildering gap between HIC and DARM: Why is it people know what to do, are persuaded that they should do it, but yet do not carry out the desired action. What are the constraining and facilitating factors affecting the journey through DARM? Of particular interest is probing the reasons why people do take action. Here we may find some communication keys to better engage the reluctant.

**Note 3.6: Conduct a Market Segmentation exercise**

The initial statement of a behavioural objective in a COMBI Plan (Step #2) demarcates the population to be engaged in considering the recommended behaviour. For example, if the SBO is to get “everyone” over the age of 6 to have a balanced diet, the reference to “everyone" with a cough lasting more than three weeks is the first level of defining the “market” for the behavioural recommendation. Clearly, one would not engage everyone in the “market” the same way. The rural farmer will have to be approached differently from the urban office worker; each very likely thinks and behaves differently about what they eat. And even among rural farmers, the young farmer may think and behave differently from the older farmers; women farmers will differ from male farmers. It is in this way that we begin to conceive of “market segments” to facilitate our strategic approach of how to engage different categories of people.

Market segmentation can be done in a variety of ways. There is demographic market segmentation: segmenting by age, income, gender, employment, place of residence (urban, semi-urban, rural), etc. There is also psycho-graphic segmentation: the resigned poor who seek only to meet their most basic needs; the struggling poor who seek to escape their poverty; the status-driven rich; the socially competitive middle-class; the oppressed and marginalised women; etc. Another type of psycho-graphic segmentation is with respect to where people are in the process of behaviour adoption: HIC-DARM. There is ethnographic segmentation, defining sub-groups by cultural traits. In the final analysis, each individual becomes a market segment. But without going to that extreme, it is helpful to think in terms of discrete categories or sub-groups of the market for communication planning. Treating people “all the same” rarely works.

We therefore should carry out a market segmentation exercise in which we demarcate sub-groups of our primary market group. We can use a demographic and/or psycho-graphic and/or ethnographic approach to this process. And with each sub-group and available sociological, anthropological, HIC-DARM type data about it, we need to reflect on the communication implications for engaging that sub-group. For example, if women culturally are not allowed to leave home with out a male escort to seek health care, this has implications for how one would engage women in considering a health behaviour which involves visiting a health centre or going out for a brisk walk.

The HIC-DARM Analysis of Note # 3.4 above itself provides a framework for priority market segmentation. The market can be segmented in relation to where people are within the HIC-DARM process. Perhaps one sub-group is the HIC group which now needs to be engaged differently if they were to proceed to the DARM phase. And even within the DARM sub-group, there might be a large sub-group about to Act but just waiting for the “right” prompt to trigger Action.

Even within the sub-group of those about to Act, there are those closer to the point of Action than others. COMBI uses a concept referred to as NOSA: Number of Steps Away, from action. For example, an individual may be about to enter the health centre’s doors to get a blood pressure check or a diabetes check but is constrained by not knowing how long he might have to wait for service. One would say this person is one step away from Action. Another individual may want to visit the health centre but her husband prohibits her from leaving the house plus she hears that there may not be a female health provider to see her plus she has no money for transportation to the clinic. From a NOSA perspective, we would say that this person is about six steps away from Action (each constraint being given a 2-step count arbitrarily) and more difficult to engage than the individual one step away.

Then there are those individuals who have never even heard of such a thing as checking one’s blood pressure. One can treat them as being 100 steps away from Action. There os no precision about calculating the number of steps away; it is more a psychological way of looking at individuals with regard to their taking action.

The implications of NOSA for a COMBI strategy rest with the consumer communication experience that one’s first priority is to deal with the potential customer who is just a few steps away from action and eager to step through that door. When that individual is treated well, he or she becomes your best sales person. Responding to the need of those who are almost at the point of Action is also to respond to the needs of those in other phases of HIC-DARM. Well-designed messages focusing on those who are one-step away from Action also serve the needs of those who would like their new behaviour Reinforced or Maintained, or those who are yet to be Convinced of the merits of a recommended behaviour. An advertisement for a BMW car is read by those who are thinking of buying a car and also those who have already bought a BMW. For the latter, the advertisement serves a reinforcing role.

Market segmentation allows one to set priority market segments. And while one would be tempted to tackle the entire market out of a social development conscience, it might be more prudent to tackle priority segments, establishing a network of satisfied clients who in turn “sell” the recommended behaviour to others.

Think Diffusion of Innovation. A new behaviour accepted by 2% Innovators who then help sell to another 14 % Early Adopters who then help sell to another 34% Early Majority who then help sell to a tougher market of 34% Late Majority who then help sell to the truly tough market of 16% Laggards, recognising that one would never be able to sell a behaviour to 100% of the market.

Another way of looking at priority market segmentation is the old prescription when knocking mangoes off a tree:: Go for the low hanging fruit. And even among the poor and marginalised one can find “low hanging fruit”.

 **Note 3.7: Conduct a “Force-Field” Analysis**

The Force Field Analysis poses the question: What are those ‘forces’ or factors in the field (society, community, environment) which would help achieve the desired behavioural objective or prevent its achievement? Understanding these constraints and/or supporting factors provide useful information about those themes that will form the basis for communication with the public. On the other hand, the analysis may suggest that the forces which will deter acceptance of the recommended behaviour are so formidable that it is pointless to embark on any kind of public communication effort.

Note 3.8: Conduct a “SWOT” (Strength, Weaknesses, Opportunities,

 **Threats) Analysis**

A COMBI Plan needs to be seen as an integral part of an overall disease control/prevention programme. Achieving the specific behavioural objective of the COMBI Plan is closely linked to the dynamics of the disease programme within the institution managing the disease programme, e.g. the Ministry of Health Carrying out a SWOT analysis of the disease programme environment and the “managing institution” will help us to focus on **Strengths**, minimize **Weaknesses**, and take the greatest possible advantage of **Opportunities** available whilst addressing the **Threats** to achieve the behavioural objective(s).

This may appear similar to a Force Field Analysis, but by the use of different terms new issues may emerge not previously discovered in the earlier analysis.

A SWOT Analysis can be done as a group exercise with a multidisciplinary disease programme team. At the end of a SWOT analysis ideally we should have two lists:

* an SW list describing the programme’s main strengths and weaknesses (internal factors), and
* an OT list describing the chief opportunities and threats (external forces).

As we prepare these lists, we need to note the implication of the various factors or forces for planning communication interventions to engage the public in considering the recommended behaviour.

**Note 3.9 : Examine the behavioural objective in relation to the Four C’s of Integrated Marketing Communication (IMC)**

Integrated Marketing Communication (IMC) offers a new conceptualisation of Marketing in the “Four ‘C’s”, one more appropriate to health-related behavioural outcomes than the more conventional marketing concept of the Four P’s. And an analysis of these Cs vis-à-vis the recommended behaviour provides useful insights in the HIC-DARM gap: why people know what to do but don’t carry out the recommended action. COMBI’s major contribution to our most fundamental health challenge, bridging the gap between knowing what to do and doing it, is the application of the 4Cs of IMC. It is in the 4Cs we find the critical communication keys for helping individuals through the HIC-DARM process.

The first ‘C’ is *‘Consumer Need/Want/Desire’* rather than the “P” of Product. The first C, C1, focuses immediately on the consumer and the consumer’s perception of need, want or desire, and how we can connect to that. One does not sell a product per se; one offers a solution to a consumer’s need or want or desire, which may be either at the top of his or her mind or hidden. Coca Cola is not selling sugared, carbonated, caffeinated, coloured water – it is selling an experience in response to consumers’ desires. A recent Coca Cola campaign theme is: “Open Happiness”. Coca Cola is selling Happiness.

One does not create these needs or wants or desires; one responds to existing needs or, at best, stimulates that which is latent. Note Maslow’s Hierachy of Needs as shared in the workshop. These needs already exist. Note the Young and Rubicam’s Consumer Cross- Cultural Characteristics categorising the market place in terms of different types of people and their existing goals, motivation and values, Health programmes respond to one such need and desire: good health. This need does not have to be created; it already exists. No one wants to get a stroke; no one wants their leg amputated because of diabetes. People want to look good and feel good.. People want self-esteem. In the SMACK we need to examine what “consumer need/want/desire” is being addressed by the recommended behaviour and explore how this is perceived by the individual. C1 often provides insight in to why we have the HIC-DARM gap: it is our failure to connect with the consumer with regard to the behaviour being offered and his or her need, want, or desire.

The second ‘C’, C2, as in *‘Cost’* (in contrast to the “P” of Price) focuses on a combination of monetary costs, opportunity costs and effort costs. One needs to examine the ‘Cost’ involved in carrying out the recommended behaviour in relation to the Value promised if the behaviour is carried out. We focus here on Value as perceived by the individual and not on “Benefits.” A behaviour may have benefits but those benefits do not rank as valuable to the person. They do not connect to the needs/wants/desires as in C1. It is here we encounter the central decision-making point for the consumer: if the cost-value ratio is unbalanced, in that the cost seems too high for the value promised, the consumer will reject the offer. One also recognises that this calculation of cost vs value is done with regard to both the recommended behaviour and alternative/competing behaviours.

