

CHAPTER 2

A Public Health Communication Planning Framework

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LEARNING OBJECTIVES

By the end of this chapter, the reader will be able to:

- Understand how health communication fits into the broader ecological model.
- Select an overall approach to planning.
- Identify the key elements of each core strategy based on best practices.
- Identify stakeholder partnerships for a communication intervention.
- Create a macro plan for a health communication intervention.

INTRODUCTION: HEALTH COMMUNICATION IN THE ECOLOGICAL MODEL

Referring back to the ecological model in Chapter 1, our health is affected by our physical environment and limiting or enabling factors created by our society, as well as our own behavior and biology. Reciprocally, our physical condition and behavior affect the health and social welfare of others, and we obviously affect the physical environment. Public health experience has demonstrated that interventions conducted on multiple levels of the model are more effective than those focusing solely on one level. **Table 2–1** shows some of the ways that the CDC used health communication to support interventions directed at the different levels of the ecological model.

A good example of a multilevel intervention is the tobacco policy that addresses taxes on cigarettes, national advertising, worksite activities, and the availability of medical cessation aids (e.g., nicotine gum, patches), presented in Chapter 1.

In this chapter, we introduce the example of the national folic acid* campaign managed by the CDC and the National Council on Folic Acid. The CDC and its partners launched advocacy, health provider education, community partnerships, and mass media efforts to increase the availability of foods fortified with folic acid, as well as to increase consumption of folic acid supplements by any woman capable of becoming pregnant. We will come back to the national folic acid program throughout the textbook as an ongoing example that is unusual in scope and longevity.

At the opposite end of the spectrum, many community organizations or public health departments plan and execute small scale interventions on their own. These smaller efforts must work within the limits set by their organizations (chiefly budgetary), and address limited populations defined by specific factors (e.g., geography, health status, age, maternity status, ethnic identity, sexual orientation, church affiliation, school attendance, sports team fans, etc.). **Table 2–2** illustrates the levels of the ecological model and how communication might be used to create or support a public health intervention.

Whether planning for a multilevel, multi-population communication program or a highly focused one, the basic planning process is the same.

*Folic acid is a B-vitamin that is essential to human health. It is required for the body to make DNA and RNA, the blueprints for development of all cells. It is especially vital to a developing embryo because rapid cell division occurs early in fetal development. Consuming folic acid before conception and through the first months of pregnancy will prevent 50-75% of neural tube defects.

TABLE 2–1 Health Communication at Different Ecological Levels in CDC Folic Acid Program

Ecological Level	Primary Intervention	Communication Intervention
Environmental	<p>Increase number and availability of foods fortified with folic acid.</p> <p>Increase fortification level to 400 µg of folic acid in fortified cereals, bread, pasta, and other prepared foods.</p> <p>Folic acid supplements or multivitamins could be provided at low or no cost to all women.</p>	<p>Advocacy to U.S. Food and Drug Administration (FDA).</p> <p>Education and advocacy to private-sector food and vitamin supplement manufacturers.</p> <p>“Promotional support” for foods and vitamins containing 400 µg of folic acid.</p>
Societal	<p>Policies to promote consumption of folic acid prior to conception.</p> <p>Regulations to define adequate fortification levels in foods.</p> <p>More funding and resources should be committed to neural tube defect (NTD) prevention and education.</p> <p>Health communication normative campaign to promote daily consumption of folic acid supplements—food sources inadequate.</p>	<p>Partner advocacy to federal and state decision makers.</p> <p>Partnership recruitment with national and community organizations.</p> <p>Community, local health department support; media outreach.</p>
Organizational	<p>Educational and technical outreach to obstetricians and gynecologists and pediatricians, concerning reduced risk of NTDs with proper intake of folic acid. Healthcare providers could encourage women to consume folic acid, regardless of their plans for future pregnancies.</p>	<p>Partnership training materials; educational materials for healthcare professionals, managed care, and insurance companies, and health advocacy organizations.</p>
Individual	<p>Health communication: education and persuasion to begin consuming 400 µg of folic acid daily if pregnancy is possible.</p>	<p>Multimedia campaigns using entertainment, public service announcements (PSAs), and print to reach target audiences.</p>

AN OVERALL APPROACH TO PLANNING: BIG WHEEL KEEP ON TURNING

Health communication planning, execution, and evaluation are often depicted together as a circle to emphasize the ongoing nature of program improvement. The National Cancer Institute¹ uses the format shown in **Figure 2–1**.

Another way to look at this is to break down the complex planning process into several sub-plans, each with an inherent research task:

- A **macro plan** that includes analysis of the problem, the ecological setting, the core intervention strategy, and the target population.
 - This stage of planning is normally undertaken after epidemiological data indicate there is a health problem that affects specific groups of people. If there is evidence that a specific intervention has worked to reduce this problem elsewhere, feasibility testing might be conducted to adapt the intervention to the

