

MOBILIZING HEALTHY BEHAVIOUR



The control of HIV/AIDS, TB and malaria is now arguably more a political and communications challenge than a scientific or medical one. The medical and technical solutions for the major infectious diseases exist. The real challenge is to mobilize political and social capital to ensure these interventions are used widely and well.

It is not enough to have condoms at hand. It is not enough to have widespread knowledge about HIV/AIDS and how to prevent it. The knowledge has to be applied.

Only half the job is done in tackling diseases of poverty if we rest once effective health interventions are made available on a massive scale through upgraded and greatly expanded health service systems. We may bring superb health interventions to the very doorstep of those affected, but it is only with the adoption and maintenance of related healthy behaviours that will we be able to contain the ravages of the major infectious diseases.

The foundation for having people adopt healthy behaviour is knowledge, once the required health services or products are within reasonable reach. The World Bank's World Development Report 1998/1999: *Knowledge for Development*, drew particular attention to the importance of knowledge acquisition in reducing poverty. Yet 50 years of public health experience resoundingly point to the inadequacy of such an approach if it ends there. What is central to adopting healthy behaviour is the application of knowledge in the complicated context of culture, social norms, and a variety of social influences.

In reality, knowing what to do is quite different from doing it. The health field abounds with examples of how "knowledge" in itself fails to prompt desired behavioural results. Increased awareness and education about healthy behaviour have notoriously been insufficient bases for individual or family action, though they are essential steps in the process towards practising healthy behaviour. Regrettably, an informed and educated individual is not necessarily a behaviourally responsive individual. It is only with strategic, people-centred, behaviourally-focused social mobilization and communication that health interventions will move from the shelves to people's daily lives. This needs to be given the same devoted attention that the private-sector has bestowed on what it calls consumer communication.

Drugs, health centres and knowledge are not enough

The most fundamental challenge in confronting the major infectious diseases of HIV/AIDS, tuberculosis and malaria is convincing individuals, within the context of their families and communities, to adopt and maintain healthy behaviour. But this challenge is often assumed to be met once “everything else is in place”, once the “enabling environment” exists, once the health services are there and the health interventions available.

Quality health systems, trained staff and health services and products should be in place. Condoms cannot be used if these are not available; mothers cannot treat their children’s fever with antimalarial drugs if they are not within reach. Insecticide-treated nets will not be used unless they can be obtained fairly easily and at reasonable cost. What is so frustrating is the realization that superb medical or technical solutions to health problems do not sell themselves, even when readily available.

When nets are available, what could be easier than having that family sleep under a net? What is so difficult about ensuring people regularly swallow a few readily available drugs to rid themselves of TB? But the deceptive simplicity of these expected behaviours bedevils us. In the province of Sumatra, Indonesia, the Ministry of Health spent much effort and money to establish a substantial network of health clinics and subcenters with a midwife in almost every village. Yet health officials still wonder why these facilities are so underused and why traditional birth attendants continue to draw far more people than the trained and familiar village midwife.

People who know they are sick with TB and who know there are drugs to cure them do not jump at the mere availability of TB drugs. TB programmes are constantly challenged by the phenomenon of inconsistent drug consumption, even when clients are fully informed and seem to understand the need for maintaining a strict regimen.



HIV/AIDS: knowledge vs behaviour

HIV/AIDS research conducted in 1999 for the Mothusimpilo Working-Together-for-Health Project in South Africa, which focused on Khutsong, an area with a high prevalence of HIV/AIDS, showed the sharp contrast between knowledge of condom use for protection from HIV/AIDS and actual practice among women and men.

A high proportion (about 85% of men and women) understood that using condoms would protect them against the risk of contracting HIV/AIDS. Yet only 37% of men and 27% of women in Khutsong used a condom with their last casual partner.