In recommending a healthy behaviour, this is usually the heart of the engagement with people, facilitating their cost versus value calculation and listening to their concerns, fears and reservations. In the SMACKing, one needs to explore the Cost vs Value ratio for the recommended behaviour as perceived by the individual and their Cost vs Value calculation of competitors. A Competitor Analysis is useful at this point and this is further discussed below. For example, salt makes food tastier. When we recommend less salt, we need to recognise the competitor of more salt=tastier food. {lus in doing the costs vs value calculation, the woman cooking a meal for her husband will weigh the cost (hearing her husband complain about the lack of taste) in relation to the value (protection from a stroke) when a stroke is seen as very unlikely to happen to her vigorous and strong husband. This perception will need to be considered in planning how we will engage the public with regard to using less salt. C2 often explains why we have the HIC-DARM gap; we have failed to engage the individual in a better calculation of the Cost/Value relationship.

The third C, C3, as in *‘Convenience’*  (in contrast to “P” of Placement) goes beyond the physical placement and location of the product and raises questions about how convenient and accessible it is for the consumer to obtain the service or carry out the desired behaviour. Factors such as health centre location, opening hours, the availability of service providers, the cumbersome nature of the recommended behaviour, etc, are dimensions of the C3. In the SMACK one needs to explore the individual’s perception of the ease and conveneinece of carrying out the recommended behaviour. For example, is it conveneinet for a very busy woman to find the 30 minutes per day to do a vigorous walk?

Both C1 (Consumer need/want/desire) and C 3(Convenience) end up being part of C 2  the Cost-Value calculation. If the Cost (including the Convenience factor) is seen as too high in relation to promised Value (linked to Consumer need/want/desire), we will need to think of ways of either lowering the cost or engaging the individual in seeing the promised value as worthy of the high cost.

Perhaps the cost in terms of convenience is too high. A solution may lie in having the disease programme make it easier for the individual to carry out the behaviour; for example, if I can only come in for a blood pressure check after the close of business (say 5.00 P.M.) but the health center closes prompty at 5.00 P.M. While this is not a communication issue, the SMACK nevertheless brings this to the attention of the health system management.

See Note # 4.9 below which describes how Cost vs. Value calculations can be affected by branding a behaviour (and so increasing perception of Value) and offering an incentive (and so lowering the perception of Cost).

It is in the first three Cs that we find asnwers to the ever-present question: How come one knows the right thing to do, but fails to do it.

Finally, the fourth C, C4 , as in *‘Communication’* (in contrast to the “P” of Promotion) becomes Integrated, Engaged Communication, looking at a judicious mix of communication interventions (administrative mobilization, public relations, advocacy, community mobilization, advertising, personal ‘selling’/counselling/interpersonal communication, and point-of-service promotion,.). This is much more than just simply focusing on promotion of a product or service, and producing posters, T-shirts and pamphlets. It also recognises that there is no single magic communication bullet. Communication becomes the task of sharing with the consumer the information related to the other three Cs: *‘Here is a marvellous solution to the need you have at a wonderful cost vs. value ratio and so conveniently available.’* And it involves engaging the consumer in an examination of the cost vs. value ratio. This is quite different from simply promoting a brand. And it needs to be done in massive, repetitive, intensive and persistent (M-RIP) way. We will return to this fourth C in Steps # 4 and 5.

For the moment, however, as we examine the behavioural objective in relation to the C4, we need to clarify those aspects of the other three Cs, identifying communication keys, which become the basis for engaging the public.

**Note 3.10 Conduct a *DILO* (Day in the Life Of) and *MILO***

**(Moment in the Life Of) Analysis**

*A Day in the Life Of Analysis* (*DILO*) is used to explore the situation and daily context in which a recommended behaviour is being urged. A DILO Analysis calls for examining the daily activities of those we wish to engage in considering a health behaviour. Either by observation or by narratives from individuals, one lists their daily activities from the time they get up in the morning to the time they go to bed at night. The DILO analysis helps us to empathise with the “consumers”, to identify communication contact points, to locate the suggested behaviour within their daily lives and so understand better the factors which would support or constrain action on the healthy behaviour. In this way, one acquires another sense of how they perceive the “cost” involved in carrying out a recommended behaviour. For example, a DILO analysis in one community may reveal that most adults are out of the home for most of the day, working in the rice fields, even on weekends.

*Moment in the Life Of Analysis (MILO)* is a modification of DILO and captures features of that moment when one expects a certain behaviour to be carried out. Based on observation or role-playing, one examines what are the steps involved in carrying out the recommended behaviour. Take for example the recommended behaviour of not dipping food in salty sauces while eating in a restaurant in Vietname. A MILO exercise allows for more direct empathy with an individual who when eating at a restaurant in Hanoi automatically reaches for a different salty sauce for dipping the next bit of food he or she will eat and without that dipping eats with little taste. In exploring that moment, one tries to see the process from the individual’s point of view and notes how “burdensome” the recommended process is for “not dipping”. Once more, a sense of “cost” to the individual emerges. If through this process one can anticipate how people will react, one can better prepare them for the moment of action and facilitate acceptance of the suggested behaviour. In the case of dipping, one may wish to consider recommending not dipping everytime but every other time!

**Note 3.11 Do a Positioning/*TOMA* (Top-Of-the-Mind Analysis ) Exercise**

Top of the Mind Analysis (TOMA) allows one to explore peoples’ perceptions of and immediate associations with a particular issue. It involves the simple exercise of asking various individuals what is the first thing that comes to their mind when they hear a particular word or phrase (linked to the recommended behaviour), what is the second thing, and what is the third thing. In this way, after a round of this kind of questioning in a community, one acquires a sense of what is at the top of the mind of people with regard to a particular disease or behaviour. Insight to rumours and myths often emerge from a TOMA. TOMA also enables one to see whether a recommended behaviour is connecting to an existing C1 need/want/desire. For example, a Top of the Mind analysis of the word ‘Exercise”’ may show that people think it is too sweaty, burdensome, no value. If these are the immediate associations in a large community, they indicate the need for more substantial engagement of the community in looking at the recommended behaviour and its link to the disease we are trying prevent.

If we were to go back to Note 3.7 above on Force-Field Analysis and how it was used with regard to people’s perception, one would see how a TOMA can help one better understand people’s current perception, noting how a particular behaviour is mentally *positioned* in people’s minds. This analysis may suggest that we need to engage individuals in a process of *re-positioning* the behaviour mentally so that it is perceived more harmoniously linked to improving their health status. TOMA enables one to set out the factors which would guide this engagement with individuals for re-positioning of a disease or related behaviour. Another way of looking at TOMA is to see it as a way of checking people’s perception of the “behaviour brand”. This may lead to better branding of the behaviour.

 **Note 3.12 Do a Competitor analysis**

To do a “Competitor Analysis” is to ask what alternative behaviours are carried out rather than the behaviour being recommended. Often in health we see no competitors. We simple say that people reject the suggested behaviour and choose to do nothing. From a consumer communication perspective, this “Doing Nothing” is in fact a competitor. The individual chooses this and we are therefore obliged to explore why this choice. The answers provide another basis for engaging people in a fresh consideration of the health behaviour.

Another common competitor and another dimension of “Doing Nothing” is “take a chance” (TAC). People feel they are not at much risk and therefore choose to take a chance that they will not get diabetes, for example, rather than choose the recommended behaviour of exercise. It is helpful to examine why TAC has an appeal.

Sometimes there are other competitors in terms of alternative services or alternative behaviours. Instead of going to the clinic to have a blood pressure check, one would choose instead to stop at a friend’s house and have a drink of Kava. A Competitor Analysis helps identify those alternative behaviours or services which are preferred options to the recommended behaviour. The more we understand the appeal of these competitors, the better we are able to engage people in exploring the merits of the recommended behaviour.

Often a Competitor Analysis is done as part of the second C, C2 analysis above in relation to the consumer’s calculation of the cost vs value promised in carrying out a recommended behaviour. The calculation is always done with regard to what is being recommended and the alternative/competitor(s) in the field. One needs to explore with the consumer why the competitor is seen as a better choice, if that is the choice.

 **Note 3.13 Carry out a MS.CREFS (Communication**

 **Situation/Issues) Analysis**

MS. CREFS is an acronym which highlights the key components of the communication process. (Each letter of the acronym represents a different component of the communication act and is explained below). To carry out a MS.CREFS Analysis to examine the market from the perspective of these components, reflecting on implications for the COMBI Plan.

The communication process involves a **M**essage from a **S**ource being sent via a **C**hannel to a **R**eceiver with a certain **E**ffect intended with opportunities for **F**eedback, all taking place in a particular **S**etting. Being a process, these components are inter-linked. This is a very old and simple model to describe a very complex, mysterious process we call “Communicaton”. One recognises that no model is perfect but we must proceed with some idea of the process as we proceed to plan communication.

A **MS.CREFS Analysis** becomes the task of raising a variety of questions with regard to each component. The following is a list of some of these questions – it is not intended to be exhaustive but to be more suggestive:

**Message:** What are the current messages circulating about the particular disease and related behaviours? What messages would people want? What language should be used for messages? What messages would best position the recommended behaviour in their minds? What messages would serve as triggers to action? Would different messages be necessary for different audiences? Are there particular messages (from the private or public sector) which seem to have high re-call? What about these messages which led to their being imbedded in the community’s consciousness? Are there any persistent rumours? Can one anticipate any messages which may circulate and create an implementation crisis?