TABLE 2–2 Communication Interventions in the Ecological Model

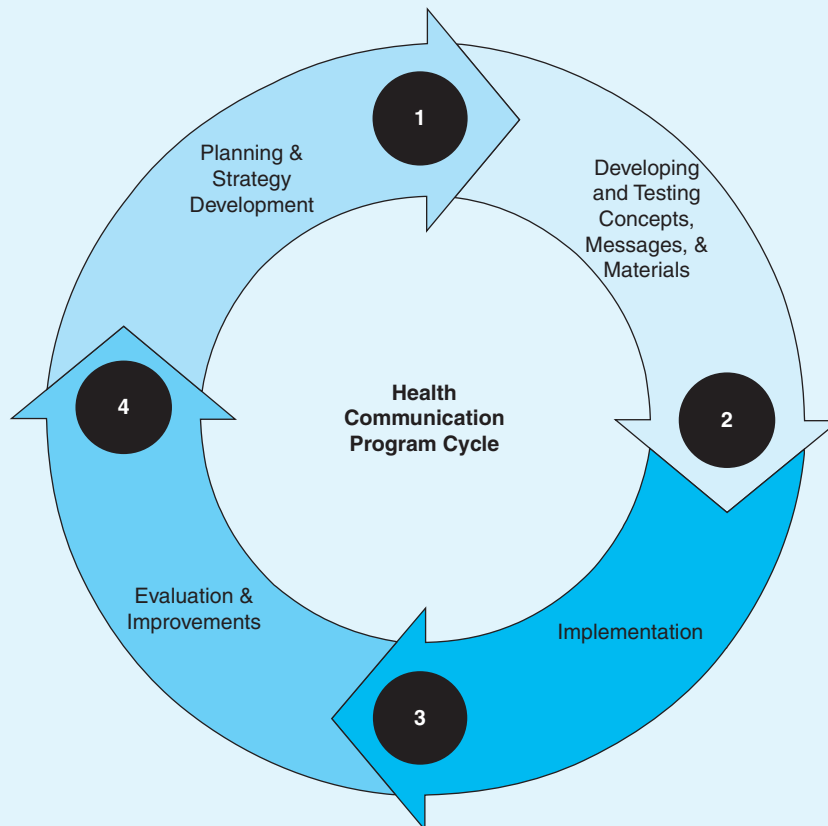
Ecological Model Level	Primary Intervention	Communication Support
State, national, global	Policies, laws, treaties, “movements,” emergencies. Examples: U.S. seat belt law; EMPOWER tobacco policy (World Health Organization); food fortification or enrichment regulations; small pox or polio vaccination programs; border closing or quarantine to control epidemiological outbreak.	Advocacy to create or maintain policy or law; national and state specific reinforcement advertising; incentive programs; package warnings and labels; government educational campaigns; social mobilization, e.g., national immunization days; multimedia emergency information campaign to advise and calm public.
Living and working conditions	Environmental conditions; hours; policies. Examples: worker safety; time off and vacation policies; creation of walking paths; elimination of lead in gasoline, paint; availability of healthy food choices, healthcare services.	Citizen or worker advocacy (multimedia) to improve conditions; awareness and promotion campaigns for improved facilities, services; state or local lead education campaigns; private-sector advertising for healthy food choices, services.
Social, community, family	Social norms; elimination of social disparities; provision of community health and social services; cultural “rules” for group behavior. Examples: Community Watch, day care, church ministries of health, volunteers.	Grass roots campaigns; radio, TV, Internet, print or locale- (e.g., church, bar) based social marketing or promotional campaigns; opinion leaders and role models; PSAs; health fairs, small media educational materials; reinforcement of norms through group processes.
Individual behavior	Acquisition of beliefs, attitudes, motivation, self-efficacy, products, and services through social marketing, behavior change communications, paid advertising, or psychological counseling.	Multimedia decision aids; educational materials; guidelines; promotional advertising; reinforcement through home, healthcare providers, community.
Individual biology, physiology	Prevention or treatment of illness; healthcare provider visits; screening tests.	Behavior change communication to maintain or establish good health habits; reminders for screening; healthcare provider communication during office visits.

new population. The less we know about the problem, potential solution, or the intended audience, the more formative research must be done before taking the next planning steps.

- A **strategic health communication plan** that focuses on specific change objectives, audiences, messages, and media.
 - Concepts, messages, materials, and media strategies are tested at this stage of planning. This “pretesting” is sometimes referred to as formative research, and at times it is considered “process” research. It should

precede finalization of the implementation plan that comes next.

- An **implementation (or tactical) plan** that says what will be done, when, where, how, with what money, and who is responsible for every piece.
 - Process research is often conducted shortly after the launch of a program to make sure all operations are running smoothly and that messages are getting out and being interpreted as planned. Corrections can be made if this assessment is done early enough.

FIGURE 2–1 Health Communication Planning Cycle

Source: Redrawn from: National Cancer Institute. *Making Health Communication Programs Work*, p. 11. (DHHS, 2004.)

- An **evaluation plan** that says what aspects of the intervention will be monitored or evaluated in order to determine the intervention's worth to key stakeholders. Since most programs want to achieve *measurable* objectives, baseline data often need to be collected before a program is launched. Therefore evaluation planning must begin in the first days of program development.
- A **Partnership, continuation, and/or expansion plans** might also be initiated at the outset of a program to ensure a broader reach, diffuse expenses, and provide continuity of leadership and ownership.
- A **Dissemination and publication plans**, if desired.

The CDC developed a software tool called *CDCynergy* to help program planners develop and implement health

communication programs. *CDCynergy* refers to each of these plans as “phases.” Even though the term “phase” suggests taking one step at a time, in practice several of the phases need to be considered interactively. However, the development of the macro plan is definitely the starting point of the planning process. A health communication program can take more than a year to develop, particularly if a great deal of formative research is necessary. Most interventions run for several months to several years and are followed by evaluations that may also extend from days to years. The involvement of a health communicator in a program from start to finish could turn out to be a five or more year chunk of his or her life.

Several of the best-known approaches and models for planning are discussed in **Box 2–1**.

Box 2–1 Variations in Health Communication Planning

Some of the variation in how health communication planning is approached is based on whether an organization is at the macro stage, developing a communication strategy, or managing the program implementation. Plans that you will commonly encounter include:

- ❑ UNICEF’s Triple A Cycle. This consists of “assess–analyze–act,” and was developed for any form of planning, not only communication.
- ❑ SCOPE,^{*} created by the Center for Communication Programs at Johns Hopkins University.
- ❑ CDCynergy,[†] developed by Centers for Disease Control and Prevention (CDC).
- ❑ The six-stage planning model in the National Cancer Institute NCI “Pink Book.”
- ❑ The social marketing “wheel” found in multiple social marketing resources, including those supported by the U.S. Agency for International Development (USAID) and the Turning Point Social Marketing National Excellence Collaborative.[‡]

SCOPE and CDCynergy are among the more complex planning tools and use interactive computer models to build a detailed, multifunctional plan based on individual program data.

International health communication planning models tend to adapt generic planning tools to specific development issues, such as reproductive health, nutrition, and HIV or other infectious diseases. Probably the most comprehensive planning tool ever developed in print is *A Toolbox for Building Health Communication Capacity*.[§] The Academy for Educational Development (AED) created this “workbook” using social marketing as well as an “applied behavior change framework” to support child survival programs for USAID. This is available online, free of charge, from AED.