Two key issues emerged from the research: firstly, “knowledge” is there but it is not consistent with behaviour and secondly (and this may explain the resulting behaviour), there is a lack of perceived risk. The idea that “it couldn’t happen to me” prevails. Among women about 70% said they either did not know the risk or felt there was no chance of getting infected. Among men, the percentage was 64%. Others felt they had a moderate or good chance of getting infected. Those who did want to know their HIV status were offered free testing and counselling but it was not taken up. Studies among gay communities in San Francisco have shown that only when three or more personal friends started dying around them did people realise there was a problem and that they should be taking some kind of preventive action.

In malaria-endemic parts of sub-Saharan Africa and India, the behavioural response to a possible malaria fever is more often a shrug and “ride it out” until it is too late. People have been living with these fevers for generations; so why worry now, they conclude. Stockpiles of nets are meaningless if families fail to appreciate the value of owning them and sleeping under them. Sleeping under a net is often seen as quite burdensome.

Abundant access to condoms matters little if people are unwilling to use them. In southern Africa and the Caribbean, two regions with the highest rates of HIV/AIDS infection, field reports suggest that the behaviour of being faithful to one’s partner is snappily dismissed, despite widespread familiarity with the causes of AIDS and extensive dissemination of the message “Be faithful”. In circumstances of high HIV/AIDS prevalence, where condoms are relatively easy to get and where most people understand their HIV/AIDS preventive function, the consistent use of condoms in sexual activity is no more than about 20% at best.

RESOURCES FOR MOBILIZING HEALTHY BEHAVIOUR

The control of HIV/AIDS, TB and malaria is arguably now more a political and communications challenge than a scientific or medical one. The medical and technical solutions for the major infectious diseases exist. TB can be cured by available drugs; HIV/AIDS can be prevented when communities mobilize to support behaviour change; and the malaria burden can be reduced by available drugs and the use of insecticide-treated nets. The real challenge is to mobilize political and social capital to ensure these interventions are used widely and well. Unfortunately, most of the resources required for planning and implementing behaviourally-focused social mobilization and communication programmes remain untapped. Consequently, we continue to

make only a marginal difference in addressing the behavioural challenges posed by diseases of poverty.

Political will

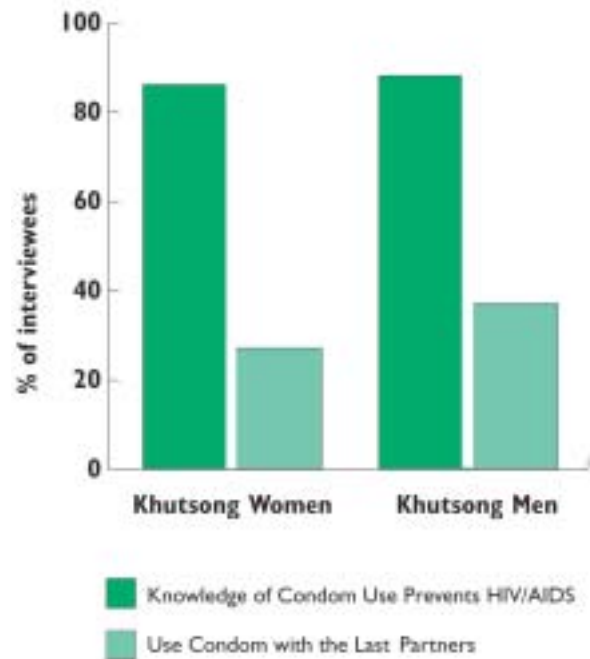
A key resource in pursuing behavioural goals in national disease prevention programmes is good, old-fashioned “political will”. It may have become a cliché of development rhetoric, but dynamic national leadership can transform moribund intent into sparkling endeavours. The late James P. Grant, former Executive Director of UNICEF, had a visionary grasp of the importance of political will and advocacy for children’s issues as became evident in the success of universal child immunization as he pressed government leaders into action-expressed commitment. When national leadership expresses a vigorous, impassioned commitment to tackling health problems and lends substantive support to field programmes, then individuals, families and communities are propelled into action.