**Source:** Who are currently credible, trustworthy sources of information in the community**?** What makes them so?Are there particular popular individuals (sports personalities, actors, politicians) who would be seen as credible, trustworthy sources of information? Are there particular characteristics of a credible, trustworthy source which the community holds dear? For the particular behaviour being urged, who might be credible, trustworthy sources of information about the particular behaviour in the community? To what extent is the health staff credible, trustworthy sources of information? To what extent do their training and appearance (e.g. a uniform) enhance perceptions of credibility and expertise? To what extent are teachers and school children sources of information?

**Channel:** What are the existing channels of communication in the community? What communication channels have been used in past health communication campaigns? What channels have been used in political campaigns? Are there community meetings as part of the local governance structure? Is mass media readily available? How many have and listen to radio? Television? How many read newspapers? What are the popular radio and television channels or programmes? What are the most widely read newspapers? What traditional media are used for communication? What is the reach of social media in the community? Are “houses of prayer” potential channels of communication for health messages? Are there existing places where people congregate (formally or informally) and share information? What new inexpensive channels of communication can be introduced to the community? Are there skilled advertising agencies in the community adept at using the available channels of communication?

**Receiver:** Who are the various audiences/market segments to be engaged in communication about the specific behaviour? What do we know about them from a demographic or psycho-graphic or ethnographic point of view? What is their HICDARM status vis-à-vis the recommended behaviour?

**Effect:** What has been the impact/effect of other health communication efforts? What accounts for that impact/effect? What would be the intended effect of planned communication efforts with regard to the stated behavioural objective?

**Feedback:** What feedback mechanism exist in the community which would enable one to check whether messages are being heard and understand as intended? What feasible feedback system may need to be put in place for such a check if no system now exists?

**Setting:** For the various possible communication interventions envisaged, in what settings will these take place? At people’s doorsteps? In their living rooms? In health centres? Under trees? In facilities with or without electricity? In the village chief’s yard? In a school hall? On the roadway? How would these settings affect the design of the communication intervention? Do particular settings suggest particular convenient time periods for communication action?

This MS.CREFS exploration provides the basis for detailed communication actions to be presented in subsequent Steps.

**Note 3.14 Point to Further Research Needed**

As the SMA is conducted, there will be questions raised for which there are no readily available answers. This would suggest areas for further research. These areas should be identified and, if feasible within the time frame for developing the COMBI Plan, arrangements should be made to have such research conducted.

**Note 3.15 Set out COMBI Plan Pre-requisites**

As the SMACK is conducted, issues and themes may emerge which are not amenable to communication interventions. For example, there may be a variety of service related issues such as opening times of clinics, or treatment drugs not being available at clinics, etc. Since it would be wasteful to embark on a COMBI effort unless the services related to the recommended behaviour are in place, it is important to indicate what might be the disease programme pre-requisites for a COMBI Plan, such as ready availability of trained health staff and treatment drugs at service sites. These pre-requisites should be presented to the disease programme manager with the notation that the COMBI effort should be undertaken only after the service issues have been resolved.

**STEP #4**

**4. Develop the COMBI strategy for achieving stated behavioural objective(s)**

The overall COMBI strategy points to the broad approach that the COMBI programme will take to achieve its behavioural objectives. It is made up of a judicious, integrated, synchronised blend of specific communication activities directed towards the expected behavioural results. The COMBI strategy should include key messages, their sequencing, the overall tone for the strategy, the blend of communication actions (administrative mobilisation/public advocacy/public relations, community mobilisation, advertising, personal selling/inter-personal communication, point-of-service promotion), the relationships between these different communication actions, and an overview of how the plan will be managed and evaluated. The following notes are intended to help guide one through this Step. The notes would also apply as well to the more detailed specification of communication actions in Step #5.

## Note 4.1 Re-state the behavioural objectives(s)

In light of Step #3 (SMACK), it is useful at this point to re-visit the behavioural objective(s) stated in Step #2 and refine those objectives, if need be. One may now have better “market” information and insight which can help in re-stating the behavioural objective(s) with greater precision and specificity.

**NOTE 4.2: Set out “Communication Keys /Objectives/ Intended communication effects” to be achieved in order to contribute to achieving the behavioural objectives.**

In operational terms, COMBI is to a large extent about (but not limited to) carrying out a variety of communication actions which would contribute to achieving specific behavioural outcomes. And the way this contribution is made is by “engaged communication” with “consumers” about those facilitating factors and constraints emerging from the SMACK (Step #3) which can be addressed by communication interventions. The SMACK may have indicated that a constraining factor has to do with the inconvenience caused by the opening and closing hours of a health centre. This is not a matter amenable to a communication intervention. However, if the SMACK indicated that a constraining factor was that people do not know the connection between too much salt in their food and stroke, then we have a Communication Key here which is that people need to have a better garsp of the kink between salt and stroke. Communication Keys can be set out as a brief statement of why would an invidual carry out the recommened behaviour, based on insights from the SMACKIng. Note the handout distributed in the workshop showing an example of presenting the Communication Keys

**NOTE 4.3: Anticipate the Three Pains of Communication as one develops the strategy: Selective Attention, Selective Perception, Selective Retention.**

While developing the COMBI strategy as well as the COMBI Plan of Action, we need to anticipate obstacles to effective communication. There are three key phenomena in the communication experience which impinge on communication effectiveness. They are very common with the use of mass media but also quite prevalent in interpersonal communication. The three phenomena are:

* Selective Attention
* Selective Perception
* Selective Retention

**Selective Attention:** In any communication interaction, it is not possible to be totally attentive all the time. We will naturally drift, and our minds will wander. Usually we are fully attentive for about 40 seconds or so, and then we are off, thinking about any number of other things. After some seconds of this drifting, we return to the message/messenger at hand, are fully attentive for a while, and then once more drift off. This tuning-in/tuning-out continues for the duration of a communication action.

This phenomenon happens in both face-to-face interactions and also while exposed to the mass media. While it is not possible to totally eliminate the tendency to tune-out, we need to work towards limiting the frequency of tuning-out by means of various attention-maintenance devices. As people drift in and out, constant varied repetition of key themes becomes important so that those who did not get them earlier may get them later.

Paying Attention

Paying

attention

Paying attention

Attention Wanders

Attention Wanders

With the mass media, one is subject to the brutal assault of selective attention. The reading of a newspaper illustrates well how some stories capture attention and others do not, by the nature of the headline and the lead paragraph. The preparation of materials for the press should therefore be guided by the need for attractive headlines and engaging lead paragraphs. The production of radio and television programmes should also be informed by this tendency of people to drift. There is an old tradition in radio and television advertising that one needs to grab a person’s attention within the first seven seconds of an advertisement; if not, one loses the person for the rest of the advertisement.

Selective attention with regard to electronic mass media can also be as basic as choosing to listen to a competing programme. A Ministry of Health routine 15-minute health programme may be tuned out in preference for a programme of popular music on another radio channel, unless that 15-minute health programme is presented in such a way that the listener feels compelled to tune-in. Of course, if there is no competing programme, the radio may very well remain on during the 15-minute broadcast but it may be treated as background noise with no active listening to it, unless it so produced that it fully engages the listener.

There is also a psychological dimension to selective attention. A message which confirms what one already believes is usually attended to more earnestly than a message which disturbs one’s existing values and beliefs. A cigarette smoker is more likely to tune out a message which says that smoking will kill you. One’s communication strategy will need to find a way to overcome this tendency if what is to be presented will in fact be troubling to the individual. People, naturally, will tune in to what they want to

hear. If they are already interested in obesity by having experienced the codnition or knowing someone who has, they may be more receptive to continue listening to a radio programme on the issue. People, who do not see it as a problem, however, will tend to ignore a long narrative on the subject on radio or television, unless their attention is caught immediately and they very quickly understand why they are at risk.

**Selective Perception/Interpretation:**This refers to the natural tendency of people to perceive or interpret symbols and messages from their own perspectives, influenced by culture, tradition, language, social mores, educational level, etc. It is a miracle that effective communication takes place at all, given this phenomenon of selective perception, with people very likely to interpret words and signals in ways different than originally intended by the source of the communication. Communication strategies, therefore, need to be extremely mindful of the hazards created by this phenomenon. Every effort must be made to ensure that what is intended in a communication is what is perceived. Keeping messages simple and free of jargon is one way to overcome selective perception problems. We all know of poster designs and messages being interpreted in totally different ways by different people. Hence the need for careful pre-testing of messages and designs to ensure, to the extent possible, that these will be grasped as intended throughout a community.

People often interpret new information in relation to existing beliefs and attitudes, often interpreting new information in a way that existing beliefs remain intact. The more we know about those beliefs and attitudes the better we are able to plan communication actions which take those into consideration as we try to overcome the hurdles created by selective perception.

**Selective Retention:** This refers to yet another natural phenomenon in communication: our tendency to simply forget. As a consequence, an effective communication strategy will attempt to ensure constant repetition of messages as a way to overcome this tendency. A radio public service announcement broadcast once a day is definitely more likely to be forgotten than one broadcast eight times per day.