^{*}<http://www.jhucpc.org/training/scope/ScopeAbstract.htm>

[†]<http://www.cdc.gov/healthmarketing/cdcynergy/>

[‡]<http://socialmarketingcollaborative.org/smc/>

[§]<http://www.globalhealthcommunication.org/tools/29>

DEVELOPING THE MACRO PLAN

The key steps in this plan are:

1. Analyze the problem and the level(s) of the ecological model where you hope to create a change. Based on that analysis, determine what you want to change and where the change must take place.
2. Select the most effective intervention for bringing about this change based on evidence.
3. Choose a core strategy for communication. This identifies target audiences (primary, secondary, and tertiary, discussed later), and the form of interaction with each, for example, education, empowerment, marketing, or political.
4. Identify and recruit partners to accomplish the task.

Let’s review each of these steps in detail.

Step 1: Analyze the Problem and Its Place in the Ecological Framework

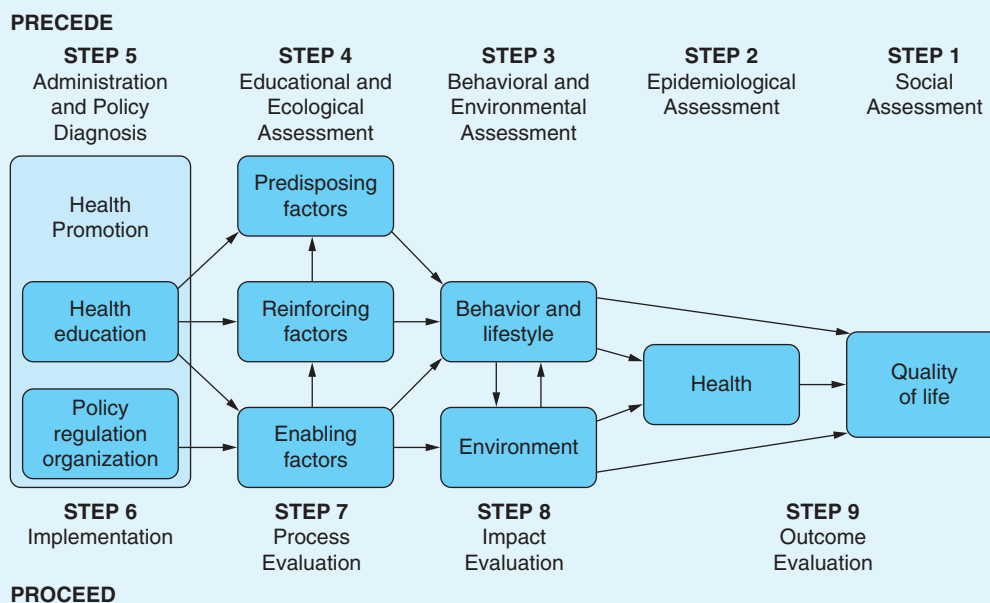
Diagnosing the Problem: The PRECEDE–PROCEED Model

The **PRECEDE–PROCEED model** has been used to guide countless public health interventions. Developed by Green and

Kreuter, and their associates, in the 1970s,² the model works backward from a desired state of health and quality of life and asks what environment, behavior, individual motivation, or administrative policy is necessary to create that healthy state. **Figure 2–2** shows the basic PRECEDE–PROCEED model.³

PRECEDE–PROCEED divides the process into two phases, assessment and implementation. The needs assessment phase examines the *predisposing*, *reinforcing*, and *enabling* constructs in *educational/environmental diagnosis and evaluation (PRECEDE)*. The implementation phase addresses *policy*, *regulatory*, and *organizational* constructs in *educational and environmental development (PROCEED)*. Predisposing factors include existing beliefs, attitudes, and values (e.g., cultural or ethical norms) that influence whether a person will adopt a behavior. Enabling factors are largely structural, such as the availability of resources, time, or skills to perform a behavior. Reinforcing factors include family and community approval or discouragement.

PRECEDE–PROCEED is discussed extensively in Edberg⁴ and will be reviewed in Chapter 9. A comprehensive diagnosis of a problem often reveals that more than one population and more than one level of the ecological model are involved

FIGURE 2–2 PRECEDE–PROCEED Model

Source: National Cancer Institute. *Theory at a Glance, A Guide for Health Promotion Practice*, 2nd Edition. NIH Publication No. 05-3896; 2005. <http://www.cancer.gov/PDF/481f5d53-63df-41bc-bfaf-5aa48ee1da4d/TAAG3.pdf>

in creating a problem. All should be addressed in the planning of a successful health communication intervention.

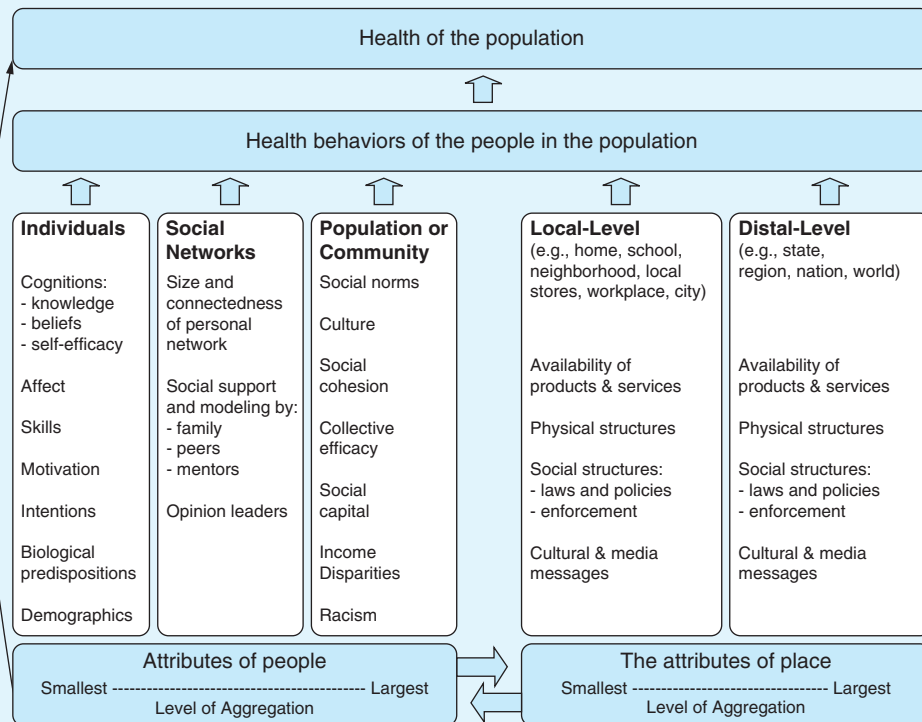
For example, when families share meals, changing the foods served in those meals often requires agreement by several family members (predisposing factors: beliefs about taste and nutrition, food customs and traditions). Food availability can be limited by season of the year, location of markets, as well as food purchasing power (enabling factors). Or if family members criticize the food (e.g., not tasty) the food preparer is unlikely to repeat the performance (reinforcing factors).