The often-cited examples of inspired national leadership in the fight against HIV/AIDS are worth repeating. The political leadership of Brazil, Senegal and Uganda have shown how leaders can drive national movements to take concerted action against HIV/AIDS. The success of Thailand’s HIV/AIDS prevention is the result of strong political commitment supported by dedicated and coordinated government action involving many partners. Likewise, success by Nepal and Peru in controlling tuberculosis has been primarily due to high-level political support.

The evidence is clear that the control of HIV/AIDS, TB and malaria is not a politically insurmountable challenge. Governments in poor and affluent countries alike have demonstrated the capacity to stage multibillion dollar Olympic and football competitions and enact extraordinary safety measures to protect their citizens from health threats such as plague or “mad cow disease”. They also have the political capacity – if not yet the will – to turn back diseases of poverty.

Condom knowledge and people’s behaviour

(75 000 interviewees)



Source: A biomedical and social survey, Carletonville, Johannesburg, 2000



With political will comes one key essential resource: Money. There is a prevailing view among government agencies and NGOs that effective advocacy and social mobilization projects can be done on the cheap. The private-sector experience with consumer communication tells us otherwise: if it is to be done well, it is an expensive exercise. For every dollar cost of a bottle of perfume, as much as 70 cents is spent on promotional communication. In the health sector, it would be rare to find even 15 cents on the dollar spent on communication and education. Scaling up interventions to massively confront the major infectious killers will require substantially increased financial resources for behavioural social mobilization programmes. Without this, our medical and technical solutions will sit patiently in our store-rooms.

Consumer communication and marketing expertise

Paradoxically, while most politicians have an innate understanding of the importance of strategic mobilization and communication in an election campaign, the bureaucracies they eventually manage frequently lack this sensibility in meeting social development objectives. The media visibility once coveted by a politician when campaigning for office becomes feared and dreaded once the elected official is in the position of maintaining the office. Creativity – once valued in preparing political campaign advertisements – is thwarted when applied to government public service announcements that must face bureaucratic and political realities.

Currently, a large share of health promotion and communications activities is managed and designed by government offices and global, intergovernmental agencies. With so many forces encouraging staff cautiously to embrace the status quo, many government health programmes end up conducting tepid health promotion strategies designed to cause the least offense to the smallest number of people. This is most evident where health education departments become confined to producing posters, pamphlets and T-

shirts. When a senior health official asks about the status of an I.E.C. (information-education-communication) effort for prevention of a particular disease effort, he or she is usually asking “Where are the posters, the banners, the caps?” This fascination with communication materials distorts a highly disciplined process for the strategic design of programmes intended to engage people in fresh consideration of healthy behaviour and associated knowledge.

The ability to plan and use communication effectively for behavioural impact in development programmes calls for a special expertise which is not readily available in the public sector. By comparison, the private-sector has a rich tradition of marketing, promotion, consumer communication and a demonstrated track record of changing personal behaviour. For example, over the past decade, massive marketing strategies have successfully convinced Americans to pay nearly US\$ 1 a bottle for a third of the water they drink – rather than drinking it free from the tap. Certainly, the same magnitude of marketing and consumer communication resources and expertise will be required to convince 100 million Africans to spend one third of their day under an insecticide-treated net. While a net is not the same as bottled water, the process and methodology of consumer communication to promote their acquisition and use are the same in both instances.

This private-sector consumer communication resource needs to be better tapped for health programmes. Currently, however, it remains a poorly-used resource, at both global and country levels, partly because the language of consumerism is often not palatable to those in the field of social development. Yet even the poorest people in a society are consumers. Key consumer research and communication methods are increasingly used in development communication programmes. For example, focus group discussions, target audience segmentation, audience analysis, and knowledge, attitude and practice studies are now accepted as essential for understanding what communication interventions are needed and how and when to apply



them. “Social marketing” of subsidized health products has shown some impressive results in the promotion of condoms in family planning and nets for malaria. Concerted efforts are now called for to engage a large cadre of private-sector marketing and communications professionals to design and implement effective people-centred communication programmes. With this resource we are more likely to escape the “poster production” mode of hoping for behavioural impact.