Selective retention may also occur at a sub-conscious level. Each person remembers events that mean something to them; selective retention is often about forgetting those things that one wants to forget, such as unpleasant memories or points of views that do not coincide with one’s own.

Information overload also works towards much forgetting, such as with a presentation with too much information. A common advice in making presentations is that one should stick to three main points since we are unlikely to remember more than three major points following a presentation. And here too the repetition of the three major points counters the tendency to forget.

**NOTE 4.4: Think M-RIP (Massive, Repetitive, Persistent, Intense) as the Strategy is designed**

Communication programmes of minimal intensity is like spitting in the wind, or throwing a mosquito at an elephant. To produce one 60-second radio spot announcement and use it just a few times before the national news programme will have near zero impact. Communication interventions and actions need to be carried out in a **M**assive, **R**epetitive, **I**ntense and **P**ersistent fashion**.** Among many marketing communication specialists, there is the view that when one uses a particular medium, one should dominate the medium. If radio spots are to be used, then don’t use only one spot per day; plan on using 6-10 spots per day.

M-RIP communication is an effective approach to dealing with the tribulations of selective, attention/perception/retention. But one should be forewarned: M-RIP programmes cannot be done on the cheap. While the private sector knows this well and plan and budget accordingly, we in the public sector have yet to grasp this fully as we work towards extensive behavioural impact in health.

M-RIP communication programmes usually provoke the reaction “Can’t we just restrict ourselves to a few key interventions?” The following is an instructive response: The Chief Executive Officer of a major consumer product company in the United States, in response to a similar query from some business students, remarked that 50% of what his company does in consumer communication is probably a waste of time but that it is hard to tell which 50% is the waste. And instead of spending vast amounts to find out which 50% is the waste, he would rather use that money in more of the same, as long as the consumer behavioural result keeps on happening. M-RIP communication plans may appear excessive at first but for behavioural impact, they are required.

There is one other aspect of M-RIP communication worth noting: Consumer communication experience suggests that a consumer needs to be “hit” visually and aurally about six times per day, several days per week, over a three week period or so, in a variety of communication moments, in order for a behavioural theme to register sufficiently to prompt behavioural leaps.

## NOTE 4.5: Outline the blend of integrated communication interventions in relation to the last “C” of the four C’s of Integrated Marketing Communication (IMC)

The last “C” of the four C’s of IMC (See Note #3.9) refers to a judicious blend of integrated communication interventions, focusing on the behavioural objective and the engagement theme: “We have a wonderful solution in response to your need/want/desire, and we have it at a great cost vs. value relationship and we have it conveniently available.” In setting out the COMBI Strategy in this Step #4, we need to present a description of the integrated communication actions which will engage people in actively considering the recommended behaviour. These communication actions have been grouped under five major categories presented a Five-Point Star Blend of Communication Actions handed out at the Workshop and presented on the next page.

*(a) Administrative Mobilisation/ Public Relations/ Advocacy for Behavioural Impact (ABI)/Business Partnerhsip:* Here we put the recommended healthy behaviour on the public and administrative/programme management agenda using various communication channeles: news coverage, talk shows, soap operas, celebrity spokespersons, discussion programmes; meetings/discussions with various categories of government and community leadership, service providers, administrators; official memoranda; partnership meetings; press conferences and press briefings; social media. Past experience confirms that the public needs to have a sense of the urgency of a health issue and a sense of being at risk in order for a recommended healthy behaviour to be full considered. And we know that if we do not have the full and enthusiastic support of health management and administrative staff for a particular health campaign we are unlikely to have health staff respond appropriately to those seeking the means to carry out a particular healthy behaviour. One should also consider the formation of a Business Partnership with a few key private sector companies such as mobile phone companies, banks, airlines, supermarkets. This Partnership can support various components of the communication plan.

*(b)Community Mobilisation*: Here we engage community institutions, community governance structures, and community leadership in examining the recommended behaviour and in arousing community involvement in presenting the behaviour to families and individuals. The communication actions include participatory research, community group meetings, partnership meetings, traditional media, social media, music, song and dance, road shows, faith-based events, community drama, community sound trucks or other mobile sound systems, leaflets, posters, wall paintings, pamphlets, videos, home visits, promotional bicycle riders visiting villages, etc. We know from past experience that keen community involvement advances the adoption of health behaviours.

*(c) Advertising, (Promotion, Branding and Incentives)*: Here we use the techniques of advertising via radio, television, newspapers, social media, and other available media (such as posters, banners, flags/danglers), engaging people in reviewing the merits of the recommended behaviour vis-à-vis “cost” of carrying it out. The private sector has shown us the special and powerful contribution of advertising (done in M-RIP fashion) in prompting behavioural responses. (Specials concerns in using advertising are addressed in Step #5). In addition, one may suggest various modest incentives and ways in which to brand the behaviour and promote it for

behavioural consideration. The Business Partnerhsip mentioned above could also be helpful in supporting an advertising campaign by donating advertising time and space, with modest credit being given to the sponsors.

##

**The Five Integrated Communication Actions**

1. Administrative Mobilization/

 Public Relations/Advocacy for Behavioral Impact (ABI) + Business Partnership

5. Point-of-service-promotion

4. Personal selling/

 Interpersonal

 Communication

3. Advertising

2. Community Mobilization

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*(d)Personal Selling/Interpersonal Communication/Counselling:* Here we involve community volunteers, community health workers, school children (see Step #5 for ideas on involving school children), social development field staff, at the community level, in homes and particularly a health care service points, in engaging others with appropriate informational literature and additional incentives, and allowing for careful listening to people’s concerns and addressing them. “Personal selling” for decades has been the most powerful consumer communication approach for some of the most successful consumer companies in the world: e.g. Amway, Fuller Brush, Avon, HerbaLife. And in health communication it has been long documented that interpersonal communication holds a similar powerful role in engaging people in taking action on health issues. With some recommended health behaviours, we expect people to come to a health booth or a health centre. We have found that , when appropriate, the personal delivery of the “health behaviour” to one’s door substantially enhances behavioural response rates. It is crucial that these door-to-door “personal sellers” be properly trained for their tasks (especially the communication dimension) and are appropriately dressed to enhance perceptions of credibility and expertise. Often we call our “personal sellers” Health Volunteers or Community Health Aides/Workers. One may wish to consider branding our personal sellers differently to enhance their perception of their role. In some countries, we have used the following branding terms: Better Health Ambassadors, Lifestyle Ambassadors. Our personal seelrs will need to be quicky trained and for most recommended behaviours, this training can be done in a day, with half of the session focusing on technical details and communication keys linked to the first three Cs of IMC, snd the other half on role-playing a communication session in someone’s home. We must also plan ways to motivate our personal sellers without necessarily paying them Having a few Thank You events in the year with gifts donated by the Business Partnership.

*(e)Point-of- Service Promotion:* Here we promote via visible promotional signs and symbols at service points the easy availability and accessibility of the means for carrying out a recommended healthy behaviour. One recognises that in the public sector health centres are rarely promoted as points of service for particular kinds of health care. In many countries, it is far easier to find signs promoting the availability of Coca Cola than it is to find a sign pointing to a health centre. In the same way that people need reminders for the fairly obvious (where to buy Coca Cola), people need reminders of where the health centres are and what services are provided. Another kind of Point-of-Service Promotion is the putting of psoters at places where people go for services: hair salons, supermarkets, the market place, the local butcher, the community centre, banks, etc. And when “postering” is done, do remember to put up multiple posters, the same poster perhaps 3-5 placements in the same general spot, as politicians do in their political campaigns. One lonely poster will be selectively tuned out.

The above presentation of “communication” strategy provides a brief description of what is proposed for each communication action area. It should be in just enough detail that if a busy Ministry official has time to only read this section, he/she would have a sufficient sense of what is intended. These activities will be repated in much mor operational detail in Step #5 below.

The following needs emphasis: One strives for a strategic blend of communication actions rather than emphasising a particular type of communication action. No single communication activity or material (e.g. a poster, or a wall painting, or a radio soap-opera) will deliver the desired behaviour impact. A COMBI strategy requires that judicious blend of different but integrated, synchronised actions appropriate to the behavioural objective being sought.

**NOTE 4.6: Use what exists in terms of communication systems and approaches but yet strive for alternative, creative interventions**

In Note #3.13 of the SMACK we explored what communication means and systems exist in the community. In developing the communication strategy, we should return to these findings and format. If drummers are used as communication agents in a village, then let us find ways to use this medium. If mobile sound systems on bicycle rickshaws are still used, then one would urge their continued use.

Strategically put to use whatever communication systems are in operation. This should be our first priority rather than attempting to develop or initiate new communication methods. If there is a popular radio drama, then one should explore how to get behavioural themes into a script or two. One would not suggest investing in producing an entirely new soap opera. If there is no tradition of radio soap operas, it is perhaps best not to bother with the challenge of trying to introduce that expensive.