As another example, it is well known that many individuals living in the inner city are too afraid of crime to walk around their neighborhood or send their children out to play. All the desire in the world to start an exercise program, and even the offer of free athletic shoes, may not overcome these fears. A “simple” problem in reality is often a complex set of antecedent factors that predispose a belief set, enable or prevent choice, reinforce the status quo, or facilitate change. These factors must be addressed on multiple levels to achieve behavioral change.

The People and Places Framework

Maibach, Abrams, and Marosits⁵ have developed a framework to diagram the processes of communication and marketing in terms of their potential for social impact they call the **People and Places Model of Social Change**. Their full model is presented in **Figure 2–3**.

Speaking very plainly, they view the ecological model as people in environments or places, “What about the people, and what about the places, needs to be happening in order for the people (and the places) to be healthy?” Forces that affect people at the individual, social network, or community/population level are referred to as “people fields of influence.” Forces that are linked inextricably to a local level or higher administrative level (state, nation, world) are referred to as “place fields of influence.” The People and Places Framework (PPF) suggests that organization marketing and business-to-business approaches and policy (legislative, corporate) advocacy are more effective at bringing about change in place fields of influence. Social marketing and health communication, which promote voluntary behavior change based on information,

FIGURE 2–3 People and Places Model

Source: Maibach, E.W., Abrams, L.C., Marosits, M. *Communication and marketing as tools to cultivate the public's health: a proposed "people and places" framework*. BMC Public Health; 2007, 7. <http://www.biomedcentral.com/1471-2458/7/88>.

motivation, and self-efficacy, among other psychological processes, are more effective at changing people fields of influence. A public health planner can use this information to develop an overarching intervention strategy that will target the desired ecological level(s).

By using the above tools you will develop a fuller understanding of the problem to be addressed, the nature of the required behavioral change, and the levels of the ecological model at which you need to work in order to produce an effective intervention.

Step 2: Select a Primary Intervention Based on Evidence

Unless you are developing an intervention that has never been tried, it is better to adapt an existing **evidence-based intervention** for your community than to develop something from scratch. This way you will be able to estimate your projected

impact and programmatic needs (time, personnel, budget, evaluation needs) more accurately than if planning your approach from a blank sheet of paper. And, it is almost impossible to acquire grant funding without reference to evidence-based interventions (EBIs) in your application.

Chapter 5 will discuss how to consult an evidence base for public health interventions, such as The Community Guide* or Cochrane Reviews.† These are **meta-analyses** of programs and studies that, taken together, provide an estimate of how effective a particular intervention might be in a particular population. Some interventions have not yet generated sufficient evidence to be supported by these resources. It does not mean they do not work, only that there have been

*<http://www.thecommunityguide.org>

†<http://www.cochrane.org>

an insufficient number of studies with appropriate criteria (sample size, external validity controls, etc.) to be included in a meta-analysis. It is still important to read the primary literature in reputable journals to understand prior approaches and outcomes.

In addition to these research sources, health communication planners need to consult with the target population and its representatives. Interaction with community leaders, either before or after opinion polling, will help you merge what the scientific literature suggests is best with what your community desires. At the conclusion of this stage, you will also determine whether communication will be the primary intervention or will be developed in support of another intervention, such as a new product or service.

Step 3: Identify Relevant Audiences and How You Plan to Interact with Them

Primary, Secondary, and Tertiary Audiences

When planning a communication intervention, you may decide it will be most effective to share information directly with the group of people who are most affected by a problem and whose behavior you hope to change. This group is defined as the **primary audience**. (Sometimes the term “target” is included, as in primary target audience.) For example, if you are trying to get mothers in a developing country to use a more nutritious complementary food for their infants, you might think your best strategy is to speak directly to these mothers (the primary audience) and tell them the benefits of nutrition.

But, after some research in this particular community, you might find that young mothers have very little control over what happens in the household. They live in their husband’s home, and their mother-in-law, in fact, makes most of the decisions. So, you decide that before trying to communicate with mothers, you will need to convince the mothers-in-law that their grandchildren can benefit from improved nutrition. In this case, you are reaching out to what is called a **secondary audience**, the group that has a great deal of influences over the behavior of the primary audience.

Finally, you realize that in order to produce change in the behavior of the mothers and mothers-in-law, you will need to reach out to the health workers and other influential people in the community and convince them of the benefits of improved infant nutrition. In this case, you are influencing a **tertiary audience**, or the audience that in some other way affects the behavior of the secondary and primary audiences.

Note that you may sometimes see the term “primary audience” used to refer to the group of people you want to reach

first in a sequence. That might be the health workers and community leaders in this example. In fact, if you need to conduct a training program for the health workers to bring them up-to-date with new infant nutrition concepts and empower them to be more effective communicators themselves, then the health workers become the primary audience for this specific intervention. After the health workers are trained, they can then address the mothers and mothers-in-law as *their* primary and secondary audiences, respectively.

In our thinking, and in this book, the primary audience is always the group whose behavior you are trying to change, that is, as a result of this communication intervention this group will think, feel, or act in a certain way. For example, you are planning a teenage anti-smoking campaign in the United States and you hope to enlist the help of musicians and celebrities who appeal to a younger group. While your initial efforts may be directed to these people—the secondary audience—to bring them on-board with your program, you are selecting them to help reach your primary audience—the teenagers.

Choose a Core Communication Strategy for Each Audience

*Decide on whether you plan to “inform” or “persuade” your intended audience. According to Healthy People 2010 health communication “uses communication strategies to inform and influence individual and community decisions that enhance health.”** Or, put differently, to *inform* and *persuade*. What is the difference?

Informing. As will be explained in Chapter 4, most of the population needs to have raw data and scientific findings decoded into a language they can understand before making an informed decision. The difference between data and information is that *information answers questions*. The same basic fact can be presented in different ways to make it meaningful to whoever is asking the question.