Networks of people and organizations

A potent resource which is almost always available and which should be used more often in healthy behaviour efforts is that of existing people's organizations and networks. In almost every community there are organizations and structures that shape social life and conversation and that influence individual and family actions. These may be churches, mosques, temples, village councils, social clubs, civic groups, youth groups, women's groups, nongovernmental organizations, service clubs such as the Rotary and the Lions, parent-teacher organizations, trade unions and employer confederations, among others.

Women and children are often the most burdened by disease and ill-health, but have the least say in decision-making and limited access to care. Yet when women's networks are provided with the tools to help themselves, there is an immediate impact on their health and the health of their families and communities. For example, in the Tigray region of northern Ethiopia, mothers were recruited to teach other mothers how to diagnose and treat malaria at home, supported by a network of health volunteers. They effectively ensured that malaria drugs were available to treat the disease before it became life-threatening, especially in very young children.

Another powerful and underused resource is the school system, with the teachers and students who can be engaged

advocates in the home and community for recommended healthy behaviour. There are ways of tapping into this rich resource without necessarily adding a major school health education curriculum to an already overburdened system. For example, a student taking home a single-page fact sheet on malaria and insecticide-treated nets (which would have been reviewed in the classroom) can be the start of a reading and discussion exercise at home on the subject with significant behavioural consequences.

Media access

Media resources are widely available in most countries; radio is often the dominant mass medium but in more and more countries television has taken over. Government ownership of electronic media resources in many countries ought to lead to more extensive and strategic use of these media for key diseases, but usually it does not. Where they exist (as they do in many countries), community radio stations can be a potent medium for fostering local engagement in health initiatives. Their community-based management and programming operations allow for tailoring broadcasts of immediate relevance to listeners. This is also a matter of political will and dynamic national leadership; the currently available media infrastructure and resources in most countries can be used much more effectively. This calls for presenting to media managers, both in the public and private-sectors, a professionally developed and coherent media plan and involving them in a review of these plans.

Another local resource in every country is the ready availability of powerful and credible voices. When used with the mass media, these voices can put healthy behaviour on the national public agenda. There is a wealth of messengers for messages, from the articulate but little known to the celebrity with the power to draw attention and foster a supportive environment. Archbishop Desmond Tutu, for example, has been a powerful voice in promoting behaviour to prevent HIV/AIDS in South Africa, despite his pro-

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fession he spearheaded the use of the word “condom” on radio and television.

STRATEGIES

The leap into behavioural responsiveness calls for engaging people, through a deliberate process of behaviourally-focused social mobilization and communication, in reflecting on acquired knowledge in relation to personal benefits, societal norms and influences and prompting consideration of action on the basis of this engaged reflection.

We have extensive knowledge about shaping political and cultural behaviour. We have decades of modern political campaigning experience that have yielded lessons for how to most effectively promote candidates and party platforms. And we have consistent findings from similar efforts to promote social issues, both as legislative initiatives and social causes.

We also have extensive knowledge of how to encourage healthy behaviour. We have 100 years of consumer communication experience and research in the private-sector which have demonstrated what works in engaging consumers in applying knowledge for very specific consumer behaviour, in relation to products and services both sublime and awful, from toothpaste to banking to tobacco. And we have the consistent findings of more than 50 years of communication research and experience in social development, and health education and promotion.

In all instances, there is no magic bullet, no single communication intervention that will produce behavioural miracles. Always, an integrated, judicious blend of a multitude of communication actions implemented in a massive, repetitive, intense, persistent, and engaging manner does make a difference in increasing healthy behaviour among risk groups and healthy policy action among decision-makers. In the most effective health communications initiatives, efforts to



influence political behaviour work synergistically with efforts to influence personal health behaviour, as reflected in the successful family planning programmes in Colombia, Mexico and Egypt among others.