While we suggest using what exists, this should not deter us from considering new, creative communication means, provided that they are operationally feasible. In Malaysia, for example, the idea emerged of using a volunteer group of bicycle riders, dressed in colourful T-shirts with a dengue behavioural theme, riding every Sunday from one community to the next, reminding people to do their Sunday 30-minute Household Check for mosquito breeding sites. This had not been done before but it was operationally feasible and worked well.

**Note 4.7: Reflect on “MS. CREFS” again**

In Step # 3 (See Note #3.13) we carried out a MS.CREFS Analysis of the market environment, with MS.CREFS representing the various components of a communication act. We should return to this analysis and extract from it ideas which might be usefully applied in the articulating the communication strategy. In this way, MS.CREFS allows one to think through the different components of communication as the strategy is designed. Each element prompts new consideration. For example, S=Source, prompts one to think through who could potentially be a credible, expert, trustworthy, empathetic “Source” of a radio communication exercise for engaged communication with listeners: A specialist physician? Male? Female? A nurse? A former patient? A political leader? A popular actor or singer? Who are our KOLs, Key Opinion Leaders, who can be used as potential Sources in our communication efforts? Who can be our “personal sellers”? The C=Channel triggers consideration of what communication media are available and may be useful in the strategy. For example, is television viewed by enough people or by an appropriate group of opinion-leaders (KOLs) to warrant extensive use? Are mobile community sound systems still used to deliver messages in the community? Is the use of social media warranted? The M=Message directs one to ask questions about the content of the messages and their structure and language for the intended E=Effect. In Message design, some questions to ask: Is there a behavioural hook or are we just doing the HIC stuff? Are we using Fear as an appeal? (Fear appeals are usually not effective). Are we appealing to both the Head and the Heart, the technical aspects and emotional aspects of the recommended behaviour? One can examine in this way each aspect of MS.CREFS in setting out the communication strategy.

**NOTE 4.8: Strive for Integrated Engaged Communication and “Vicarious interaction and Participation”**

The foundation for having people adopt healthy behaviours is knowledge, but what is central for attaining a behavioural impact is the *application* of knowledge. Applying knowledge calls for engaged communication.

The heart of the exercise of engaging people in exploring a suggested behaviour for possible adoption is listening to them. At the heart of engaged communication is listening to people about their concerns, fears, anxieties, values, perceptions and preferences, and letting our emerging understanding of their concerns inform our communication and interaction with them. If people have no voice in this exploration of new behaviours and, perhaps, re-shaping them, if there is no mechanism for a two-way information flow, if there is no opportunity for listening to community voices, there can be no engaged consideration of suggested healthy behaviours. Failure to listen to people often lead to public rejection of recommended behaviour. When we do listen to the people, however, we can respond with appropriate communication or modifications, and with that comes readier acceptance of recommended behaviours.

COMBI strives for engaged communication, in getting a “consumer” involved in considering a recommended behaviour. It would be important in elaborating the communication strategy that we ensure that the communication methods used allow for this engaged communication. This would mean, for example, special communication training of “personal sellers” or those involved in interpersonal communication focusing on the component of listening to people and responding to their concerns. Even in the use of advertising, the approach used in engaging the individual is a matter of strategic thinking. A 60-second radio spot can be structured so that it has the feel of conversation with the listener rather than beating the listener over the head, or resorting to the gimmickry of supposedly creative productions.

In radio and television, for example, one of the more popular and inexpensive formats for engaged communication is the talk show or call-in show. These prompt “vicarious interaction and participation.” The listener/viewer feels he or she is involved in the conversation or telephone call even though he or she may not have made the call. This imagined involvement facilitates “engagement” and reflection on the recommended behaviour. A question-and-answer column in the local newspaper is another way to foster a sense of engagement. It would be useful to explore the use of these media formats in formulating the communication strategy.

 **NOTE 4.9: Consider use of Incentives and Branding with a logo**

In Step #3 above (See Note 3.9) we looked at a concept in Integrated Marketing Communication called the “Cost vs. Value” calculation of the consumer with respect to a recommended behaviour. Two ways of affecting this calculation in the communication strategy is by the use of incentives and by branding the behaviour or a product related to the behaviour. For example, in encouraging people to come to a village booth to get their blood pressure checked, one could offer the chance of winning a lottery with a modest prize (say, a mobile phone) to all who come to the booth. This incentive lowers the perceived “cost” involved in getting to the booth. In a similar way, if the recommended behaviour can be “branded”, given a name and tag line associated with associated with “value”, and a logo which immediately provokes these linkages, and which is then vigorously promoted, this increases the perceived value of what is offered in the recommended behaviour.

**STEP #5**

1. **Present the COMBI Plan of Action**

The COMBI Plan of Action is the primary instrument for managing the implementation of the COMBI Programme. It should clearly and comprehensively spell out the detailed activities which will need to be undertaken to operationalise the communication strategy outlined in Step #4 above. The Plan of Action should include all the preparatory activities as well as what precisely will happen as the strategy is implemented under the various categories of action set out in the communication strategy.

For reference, an example of a COMBI Plan has been distributed at the workshop. Please review that to see how Step #5 is laid out.

**NOTE 5.1: Set out the specific activities under the five general areas of communication interventions (and add other areas if needed)**

We need here to set out a detailed specification of the communication actions outlined in the “Strategy” step above, including descriptions and plans for production, procurement, pricing and distribution of any communication materials, products, services, incentives (e.g., T-shirts, prizes), as well as identifying what staff and/or partner agency training and supervision activities are required (for whom, what, when, where, why, facilitated by whom).

For example, the plan should specify how many of a particular communication material (such as radio spots, posters) one would need, who will produce them, and how they will be distributed. If, for example, training of field staff, volunteers, drama groups, and school teachers is required, then the Plan of Action should specify when and where these groups will be trained, by whom and how. If the strategy requires close collaboration with the media and press, then the Plan of Action should detail how these groups will be contracted or briefed (e.g., how often and where news conferences will occur).

These details should be provided in relation to the five elements of COMBI communication categories referred to in Step #4, but one should not be restricted to them :

* *Administrative Mobilisation, Public Relations, Advocacy for Behavioural Impact (ABI), Business Partnership*
* *Community Mobilization, including the involvement of community organizations, NGOs, faith-based organisations, and the private sector*
* *Advertising, Promotion & Incentives*
* *Personal Selling, Interpersonal Communication & Counselling*
* *Point-of-Service Promotion*

**NOTE 5.2: Once more, return to MS.CREFS for further insights in what would enhance communication effectiveness**

As we detail the communication actions, we should be mindful of any MS.CREFS insights which would enhance the effectiveness of the communication actions. *(See Note #4.7 above).* Here are a few selected MS.CREFS themes which should guide the shape of some communication actions:

 S-Source

* *Community-based staff and volunteers as Personal Sellers*: Community health volunteers, village health workers, public health inspectors, and the many others we may use as our “personal sellers” conducting door to-door visits need to be perceived as credible, trustworthy and expert. The training of these individuals should receive attention in the plan. Such training should avoid the extensive multi-day sessions usually scheduled which attempts to impart every possible detail about a particular disease and its prevention. One instead would suggest limited one-day training, half of which should focus on technical content and the other half on communication skills involving extensive role-paying. This training will enhance perceptions of expertise. It is also important to dress our personal sellers in ways which make them stand out and which portray a credible image. An identity badge, for example, together with a cap and/or health behaviour branded T-shirt or other special clothing, and a unique bag all add to the perception of credibility and expertness. Finally, one should plan on thanking our personal sellers and showing appreciation for their input, perhaps via a ceremony at which they hear words of appreciation, receive a Certificate of Appreciation signed by, say, the Minister of Health, are given a token gift perhaps, and some light refreshments. Contented workers are seen as more trustworthy if they display pleasure and satisfaction in their work.
* *School children as Personal Sellers*: School children can be powerful sources (and channels) of information in their families. Ministries of Education, however, are overwhelmed with requests from the health sector to include so many health themes in the school system and to alter their curriculum to accommodate these requests. We have found that requesting the Ministry of Education to allow a short half-hour exercise once per term or once per year seems more reasonable. In several countries we have provided the Ministry of Education with a single page, two-sided Worksheet on a particular recommended behaviour to be distributed to every child age 9-14 in the entire school system. The teacher in each classroom reads out the content of the page and helps the students complete a quiz on the back side. The children are asked to take the sheet home, read it to their families or have someone read it aloud, have family members try the quiz, and have a parent sign a cut-off slip at the bottom of the page which is returned to the teacher. On the day the students walk out of the school with the Worksheet, they are also given something to carry such as a paper pinwheel or paper sun-shade with the health behaviour logo and behavioural theme. The children form a natural rally at the end of the school day as they leave for home with these items; in this way they become more informed about the recommended behaviour and they create a community stir with the pinwheel and sun-shade.