Recent studies of how individuals seek out health information on the internet have provided new ways for health communicators to present information offline as well. Five chapters of this textbook address the various theories and techniques that can be used to transform data into information for different users. The person making a decision might have difficulties reading, using arithmetic functions, or contextualizing information so that it is meaningful to them. Tools to enhance health literacy, numeracy, and cultural competency can be em-

*<http://www.healthypeople.gov/Document/HTML/Volume1/11HealthCom.htm>: 1

ployed to make health information more understandable and meaningful. Advocacy and informatics tools make numbers more eloquent for upstream decision makers. The essential public health service of “inform, educate and empower”^{*} uses the tools from this section of the text.

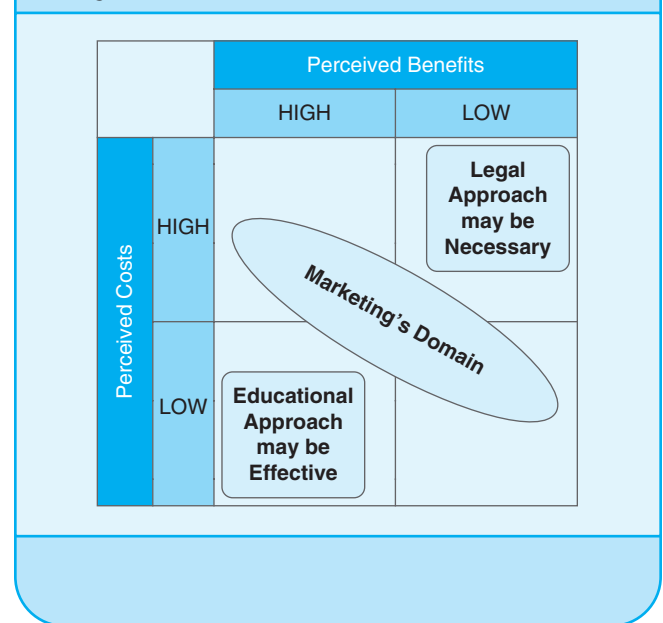
Persuasion. The more the health communicator is vested in the response to his or her information, the more he or she is venturing into the zone of persuasion. As mentioned later in the chapter, marketing provides an approach to make certain choices seem more favorable to a potential adopter. These approaches can include many of the same factors that make units of information meaningful and understandable, such as cultural cues and references. But persuasive communication takes the next step of employing theories about how individuals or groups make decisions to change behavior. Most of these theories come from the field of social or health psychology, where they have been used extensively to persuade individuals to adopt healthier lifestyles. Their application to group dynamics is relatively new but at least 20 years of practice has provided good results.

There has been a debate in the field about the ethics of using persuasive techniques in health communication. We stick by the stance we put forth in 2002:⁶

In public health, ethics are largely determined by the extent to which there is scientific consensus about a health issue and the intended and potential unintended outcomes of interventions for all persons. When there is consensus about the beneficial value of a given health behavior for the individual and for society, it is considered ethical to attempt to persuade individuals to adopt a behavior (e.g., not using tobacco, being physically active), or to persuade policy makers to enact policies, support programs, or provide resources to improve health (e.g., mandatory immunization laws for school-age children). Failing to advocate for such individual and social changes when the scientific evidence is strong has ethical dilemmas of its own. When scientific consensus does not exist on a specific topic, when there are potentially serious side-effects involved, or when personal values are critical to a decision, it may be more appropriate to enable individuals to make informed decisions.

^{*}<http://www.cdc.gov/od/ocph/nphsp/EssentialPublicHealthServices.htm#es3>

FIGURE 2–4 Interpretation of Rothschild’s Behavior Management Model



Health communicators have to decide what is their intention, informing or persuading, before planning their communication strategy. The science, the situation, the community and the principles of the public health practitioner are all included in the ethical calculus of this choice.

Select an overall approach to informing or persuading your audience. According to **Rothschild’s Behavior Management Model**, and to economists at large, when a rational individual is asked to adopt a new behavior, he or she evaluates that behavior in terms of its costs and benefits, as well as the individual’s motivations and opportunities to act. The motivation behind this change, and the strategy for best facilitation, are depicted in **Figure 2–4**.

Educational approaches. As Figure 2–4 illustrates, if an individual perceives they have much more to gain than to lose (i.e., benefits are obvious and costs are low), then merely providing information or educational approaches might be all that is necessary to prompt a change. A paramount example of this has been the ongoing “Back to Sleep” campaign[†] in which simple informational materials are given to new parents explaining that placing healthy babies on their backs to sleep reduces the risk of sudden infant death syndrome (SIDS). It does not take a lot

[†]<http://www.nichd.nih.gov/sids/>

of persuasion to convince parents to adopt an easily accomplished, no-cost, high-return behavior. **Box 2–2** lists some conditions when educational approaches are most effective.

Legal approaches. At the opposite side of the spectrum, behaviors that appear to offer the individual few personal benefits, are perceived as difficult to maintain, or are costly might require legislative means to enforce. Most public health hygiene laws, smoke-free restaurant regulations, or requirements to strap children into rear safety seats in motor vehicles fall into this category. In order for new laws or regulations to be developed, organizations (government agencies, concerned citizen groups) collect data demonstrating the harm being done, propose solutions to mitigate the problem, and begin an advocacy effort to convince a policymaker at some level (congressional or local legislatures) to take up the issue. Informatics, as well as advocacy communication, is involved in this process. (And it is discussed in Chapter 6.) **Box 2–3** presents some situations where legal or advocacy approaches are more appropriate.

Social marketing. In between compulsion and information is a gray zone where a cost and a benefit is a matter of negotiated exchange. This is the domain of marketing. **Social marketing** can be defined as the “design, implementation, and control of programs aimed at increasing the acceptability of a social idea, practice [or product] in one or more groups of target adopters. The process actively involves the target population, who voluntarily exchange their time and attention for help in meeting their health needs as they perceive them.”⁷

Box 2–2 Educational Approaches

Educational approaches work best if:

- The recipient of the information has expressed an interest in, or commitment to, the desired behavior.
- The recipient needs answers to factual questions such as: What? Who? Where? How?
- The information is simple, clear, and unambiguous. And, it is:
 - Written at an appropriate reading level.
 - Communicated in the language of maximum understanding.
 - Age appropriate.
 - Matched to the communication medium.