Influencing political behaviour: Creating a C.A.U.S.E. for changing society

Communication strategies for influencing political behaviour should be informed by what we have learnt from world social movements. To globalize public opinion, we need to create a C.A.U.S.E. with high profile celebrities, energizing

activities, attention surrounding unexpected scandals, memorable symbols and defining events. The C.A.U.S.E. elements attract public attention to a problem and mobilize efforts to find a solution. Above all, they put key issues on the public agenda.

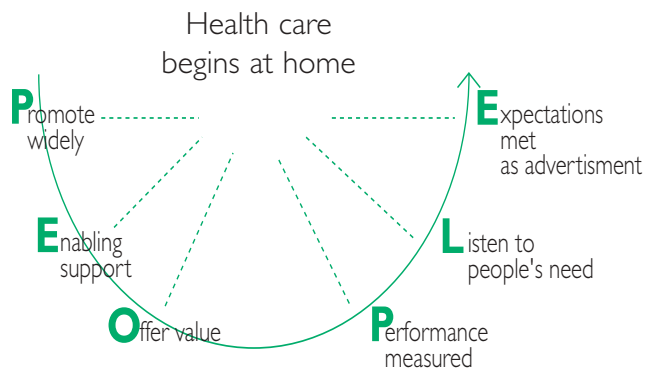
Not every social movement requires all five elements in order to succeed. For example, the visible involvement of Diana, Princess of Wales was sufficient to propel the campaign to ban land mines on to the international political agenda without, for example, the popularization of a campaign symbol. The visible advent of one or more of the C.A.U.S.E. elements makes it easier for a movement to generate other initiatives. For example, the initial success of the

Creating a C.A.U.S.E.

	Celebrity	Activity	Unexpected Story	Symbol	Event
AIDS in the United States	Ryan White Magic Johnson Rock Hudson	ACT-UP zaps	Contaminated blood supplies Reports of heterosexual transmission	Red ribbon Quilt	World AIDS Day
Civil rights in the United States	Martin Luther King Rosa Parks	Sit-ins	Medgar Evers murder	"I have a dream" Hooded klansmen	Montgomery bus boycott 1963 march on Washington Watts riots
Anti-apartheid in South Africa	Nelson Mandela Desmond Tutu	Construction of mock shanty towns Divestment campaigns	Sharpeville massacre Murder of Steve Biko	African National Congress colors	Sun City
Independence movement in India	Mahatma Gandhi	Fasting Passive resistance	Jallianwala Bagh atrocity	Spinning wheel	1930 salt march
Childhood immunization	Goodwill ambassadors Audrey Hepburn Harry Belafonte	National immunization days	Publicity by UNICEF national committees	Moni symbol in Bangladesh	Bellagio Conference World Summit for Children

Source: Reichman,B and Hershfield,E:Tuberculosis:2000

People-centred approach for enabling healthy behaviour



Band Aid concert and the song “Do They Know it’s Christmas?” in 1984 stimulated other activities to address world hunger; such as the involvement of additional celebrities and corporations in LiveAid and Hands Across America follow-up events. Effective social movements usually have a bandwagon effect, compelling an increasing number of individuals to become involved because of the apparent popularity of the cause.

The C.A.U.S.E. elements also appear in successful initiatives to mobilize a social response to other important health issues, such as reproductive health and child survival. For example UNICEF’s social mobilization initiatives in any given country have effectively involved celebrities such as the late Audrey Hepburn and Harry Belafonte to promote child survival programmes. International associations such as Rotary, Junior Chamber and Kiwanis have provided a volunteer base in developing countries to conduct special activities during national immunization days. National committees in 37 industrialized countries have supplemented UNICEF’s advocacy activities in publicizing the unexpected scandal of childhood mortality. At the country level, symbols have helped promote immunization. Political leadership has been galvanized at events such as the Bellagio Conference and the World Summit for Children.

Influencing personal/community healthy behaviour: Being P.E.O.P.L.E.-centred

The private-sector’s dedication to being consumer-focused points the strategic way to influencing personal/community health behaviour. By putting them at the centre, such programmes increase people’s control of their own health. A P.E.O.P.L.E.–centred approach to enabling healthy behaviour is characterised by 6 action components:

The first component is to **promote** extensively the recommended health behaviour and ensure that the necessary information for a proper appraisal is widely available.