 C- Channel

* *Using mass media channels* *with limited reach* such as newspapers and television: In some countries, the low literacy levels would tempt one to not use the print media. One should note, however, that those few who read the newspapers are key opinion-leaders in the community and can have tremendous personal impact on others through the multi-step flow of communication which media prompts anyway. The lone reader of the newspaper at a teashop passes along newspaper stories to many others who in turn pass them along to others. There is, therefore, still merit in using the print media, or even television, despite limited reach.
* *Working with mass media institutions and journalists:* Press briefings, press conferences, and special meetings with editors are the usual means of engaging press attention to a news story. One is less inclined to spend extensive time and funds on multi-day workshops for journalist; they are often switched from one news beat to the other and the post-workshop coverage tends to be temporary and spotty. One should be mindful of the quality of press releases and feature stories provided to the media. Too many government press releases read like official announcements rather than news stories written as if done by a professional journalist, with an engaging suggested headline and lead. In detailing the use of media in the COMBI Plan, one should offer some guidelines on the preparation of press materials.
* *Social Media:* Social media is emerging as powerful media in developing countries, especially in urban settings. One should call in local experts in this field in each market setting to determine how best to use social media. In some countries where social media is very present, one notes that when social media deals with “serious issues such as health, people ten to tune out these messages. Nevertheless, social media and use of mobile phone technology needs to be seriously considered and planned for.
* *Pamphlets vs. Fact Sheets/Worksheets…in full colour? ...and for the illiterate?:* Pamphlets have been the traditional channel of disseminating health information. Considerable funds are often spent on limited quantities of elegant full-colour, neatly folded productions. But one notices a certain level of selective inattention to pamphlets since they have become such the expected thing to receive. A single-page fact sheet or worksheet, produced in massive bulk, done in a smartly designed two-colour production and unfolded, has the potential for far greater readership. Often one is asked rather rhetorically whether it is useful to produce and distribute fact sheets in a context of high illiteracy. Our advice is that even for the illiterate the exercise is useful . There is something of tremendous symbolic value when one hands over a fact sheet to an illiterate person after one has gone over the content orally with the person. The individual usually finds someone else to read the sheet if necessary.

**NOTE 5.3: Remember the Three Pains of Communication**

We should also be mindful of the Three Pains of Communication (Selective Attention, Selective Perception, Selective Retention) and strategies to overcome them*.(See Note #4.3 above)*

**NOTE 5.4: Remember the seven-second rule in electronic advertising but best to avoid “sound-and-dance” gimmickry**

As we develop details of the advertising component, it is useful to recall the advertising tip that it is crucial to grab people’s attention within the first seven seconds of radio-television spots. Usually, if we fail at this, audiences tune out. This yet one more dimension of the Selective Attention phenomenon. A version of this applies equally to print advertising.

Producers of radio-television advertising are usually inclined towards fanciful gimmicks and sound-and-dance flair as a way to grab attention. But for most health behaviours this approach is often inappropriate. One would suggest instead an approach which fosters a sense of engaged communication, a style of simple, direct communication with a listener or viewer, done with earnestness. Remember, for example, that radio may reach thousands but when you are on radio to are speaking with just one person, that single individual listening to you. Engage them; don’t shout at them.

**NOTE 5.5:The Rule of the Magic Triad**

Usually after a presentation, we can remember just three key points, yet another dimension of the phenomenon of “Selective Retention”. This should inform the details we offer in specifying the various communication activities. In our advertising, for example, and other presentations, we should stick to three key points, if not just one. We should also repeat the behavioural theme at least three times in a particular communication act, such as a 60 second radio spot.

**NOTE 5.6: Think in terms of Advertising Flights**

One would not broadcast a 60-sec radio or television spot every day all year long, or just three times per week just before the news. We should think in terms of advertising flights. For example, a 3-week flight, with radio spots 6-8 times per day, five days per week; television spots 2-3 times per evening five days per week in the same flight period; and full-page newspaper advertisements about 3 times per week during the same three week flight. Use of social and other media can also be incorporated in the flight. Then we pause, say for about another 3-6 weeks. Then we return with another flight of say another three weeks. This approach of advertising flights should guide the detailed advertising plan in Step #5.

**NOTE 5.7: Use an Advertising Agency, if appropriate, but manage the agency diligently**

In countries where advertising agencies function well, we should use these agencies. Our detailed plan of action should include a process of briefing several agencies if they are to be used, meeting with them, and having them present a strategy or respond to the COMBI Plan. We should then pick one based on a blend of criteria (creativity but not an excess of this, cost, willingness to secure private sector sponsorship, willingness to argue over strategy). One should be prepared to manage the input of an agency with care and sensitivity. One should be able to argue with them from a marketing communication perspective, using their language. The presentation of the detailed communication actions should reflect these considerations by providing explicit guidance to an agency. The agency may argue about the suggested creative approach, for example, but we need to be able to engage the agency in a robust discussion about the merits of a suggested approach.

An agency may wish to resort to its creative charms and gimmickry but we may need to insist on earnest, direct, intimate communication. An agency may stress the need to focus on a USP (Unique Selling Proposition) or a SOCO (Single Overriding Communication Objective); but we may need to persist in our view that a recommended behaviour may need to be promoted as having several “selling propositions” and that to achieve the behavioural objective we need to pursue several communication objectives.

An agency may also be able to tap into the supportive help of the Business Partnership mentioned earlier.

1. **Management**

A description of how the COMBI Plan will be managed needs to be provided. Obviously, a well-designed plan not effectively executed is rather pointless in terms of achieving behavioural impact. In this Step a management structure is presented for assuring effective implementation, specifying the multidisciplinary implementation team, including specific staff or collaborating agencies (e.g., local advertising firms, research institutions) designated to coordinate communication actions. We should also include any technical advisory groups or government bodies from which the management team receives technical support or to whom the management team should report.

NOTE 6.1: Designate a single person as COMBI Programme Manager

There needs to be a single person assigned the role of COMBI Programme Manager who will be fully responsible for COMBI implementation, though with the advice and monitoring input of an Implementation Group (described below). Without one person being made specifically responsible, implementation tends to become chaotic.

NOTE 6.2: Designate an Implementation Group to facilitate management and deal with crises.

An Implementation Group (IG) of 3-7 individuals, who will be meet every week with the designated manager and review implementation details, should be specified. The IG provides support to the manager and also facilitates the resolution of any implementation difficulties which may arise. See the COMBI Plan distributed in the workshop for details on setting up an IG.

**NOTE 6.3: Consider the formation of an Advisory Group .**

In addition to the Implementation Group, it might be useful to have a broader advisory group which would meet every month or so to review progress. This advisory group could include various partners from the NGO and private business sector, and other collaborating sectors. This Advisory Group allows for broader input in the implementation process and also advice and assistance on overcoming implementation hurdles.

1. **Monitoring**

A COMBI Plan will comprise a mix of a very broad range of communication activities. One aspect of effective execution of the Plan is that of monitoring implementation progress. It will be through the process of progress monitoring that one will be able to note implementation difficulties and resolve them. But in addition, effective monitoring allows for tracking emerging behavioural impact and provides opportunities for strategy modifications during the process of implementation to better achieve behavioural results. In Step #7 we need to think through how we will monitor implementation progress and emerging behavioural impact, and offer a process for doing so.

**Note 7.1: Use the work plan schedule as a monitoring tool**.

The work plan schedule developed in Step #9 below can serve as the tool for

monitoring COMBI implementation progress. The Work Plan schedule sets out when each planned activity is to be undertaken and by whom . A task of the Implementation Group (see Note 6.2) is to use this schedule to track implementation progress. This provides a relatively simple way of monitoring implementation progress. It also allows for dealing with any implementation hurdles which may crop up from time to time.

**Note 7.2: Plan for tracking surveys**

Tracking surveys are small random sample surveys conducted in a few selected areas. For example, one could conduct a survey of a sample of 100 households in each of 3-5 localities, reflecting both rural and urban areas, perhaps mid-way in implementation. . The surveys can track whether we are delivering understandable messages, to the selected “target” groups, using the appropriate channels of communication. They can also explore whether people are responding to the messages in the ways we expected. One can then use the findings to modify the communication strategy if one discovers that intended communication objectives are not being achieved.

1. **Impact Assessment**

A COMBI Programme promises behavioural results. In Step #8 we need to describe how we will show that behavioural objectives were achieved. One recognises that a COMBI effort is not the only intervention to contribute to behavioural impact. Nevertheless, behavioural outcomes are promised with the support of COMBI and here we must indicate the process for assessing impact. To the extent possible, one should also describe how impact might be attributed to the COMBI intervention.

**Note 8.1: Be directed by the stated behavioural objectives in shaping an appropriate process for impact assessment, using health service attendance records or surveys or observational studies.**

In Step # 2 we were directed to state specific, precise behavioural objectives, as a fundamental initial step in COMBI planning. We need to return to those objectives. If they were set out with specificity and precision, they will now serve as the measurement basis for impact assessment. The charm of having from the outset very precise behavioural results expected is being able in a rather straightforward manner to determine behavioural impact.

Behavioural results which do not involve visits to a health centre will require the use of other methods for assessing impact. Random sample surveys, for example, may be used for self-reports of carrying out a specific action, recognising that there may be some misreporting on the part of respondents. Observational studies may supplement a survey; such studies allow one to visibly check people’s adherence to a recommended behaviour. We cannot in this section describe the many varied ways for capturing data on specific behavioural results since so much depends on the specific behaviours and the context for carrying them out.