Box 2–3 Legal Approaches

Advocacy frames issues for public attention, the media, and policymakers. For maximum impact, advocacy should:

- Answer the question: Why should we care?
- Be focused on one or a very limited number of issues.
- Get to the point quickly and end quickly.
- Add emotional content.
- Address local concerns.

In the world of marketing, people are “consumers” who are trying to solve problems. Sometimes the problems are obvious to them, and at others times, their needs are latent. A **latent need** is one of which you are blissfully unaware. Famous examples include body odor, bad breath, and dry, dull skin. If a product can be developed to solve such a latent need and if the price and convenience factors are reasonable, the marketer who develops the product should realize a profit. Hence, we have Dial soap, Listerene, and Jergens with Gold Ribbons, (and scores of other brands). Social marketing has taken this approach and used it to address problems of public health. Unlike commercial marketing, social marketing normally does not focus on a profit margin, although more recent efforts do build a **sustainability*** margin into a product’s price. Like marketing, social marketing uses many dimensions to “position” a product, including the product’s image, its price, where it is available, and how it is promoted. The four Ps—product, price, place, and promotion—form the basis for a marketing strategy. Social marketing involves more dimensions than health communication alone. Social marketing has also been used to promote intangible “products,” that is, behaviors. In this case the dimensions of price, place, and product image are metaphorical. A good example is the well-known “Friends Don’t Let Friends Drive Drunk” campaign created by the Advertising Council for the U.S. Department of Transportation, National Highway Traffic Safety Administration (NHTSA). It is explained by social marketing expert Nedra Weinreich in **Box 2–4**.

Thus, depending on whether the change that is proposed is easy or difficult to do or accept, and whether the benefits are obvious or need to be emphasized to overcome resistance,

*Sustainability is when the monetary inputs to a program can support its costs. Giving products away for “free,” besides being a bad psychological strategy, will not keep a program afloat.

Box 2–4 The 4 Ps in a Drunk Driving Campaign

Friends Don't Let Friends Drive Drunk: How It Satisfied the 4 Ps

By: Nedra Klein Weinreich

This campaign positioned the designed action (product) of friends keeping an eye on each other's level of alcohol impairment, and providing alternative transportation for those too drunk to drive, as a cool and responsible thing for young adults to do. The promotion strategy of television PSAs portraying the potential negative consequences of drunk driving—friends being injured or killed—was designed to lower the perceived social price of “nerdy vigilance.” The place where the audience would engage in this action was anywhere young adults gathered to drink. All four marketing Ps worked together to try to persuade the audience to adopt this behavior.

Source: Weinreich NK, personal communication, April 20, 2010.

a public health planner might choose education, marketing, or legislative routes as the core strategy.

Step 4: Choose Partners^{8*}

No one organization has the time, energy, and resources to make a very large impact on a community, and certainly not on a statewide or national level. Working with partners has been an essential aspect of health communication planning for at least three decades, if not longer. The term *coalition* is often used to refer to a group of different organizations working together for a common cause or campaign. Such coalitions may be formal or informal, with operational rules and governance depending on the group's mission and resources. There are numerous advantages for establishing coalitions to assist you in reaching your programmatic goals. Before you begin to invite organizations to join your coalition, you must decide whether supporting a coalition is a commitment your organization is willing to undertake. Partners selected for a health communication intervention should be able to focus their attention on a target audience and have a high level of credibility within and connection to this group. In order to achieve

*Much of this section is from a draft of the CDC *Physical Activity Guide*. A final version of this guide can be obtained by contacting the CDC. See <http://www.cdc.gov/nccdphp/dnpa/pahand.htm>.

objectives and sustain interest in a long-term program, partners must be sought and committed. The following sections describe two effective ways to select partners.

Audience-Oriented Approach

The health communication program identifies groups to receive program messages and services—for example, pregnant women, adolescents, household heads, and isolated geographic groups. You should find out which groups already work most effectively with the intended audience. Partners also may be chosen on the basis of their connection with the intended beneficiaries. Next, the lead agency and the partners develop a plan of action to reach each audience.

Task-Oriented, Problem-Solving Approach

A health communication program may want to accomplish certain tasks—for example, delivering vitamin supplements to all health posts in the country or seeing that all municipalities draft ordinances for bike paths. Which groups can help get the job done? Partners are selected on the basis of what they have to offer: resources, influence, power, logistical support, access.

Box 2–5 lists the numerous benefits as well as the barriers you must consider before involving others in your project.

Later in the book (Chapter 13) we will discuss strategic planning tools such as the SWOT analysis (assessment of strengths, weaknesses, opportunities, and threats). A SWOT analysis, in particular, helps you assess your own, or your organization's strengths, as well as where you need to fill in gaps. You would be well served in selecting partners who have knowledge, skills, resources, or connections to a target audience that you lack. You can choose partners who are in the same field as your organization, but also look beyond to other organizations that may benefit from this coalition. It is important to consider the private sector in this effort, which will be discussed later in this book.

In sum, you should strive to find partners who:

- Share your vision.
- Have experience in the community or with an approach.
- Possess skills that complement your own.

And most critically, the partners should be “stakeholders.” They have something “at stake” (their lives, health, reputation, or funding) that depends on the success of the program. Stakeholders might include, among others:

- Representatives of the Primary, or “target” audience for behavioral change

Box 2–5 Benefits and Barriers of Health Communication Coalitions

There are several possible benefits to forming coalitions. They can:

- Provide the knowledge, expertise, perspective, resources, or credibility needed to bridge gaps in your overall program.
- Conserve resources by avoiding duplication of services, combining resources, and decreasing costs through collective resource-saving opportunities.
- Increase visibility and credibility of your program with decision and policymakers, funders, and the media.
- Use their relationship with the community to mobilize them toward action through collective advocacy.
- Combine the forces of leaders, agencies, gatekeepers, and influential people that may be needed to reach your program's goals.
- Reach specific subgroups within the total population or reach more people within your target audience.
- Broaden community support and strengthen the community's trust in your program.
- Identify gaps in current services and then the members can work together to create programs to eliminate those gaps.
- Make a bigger impact.

Consider these potential problems when deciding if a coalition is the best way to accomplish your goal:

- Coalitions are a time-consuming effort that may take your time away from other projects.
- You must identify potential members of your coalition, convince them to work with you, gain internal approvals, and possibly undergo training—all before you can plan the details of your program.
- The coalition members may require significant alterations in your program ideas.
- Coalitions may also result in a loss of your “ownership” and control for your program.
- The coalition, or individual members, may take credit for the program's results.