Prominent voices – from celebrities and civic leaders to trusted peers – have tremendous power in influencing personal behaviour. Whether the behavioural goal is to persuade people to wear seat belts or to use condoms, the success of public health campaigns depends on the degree to which astutely-crafted messages are promoted by credible voices.

Action must be directed to **enabling** support from important social and cultural traditions and institutions. For example, women's health-seeking behaviour has a substantial benefit for children and the family. But when their voices and very presence are marginalized, both in society and in the home, opportunities to involve them in considering suggested behaviours are diminished. Conscious and deliberate communication action is required which not only purposefully seeks out women's participation, but also addresses the transformation of institutions, practices and traditions which present barriers to their participation.

A third component is to **offer value** in relation to the "cost" involved in carrying out the healthy behaviour. People need to see that it is "worth the effort" to accept a suggested behaviour; that there is value in making the behaviour part of their lives. Every behaviour adopted is based on this personal calculation of "cost" versus value. And for some the value offered is enhanced when an incentive is also part of the offer. This may take the form of promoting an offer of food for those who must incur the significant "cost" of time to come for tuberculosis treatment (as was done in Peru).

The fourth is to have a rigorous measure of **performance** to track the behavioural impact of social mobilization and communication activities. Without this it will not be possible to determine whether the behavioural results that are being sought are achieved.

The fifth is to **listen** to people (by way of research and personal and community engagement) so that a sensitive understanding of their concerns, preferences, needs,



desires, attitudes and behaviour informs the interactions with them. The world of consumer communication is full of case studies of market failures due to not listening to the consumer and not responding to their concerns and preferences.

The sixth is to ensure that **expectations** are met in the practice of a recommended healthy behaviour; that the promised value offered in relation to cost is delivered and to reiterate it in a reconfirmation of the merits of the behaviour adopted. This is an important part of the process of maintaining adopted behaviour:



The COMBI approach

In exploring a way to integrate the communication lessons of the past as reflected in the C.A.U.S.E. and P.E.O.P.L.E.-centred approaches. WHO has been applying a concept called “COMBI” (communication for behavioural impact) in the design and implementation of behaviourally-focused social mobilization and communication programmes. Recently this has been used for the elimination of leprosy in India and Mozambique, the prevention of lymphatic filariasis in India and the United Republic of Tanzania, and dengue prevention and control in Malaysia. It is an approach which may be well suited for achieving behavioural impact in confronting HIV/AIDS, tuberculosis and malaria. COMBI interprets social mobilization as the process which judiciously and strategically blends a variety of communication interventions intended to “mobilize” the societal and personal influences which prompt an individual to adopt and maintain a particular behaviour.

COMBI, drawing on consumer communication experience, begins with the “people” (clients, patients, beneficiaries, consumers) and their health needs, wants, desires, and a sharp focus on the behavioural result expected in relation to these needs, wants, desires. The “market/community” is intimately involved from the outset through practical, participatory community research and situation

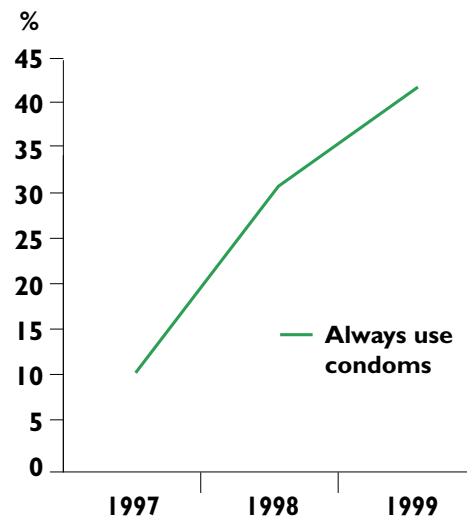
analysis relating desired behaviour to expressed or perceived needs/wants/desires. This situational analysis also involves listening to people and learning about their perceptions and grasp of the offered behaviour; the factors which would constrain or facilitate adoption of the behaviour; their sense of the costs (time, effort, money) in relation to the perceived value of the behaviour to their lives. People are then engaged in a review and analysis of the suggested healthy behaviour through a judicious blend of integrated communication actions in a variety of settings, appropriate to the “market” circumstances and based on community research, recognizing that there is no single magic intervention. The blend of communication actions include advocacy and public relations, administrative and community mobilization, sustained appropriate advertising, interpersonal communication/counselling and point-of-service promotion. The 2001 Malaysia Dengue communication programmes in Johar Bharu was an impressive example of COMBI in full action. Preliminary results show an 87% behavioural response to the public message of “Check your home every Sunday for mosquito breeding sites”.