**Note 8.2: attributing impact to COMBI intervention**

The COMBI promise is that COMBI interventions will contribute to behavioural impact. One dimension of impact assessment is showing that there was or was not the promised impact. But it may be bit more difficult to attribute impact to the COMBI programme. In planning for assessing impact, one should structure the process so as to be able to trace impact to COMBI. One way of doing this, for example, is to have a system for comparison of health service attendance records (presuming the expected behaviour result is reflected by these) before and after the COMBI intervention. Similarly, a baseline survey measure of behavioural practice before COMBI can be compared to results post-COMBI. Of course, in a simple pre- and post-COMBI impact assessment, one needs to be mindful of other possible intervening factors which may also have contributed to behavioural results.

**Note 8.3: Use an Evaluation Specialist**

Impact assessment can be simple but it can also be quite complicated. It would be wise to draw on the services of an evaluation specialist in designing the impact assessment component.

1. **Scheduling: The Work Plan**

Steps #5-#8 would have elicited a long list of COMBI activities to be carried out. In Step #9 we proceed to set out these activities into a detailed scheduled work plan which becomes the key implementation and management tool in executing the COMBI programme. The detailed work plan provides a time schedule for the preparation and implementation of activities required to carry out each communication action as described in Steps #5-8, and also includes the designation of specific individuals responsible for implementing specific activities. The work plan format may consist of such column headings as: Activities, Completion Date, Responsibility (staff member, partner agency, and so on).(See the sample work plan as part of the COMBI Plan in Annex ??). The “Activities” column may simply repeat (in much smaller print font) all the activities specified in Step #5 and elsewhere. The “Completion Date” column section may take the form of a tabular flow-chart with weeks, months, quarters, or years as sub-column headings along the top. Such a diagram allows instant comprehension of when different activities begin and end, whether preparatory activities have been given enough time, whether communication actions that need to be integrated are indeed integrated, and highlights periods of peak activity.

**NOTE 9.1: Follow-up first draft of scheduled work plan with a group exercise involving implementation partners and individuals.**

The first draft of the Work Plan together with the full COMBI Plan document can serve a critical implementation role when used in a group review process involving key implementation partners (institutions and individuals) as one moves towards a final work plan. In a group review there is the opportunity to re-visit each activity, raise afresh questions about their relevance to behavioural impact and their feasibility, and within the group process set deadlines and assign responsibility. This process also advances the sense of local ownership of the plan, even though it may have been initiated with external technical support.

1. **Budget**

In Step #10 we present a detailed budget for the various activities being proposed in the COMBI Plan. We suggest a presentation format which covers the key communication areas such as Administrative Mobilisation/Public Relations/Public Advocacy, Community Mobilisation, Personal Selling, Advertising and promotion, and Point of Service Promotion (if applicable). Within each area we specify the activities, quantities of items to be produced, per unit cost, etc. (See sample budget as part of the COMBI Plan in Annex ??)

**Note 10.1: COMBI Plans cannot be implemented on the**

**cheap; so anticipate the outcry that the budget is too rich**

In the public sector it is generally felt that information-education-communication (IEC) programmes can be done cheaply, with very little investment. This may be so if we continue to see IEC or health communication as the production of a minimal number of posters and T-shirts and the sporadic use of the media. This minimalist approach to health communication will not deliver behavioural impact (our ultimate goal) but it will soothe the demands of those who want to see some kind of IEC, regardless of impact.

If the private sector teaches us anything about consumer communication, it is this: To engage the consumer, substantial funds need to be spent. Some private sector companies spend twice as much funds on engaging the consumer than in actually producing the product or service to be offered. The production of bottled water and the promotion of the product is a noteworthy example.

We have already noted that superb medical-technical solutions do not sell themselves. And while enormous funds are rightfully used to enable the physical provision of these health solutions (training staff, building testing labs, purchasing the drugs, etc), we must expect that just as substantial investment will be needed to engage people in considering the solutions we offer.

Yet we must anticipate the outcry that the proposed budget is too rich. We suggest that the budget be developed with regard to what would be an effective programme for behavioural impact. At a later stage, when it becomes clearer as to what actual funds might be available, one would then return to the budget and make adjustments accordingly. In doing so, one would need to ensure a judicious integrated blend of activities but at lower cost. If the budget allocation is too tiny, however, and the radical surgery to the project leads to a dismal COMBI Plan, it would be better to postpone implementation until such time as adequate funds are available for a COMBI Plan which would better assure behavioural impact.

**NOTE 10.2: Build in private sector/business partnership possibilities**

As the budget is developed, it would be useful to identify those interventions which could be supported by the private sector in exchange for modest promotion of a product logo provided that the product affiliation meets Ministry of Health guidelines on such collaboration. For example, a fact sheet to be distributed to each school child to be taken eventually to homes would provide a useful promotion opportunity, say, for toothpaste. A toothpaste manufacturer may find it appealing to position a modest size logo of its toothpaste brand in a corner of the fact sheet and to pay part of the printing costs. Similar co-sponsorship may be possible for other materials or radio and television shows, and advertising. A local advertising/marketing communication agency may be able to help identify possible promotional partnerships. As mentioned earlier, the Business Partnership may also be able to help with providing incentives for the public, and motivational gifts to the network of personal sellers in the programme. The Partnerhsip may also be able to support some of the advertising budget.

**###**

**Conclusion**

There is nothing sacred about the 10-steps for COMBI Planning. And as we embark on COMBI design, we need to constantly remind ourselves of the mystery of human behaviour. We do the strangest things for the oddest reasons.

But we have found the 10-Step approach most useful in our COMBI design work in dozens of countries and with a varied range of behavioural objectives.

You will note that considerable emphasis has been put on Step #2 (Stating the Behavioural Objective) and Step #3 (The Situational Market Analysis for Communication Keys). Our experience has been that 80% of our planning effort is taken up by these two Steps, and often in delightful frustration. But once they are done well, all else falls nicely into place.

Please do contact us should you require any assistance in your COMBI work.

Contacts: ---------------------,------------------------,------------------

**\*\*\*ANNEXES-------------------------------**

**ANNEX I: SUMMARY PRESENTATION OF THE 10 STEPS FOR COMBILANNING**

**ANNEX II: A FORMAT FOR PRESENTING AN NCD COMMUNICATION PLAN**

**ANNEX III: ACKNOWLEDGEMENTS**

ANNEX I

#### THE COMBI DESIGN PROCESS: TEN STEPS FOR DESIGNING

#### A COMMUNICATION-FOR-BEHAVIOURAL-IMPACT (COMBI) PLAN

While the design of a COMBI Plan cannot be done in a neat linear fashion, the following 10 steps are suggested. One should feel free, however, to go back and forth between steps and even within each step.

1. State Overall Goal
2. State Expected Specific Behavioural Results/Objectives (SBOs)

(Return to this during and after Step 3 below and keep modifying as necessary. It is the behavioural result which drives the design of the COMBI Plan. And remember Mantra #1: Do nothing….make no posters, no videos, no soap-operas, no T-shirts, no caps….do nothing, until you have a sharp sense of the desired behavioural outcome(s).)

1. Conduct Situational Market Analysis for Communication Keys (SMACK) vis-à-vis Specific Behavioural Result(s)/Objective(s)-- SBOs**:**

**This “smacking” around is messy and deliciously frustrating and takes up about two-thirds of your time; while doing this, keep track of those issues which are not amenable to communication solutions and those that are and, for those that are, note the communication implications for strategy and actions in #4, 5, and 6 below. Here are some areas (but do not be limited to these) which you should explore in this Step, working with available research and incorporating the perceptive insights of field staff, local experts, community members and yourself:**

***√ Current situation* – HICDARM Analysis: knowledge levels, attitudes, current**

 **behaviours, behavioural trends*.***

 ***√ Market segmentation*: NOSA analysis-- .target groups, priority market segments.**

***√ Force field analysis*:** **those forces in the field which serve as constraints and/or**

 **supporting factors.**

 ***√ SWOT Analysis*: An analysis of Strengths, Weaknesses, Opportunities, Threats, in**

 **relation to the achieving the behavioural goal(s).**

**√ *Consumer Need/Want/Desire (C1), Cost (C2 ), Convenience (C3 ) Analysis*: Exploring**

**consumer need/want/desire being addressed; what "cost" is involved in carrying out recommended behaviour in relation to value promised if the behaviour is carried out; how convenient and accessible is the recommended behaviour; DILO (Day in the Life Of) and MILO (Moment in the Life Of) Analysis for exploring issues of "cost" in carrying out recommended behaviour.**

***√ Positioning*: Current perception and mental positioning based on TOMA (Top-of-the-**

 **Mind) analysis; preferred positioning/perception; how is the behaviour perceived**

 **now; what would be preferred perceptions.**

***√ Competitors:* alternative behaviours or services being offered; include an examination**

 **of "Do Nothing” option, and TAC-Take A Chance option.**

***√ Communication Situation/Issues (MS.CREFS)*: what media/channels are most popular**

**and most influential; what traditional media are used; who would be credible sources of information; what media would provide useful triggers and prompts to action; how does information and influence flow in communities and families; are there local marketing, advertising, public relations agencies, etc. Relating to MS.CREFS factors**

***√ Further Research:* Indicate what further research might be needed.**

***√ Programme Pre-Requisites*: Indicate what might be programme pre-requisites for a**

 **COMBI programme, such as ready availability of trained health staff and treatment**

 **drugs at service sites.**

(Continue refining Step #2 on basis of the situational market analysis and the “smacking” around of the behavioural offer. Remember Mantra #2: Do nothing….make no posters, no videos, no soap-operas, no T-shirts, no caps….do nothing, until you have done the situational market analysis…the SMACK. A tabular version of this Step is offered below to facilitate the exercise for some of the above themes. But do not be trapped by it. Muddle through if necessary.)