You also will need to handle the difficulties that occur when groups work together. Some of these obstacles are:

- Historical or ideological differences.
- Institutional disincentives to collaboration or partnering.
- Competition for resources.
- Lack of leadership and a clear sense of direction.
- Domination by one organization or individual.
- Inadequate participation by important groups.
- Unrealistic expectations about partners' roles, responsibilities, or required time commitments.
- Disagreements among partners regarding values, vision, goals, or actions.
- Inability or unwillingness to negotiate or compromise on important issues.

Source: Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity. *Guide to Working with Coalitions*. Unpublished; 1993.

- Secondary audience, gatekeepers to your target audience—they control access to communicating with your target audience (e.g., religious leaders, block captains, organizational leaders).
- Tertiary audience, influencers, who have earned the respect and admiration of your target audience (e.g., local personalities such as local news anchors, respected politicians, other opinion leaders, national figures such as health authorities or celebrities), if they have a reason to be concerned.

Box 2–6 features the partners who joined the National Council for Folic Acid and some of the resources they brought to the partnership.

CONCLUSION

The first stage of health communication planning involves forgetting about communication details and focusing on the major goals of your project, and the best ways to reach them. This is the macro plan, the big picture, an overall view of the projects and its components. The macro plan is often devel-

Box 2–6 Partners in the National Council for Folic Acid

The Centers for Disease Control and Prevention had resources for beginning the health communication planning process and technical experts to do the process in a systematic manner. Under CDC's leadership, the National Council on Folic Acid (NCFA) was established. Members of the council included:

- American Academy of Pediatrics.
- American College of Obstetricians and Gynecologists.
- Association of Maternal and Child Health Programs.
- Association of State and Territorial Public Health Nutrition Directors.
- March of Dimes Birth Defects Foundation.
- National Coalition of Hispanic Health and Human Service Organizations.
- Shriners' Hospitals for Children.
- Spina Bifida Association of America.
- State health department representative(s).

NCFA served as a steering group, making decisions and broad directives, with ad hoc committees formed to tackle specific projects identified during the planning process. Early in this process, NCFA members delineated their roles based on each of member organization's resources and capabilities. For example, CDC had resources and expertise to conduct the formative and summative research for the campaign, so they took the lead on this activity. March of Dimes and others had the capacity and infrastructure to disseminate materials. The healthcare professional organizations had the capacity to reach their members with information about folic acid. Every member had something to contribute to the overall effort.

Source: From *CDCynergy*, Folic Acid case study. Step 1.3.

oped in consultation with organizational partners, each of whom will have a topical focus, a methodological expertise, and a constituency base. Appendix 2A provides an overview of the specific pieces you might include in your own macro plan, as well as an example plan that was developed for the CDC's original Folic Acid program.

KEY TERMS

Continuation plan

Dissemination plan

Evaluation plan

Evidence-based intervention (EBI)

Expansion plan

Implementation (tactical) plan

Inform

Latent need

Macro plan

Meta-analyses

Partnership plan

People and places model of social change

Persuade

PRECEDE–PROCEED Model

Primary audience

Publication plan

Rothschild's behavior management model

Secondary audience

Social marketing

Strategic health communication plan

Sustainability

Tertiary audience



Chapter Questions

1. Name several approaches to health communication planning.
2. What are the key steps to developing a macro plan for a health communication intervention?
3. Sketch out the basics of the PRECEDE–PROCEED model.
4. What are the differences between *informing* and *persuading* your intended audience?
5. Define social marketing. Do you think it is an appropriate approach to use in health communication?
6. What are some criteria for choosing partners for a health communication intervention?

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APPENDIX 2A

Folic Acid Macro Plan Example

APPENDIX 2A Macro Plan Template

Step	Information	Tools
1	Analyze the problem and its place in the ecological framework.	
1.1	<i>Health Problem Statement:</i> What is occurring? What should be occurring? Who is affected, and to what degree? What could happen if problem is not resolved?	Worksheet 2.1 PRECEDE diagnosis
1.2	What needs to change? Individual behavior, policies, environmental conditions?	People and places framework (PPF)
2	<i>Primary Intervention:</i> What is it? What is the evidence base? What are its advantages and disadvantages?	
	What needs to happen in order for this intervention to solve the problem? What role will communication play: primary or support?	Review PRECEDE and PPF
3.1	Identify the primary, secondary, and other audiences.	
3.2	For each audience, will you inform, empower, or persuade them?	
3.3	What core strategy will you use (education, marketing, advocacy/law)?	
4	Who needs to be a partner in your coalition? What is their overall partnering role? (Access to people, task specific.)	
5	Logic Model and SWOT analysis*	(See Chapter 13)

*In a “public health reality,” you would do these steps now. We will introduce them later in the textbook because you need to learn more before you can accomplish these tasks.

Source: Based on CDCyergy, Folic Acid example.

WORKSHEET 2–1 Health Problem Statement

1. What is occurring?

2. What should be occurring?

3. Who is affected, and to what degree?

4. What could happen if the problem is not addressed?

FOLIC ACID MACRO PLAN EXAMPLE**1.1 Health Problem Statement*****What Is Occurring?***

The Centers for Disease Control and Prevention (CDC) uses surveillance and epidemiological data to track the prevalence of birth defects in the United States. In 1990, the CDC reviewed data collected since 1983 and reported that the average state level prevalence of neural tube defect (NTD) affected births during this period was 4.6 per 10,000.* NTDs are among the most fatal or debilitating birth defects and include incomplete closure of the spine (spina bifida) and malformation of the brain (anencephaly). Babies born with spina bifida have an opening along their spine, through which the spinal tissue protrudes. These babies often need to have many surgical treatments when they are young, and most grow into adulthood with varying degrees of disability, including paralysis of the feet and legs and lack of control of the bowels and bladder. Mental retardation sometimes occurs, and learning disabilities are com-

mon. Anencephaly is a fatal condition in which most, or all, of a baby's brain and skull are missing. Babies with anencephaly are either stillborn or die within a very short time after birth.

What Should Be Occurring

Folic acid is a B-vitamin that is essential to human health. It is required for the body to make DNA and RNA, the blueprints for development of all cells. It is especially vital to a developing embryo because rapid cell division occurs early in fetal development. In clinical and effectiveness trials, the CDC and multicountry teams were demonstrating that consumption of 400 micrograms (μg) of folic acid prior to conception reduces the risk of NTDs by 50% to 75%.