1. Present an overall strategy for achieving stated behavioural results/objectives:

**Describe the general communication approach and actions which need to be taken to achieve the behavioural results/objectives in light of #3 above and the communication issues identified.**

1. **Re-state Specific Behavioural Objective(s) (SBOs).**
2. **Set out the “*Communication Keys”* discovered in Step #3 above, which will become “*Communication* *Objectives*”/*Intended Communication Effects* to be achieved in order to secure the desired behavioural result (s).**
3. **Outline Communication Strategy: Broadly present proposed communication actions for achieving communication and behavioural objectives. Think in terms of the following (but do not be restricted by them):**

√ **Administrative Mobilisation/Public Relations/Advocacy/**

**(including memos, partnership sessions, staff meetings, radio, television, newspapers, community meetings/discussion, etc)**

√**Community Mobilisation (including community meetings and**

**events, mass media use: e.g. talk shows; folk/traditional media, road-shows, school involvement, community miking, with supporting materials, etc)**

√**Personal Selling (Interpersonal Communication) via volunteers,**

 **school children, counsellors, others at the field and clinic level);**

√**Advertising and Promotion(Radio, TV, newspapers, billboards, handbills,**

 **pamphlets, brochures, banners, danglers, T-shirts.)**

√ **Point-of-service promotion.**

1. Present the COMBI Plan of Action:

**Specify integrated communication actions to be undertaken with specific communication details in relation to: (a) Administrative Mobilisation/Public Relations/Public Advocacy/; (b) Community Mobilisation; (c) Personal Selling (Interpersonal Communication) (d) Advertising; (e) Point-of-Service Promotion, as described briefly above in #4.**

1. Management: **Describe structure for managing the implementation of COMBI Plan.**
2. Monitoring: **Describe how implementation progress will be monitored.**
3. Impact Assessment: **Describe how behavioural impact will be assessed.**
4. Scheduling: Provide a Calendar/Time-Line/Implementation Plan
5. Budget: **Present Budget**

*Step #3 in Tabular Form (Optional Use)*

A TABULAR FRAMEWORK FOR SITUATIONAL MARKET ANALYSIS FOR COMMUNICATION KEYS (SMACK) VIS-A-VIS DESIRED SPECIFIC BEHAVIOURAL OBJECTIVES (SBOs). A suggested framework, not to be stuck to rigidly.

SITUATIONAL MARKET Emerging Issues which can Emerging Issues which can Communication

ANALYSIS FOR COMMUNIC- not be resolved with be resolved with Implications in

ATION KEYS (SMACK-ing) Communication Solutions Communication Solutions Relation to MS.CREFS

  *(So, wave a flag to Technical*

 *Programme Managers!)*

1. *Current situation /*

*HICDARM analysis*

 ***-Current behaviours,***

 ***usage/behaviour trends***

1. *Market Segmentation*

***-target groups***

***priority market***

***segments; NOSA)***

1. *Force field analysis****:***

***-forces/factors in field which***

***constrain/support; SWOT***

1. *Consumer need/desire/want*

***being responded to with an***

***offer of a solution***

1. *Convenience* ***in terms of***

***accessibility, availability;***

***DILO/MILO***

1. *Cost* ***in terms of pricing,***

***effort, time, other “cost”***

***factors; DILO/MILO factors;***

***cost/value calculations***

1. *Perceptions: Positioning*

***TOMA;How current***

***perceptions position the***

***offered behaviour in the***

***consumer’s mind; how can***

***it be re-positioned in***

***relation to best desired***

***perceptions***

1. *Competitors*

***- alternative behaviours,***

***Do Nothing, TAC-Take***

***A Chance);***

1. *Communication Situation*

ANNEX II

The COMBI 10 Steps Planning Process leads to a COMBI Plan document. This document (such as the COMBI Plan shared at the workshop) will be written others who would not have attended the workshop and would not be familiar with the terms used in the 10-Step process. The results of using the COMBI tools will need to be presented in the COMBI Plan document without using the special language of COMBI, such as SMACK and DILO and MILO. In addition, the flow of the document will be a little different from the 10-Step process. Here we offer an outline format for writing up the COMBI Plan document. Please also refer to the COMBI Plan distributed at the workshop.

A FORMAT FOR PRESENTING THE COMBI PLAN DOCUMENT

1. *Introduction*

In the Introduction, one presents the context within which the COMBI Plan was prepared. It may outline the extent of the disease, the challenge faced, past efforts, and the process used in developing the COMBI Plan.

1. *The Overall Goal:* (See Step #1 in the 10 Step Planning Process))
2. *The Specific Behavioural Objective(s) (SBOs):* (See Step #2): Including a commentary on how one arrived at the particular SBO(s).
3. *Strategy:* This section pulls together succinctly observations and findings from Step #3 –SMACK (Situational Market Analysis for Communication Keys) and links them to the strategy outline from Step #4 (Developing the COMBI Strategy) which provides a general description of communication under the Five Point Star Blend of Communication Actions, which will be operationally detailed in the next section.
4. *Communication Actions:* This section presents the detailed COMBI Plan of Action as developed in Step #5 (COMBI Action Plan) using the Five Point Star Bend of Communication Actions. It details each precise communication action under the broad headings of Administrative Mobilisation/Public Relations/Advocacy for Behavioural Impact (ABI)/Business Partnership, Community Mobilisation, Personal Selling, Advertising (and Promotion and Incentives), and Point-of-Service Promotion. This section ends with a short bulleted summary of the various communication interventions.
5. *Management and Monitoring:* (See Step # 6 and Step #7)
6. *Impact Evaluation:* (See Step # 8)
7. *Work Plan and Schedule:* (See Step #9)
8. *Budget:* (See Step #10)

ANNEX III

**ACKNOWLEDGEMENTS**

This Workbook has its roots in the annual three-week Summer Institute on “Integrated Marketing Communication for Behavioural Impact in Health and Social Development” which has been conducted at New York University (NYU) since 1994 and coordinated by Dr. Everold N. Hosein

The training programme has benefited over the years from the teaching input of, among others: Jeff Carr, Professor of Marketing at the NYU Stern School of Business Administration; Burson –Marsteller, the largest global public relations and communication counselling companies, ; Sudler and Henessy, and IntraMed, two New York-based international health care advertising agencies part of Burson-Marsteller; Cooney-Waters, a New York-based health public relations company; the Advertising Council; Dr. Erma Manoncourtof UNICEF; Dr. O.J. Sikes, and Dr. Delia Barcelona, of UNFPA; Dr. Gloria Coe, Dr. Marilyn Rice, Ms. Bryna Brennan of PAHO/WHO; and Diana Leidel, magazine editor and graphic designer.

### Since 2000, WHO has collaborated with NYU in the organisation and conduct of the training programme with the keen involvement of Ms. Helen Kelly, Dr. Ron Janoff, and Erich Dietrich, of the Office of Academic Initiatives and Global Programs, , and Dr. Allyson Taub, Prof. Vivian Clarke, Dr. Judith Gilbride of the Department of Nutrition, Food Studies and Public Health, at NYU Steinhardt School of Education.

Also in 2000, WHO began applying the methodology of Communication for Behavioural Impact (COMBI), based on the concepts of integrated marketing communication, to specific communicable diseases. Dr. Elil Renganathan, Coordinator of the Social Mobilisation and Training Programme, and Dr. Maria Neira, Director of the Control, Prevention and Eradication Section, in WHO’s Communicable Diseases Division (headed by Dr. David Heymann) were instrumental is establishing this initiative. COMBI was first applied to leprosy programmes in India at the prompting of Dr. Denis Daumerie of WHO’s Leprosy Elimination Programme. It has since been used successfully with dengue and lymphatic filariasis; more recently it has been applied to tuberculosis, malaria, HIV/AIDS, maternal and child health, infant nutrition, obesity and chronic diseases. UNICEF country offices have also applied the methodology to a variety of UNICEF programmes ranging from violence against children, HIV/AIDS, ante-natal care, to juvenile justice and immunisation. These field programmes carried out in collaboration with the WHO’s Regional Offices, WHO country offices, UNICEF Regional and country offices in over 60 countries have contributed significantly to the shaping of the COMBI methodology.

The COMBI Workbook was prepared by Dr. Everold N. Hosein, Senior Communication Advisor- Consultant, WHO. It includes inputs over the past 15 years from Ms. Asiya Odugleh, WHO Technical Officer (Communication); Dr. Will Parks, formerly WHO Communication Officer and now UNICEF Deputy Representative, Ms. Lotta Adestal, former WHO Consultant funded by the Swedish Government, and Ms. Diane Pollet, formerly WHO Communication Assistant; and Dr. Elil Renganathan, WHO.