In 1992, based on strong clinical evidence, the U.S. Public Health Service (PHS) issued the recommendation that women of childbearing age consume 400 μg of folic acid daily to prevent NTDs.

Who Is Affected, and to What Degree?

- Even with this recommendation, there were more babies born between 1992 and 1998 with preventable *spina bifida* and anencephaly than born with defects caused by the thalidomide tragedy of the late 1950s and early 1960s.

*Lary JM, Edmonds LD. Prevalence of spina bifida at birth—United States, 1983–1990: A comparison of two surveillance systems. *MMWR*. CDC Surveillance Summaries. April 19, 1996; 45(2):15–26.

- All women of reproductive age capable of becoming pregnant could be affected by a neural tube defect-affected pregnancy if they consume inadequate amounts of folic acid.
- Specific populations at higher risk for a neural tube defect-affected pregnancy are women with a previously affected pregnancy, women of low socioeconomic status, and women of Hispanic ethnicity.

What Could Happen if the Problem Is not Addressed?

The impact of having a baby with spina bifida or losing a baby born with anencephaly is profound—emotionally, spiritually, and financially. Costs for medical, developmental, and other services for children born with spina bifida are estimated to be about \$500 million annually. This does not include any costs associated with counseling or support of parents of children affected by NTDs.

1.2 What Needs to Change?

Policy

While some foods were enriched with folic acid, the level was too low for women to reach the goal of 400 µg/day of folic acid without consuming large volumes. Enrichment or fortification levels needed to be raised to provide 100% of daily need to prevent NTDs.

Environment

- More foods fortified with folic acid needed to be available to women at all income levels.
- Multivitamins containing folic acid or folic acid supplements had to be available for all women at an affordable price, including free.

Organizational Behavior

Physicians—in particular, obstetricians, gynecologists, and pediatricians—had advised women to take folic acid during pregnancy. They needed to understand, and support their patients taking the recommended quantity *prior* to conception.

Individual Behavior

- Knowledge. A 1995 survey by the National March of Dimes Birth Defects Foundation and the Gallup Organization showed awareness of the term “folic acid” at about 52%, but specific knowledge about folic acid to be very low—only 5% of the total sample knew that folic acid helps prevent birth defects, and only 2% knew that a woman should take folic acid before pregnancy in order for it to be effective.

- Vitamin-taking behavior. Studies showed that nonpregnant women under age 25 were least likely to consume a daily multivitamin, with only 19% reporting that they did. This group accounted for approximately 39% of all U.S. births.
- Other dietary behavior. Natural sources of folate, such as orange juice or green leafy vegetables, needed to be consumed in large quantities in order to reach this goal. Women were not generally able, or were often unwilling, to eat the large volumes of food needed to reach the goal.

Biological Level

The neural tube develops very early in pregnancy, about two to four weeks after conception. This is often before a woman knows she is pregnant; therefore, it is often before she can begin taking sufficient amounts of folic acid supplements to prevent NTDs. To provide adequate protection, all women who could become pregnant would need to take in 400 µg/day of folic acid.

2. What Is the Primary Intervention?

The CDC established a goal of increasing the percentage of women consuming the PHS-recommended level of folic acid from 25% to 50%.

Evidence Base

These are examples of key references supporting the primary intervention:

- Centers for Disease Control and Prevention. Use of folic acid for prevention of spina bifida and other neural tube defects—1983–1991. *Morbidity and Mortality Weekly Report* 40 (1991): 513–516.
- MRC Vitamin Study Research Group. Prevention of neural tube defects: Results of the Medical Research Council vitamin study. *Lancet* 338 (1991): 131–137.
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What Are its Advantages and Disadvantages?

- The primary advantage to the intervention is that it involves a taking a vitamin supplement or consuming a fortified food product (such as breakfast cereal) on a daily basis. This is a relatively simple behavior change on the part of one individual.
- The primary disadvantage is that women must have the increased level of folic acid in their bloodstream during the first few weeks of gestation. The vast majority of women do not know when this occurs, and therefore, would need to take the vitamin prior to conception. For at least half of the women in the United States, this is an unplanned event. They would, therefore, need to take the vitamin from the time they start having sexual relations.
- The secondary disadvantage is that the additional burden of consuming vitamins or fortified foods falls on young women who are either unaware of the need for or who cannot afford these supplements.

2.1 What Needs to Happen in Order for this Intervention to Solve the Problem?

Changes at the Individual Level

The proportion of women who believe that consuming folic acid daily can help prevent birth defects needs to increase. This requires changes in women's knowledge, attitudes, intentions, and behaviors regarding consumption of folic acid.

Changes at the Healthcare Delivery/Organizational Level

- NTD and folic acid awareness needs to become a routine and standard part of the delivery of preventive healthcare services to women.
- Healthcare providers and healthcare organizations need to be informed about the importance of folic acid and critical timing of its delivery.

Changes at the Health Policy Level

Government organizations and relevant nongovernmental organizations needed to agree on fortification levels, as well as the availability of folic acid as part of routine preventative care for women of procreational age.

Environmental Level

- The level of folic acid in fortified foods needs to be increased to provide an adequate daily dose to prevent NTDs.
- Private-sector food manufacturers needed to be made aware of the importance of adding the appropriate level of folic acid to foods.
- Finding the correct level required additional research, testing, and negotiation with government agencies.

3. Who Are the Various Audiences? How Will You Work with Them?

- Additional research is needed to define the primary audience of “women who can become pregnant” into smaller, more meaningful segments. Following this research, we will use communication to inform and persuade them as a primary intervention.
- Secondary audiences of intermediaries will be empowered to communicate with women about the issue. These include healthcare providers, community organizations, and national organizations concerned with preventing birth defects.
- Tertiary audiences will receive persuasive communications to make taking folic acid a new norm. These audiences include the mass media and college health programs and advisors.
- Information will be provided to agency authorities to facilitate decision making about fortification levels and other regulatory issues.
- Advocacy efforts will be directed to political entities to focus attention on the issue.
- Communication to inform and persuade will be directed to food manufacturers following appropriate legislative action to set levels.
- A combination of information and social marketing will be used to develop the communication interventions.

4. Who Are Your Partners?

See Box 2–6.