MODELS

Behavioural impact is achievable when strategically planned social mobilization and communication programmes are properly executed. In the public sector world of healthy behaviour, there are not many examples to draw on, primarily because not many behaviourally-focused social mobilization and communication programmes have been implemented in a substantial way. In the private-sector consumer world, however, there are thousands of success stories that can serve as models. In the field of dental hygiene, the massive marketing communication efforts of toothpaste manufacturers have made brushing one's teeth a daily habit for most people almost everywhere. AVON sells vast quantities of its cosmetic products in the Amazon region of Brazil,

The value of healthy behaviour campaigns

Use of condoms among brothel-based sex workers in Cambodia following “100% condom use” campaign



more so than in Sao Paulo, through its door-to-door selling approach.

Cause-related marketing in affluent countries

There are numerous examples of the business community lending both financial and promotional support to social development causes. This practice has become increasingly popular, both to the advantage of the corporations and the social cause they support. Cause-related marketing (CRM) is a strategic positioning and marketing tool which links a company or brand to a relevant social cause or issue, for mutual benefit. For the company it is a way of enhancing their image, gaining loyalty and increasing sales. For the social cause or issue it is a way of raising public awareness and prompting action to support the particular issue.



American Express and Share Our Strength (SOS), a non-profit organization tackling the problem of hunger in the United States, formed a strategic alliance and created one of the best known and most successful CRM campaigns in that country – Charge Against Hunger. It raised about US\$ 5 million per year and helped put the issue of hunger in the United States higher on the public agenda. American Express' human and financial resources were mobilized as employees volunteered to organize events, staff soup-kitchens and coordinate food drives. Celebrities such as Stevie Wonder and Hillary Clinton took part in musical roadshows and events across the country.

In Italy, Proctor & Gamble joined with the charity Action-Aid to raise money to help supply clean water to Dalocha in Ethiopia. The campaign raised US\$ 1.8 million at the same time as improving the brand image of one of their products – Dash washing powder. The centrepiece was an in-pack promotion leaflet, cassette or CD depending on the product packaging, asking customers to donate money. The cassette and CD had songs contributed by Italian pop stars. The programme filmed ACTIONAID activities in the

field and used some of the footage in TV adverts. The campaign was also promoted on popular prime-time TV programmes using a well-known personality. In fact, even viewers who did not buy the product still donated to the campaign.

An example of a long-term and cost-effective partnership is the alliance between UNICEF and British Airways in the “Change for Good” initiative. The programme is promoted on in-flight videos, using images of children and cards, asking passengers to donate any loose change from their trips that they no longer need in small envelopes provided on the back of the seats. So far, it has raised US\$ 7 million for UNICEF’s activities.

These examples are part of an emerging enthusiasm for corporate linkage to social causes. We must now channel this enthusiasm towards behavioural goals in health. The business sector can be of immense value as we tackle the major infectious diseases. Here too there is a need for organized engagement of the private-sector with the presentation to business leaders of an effectively structured “case for support” and creative ideas for how they can help. This is more than asking for a financial contribution; it is asking business to commit to a long-term collaboration with a disease effort. One, of course, has to be mindful of the need for transparency, accountability and avoidance of conflict of interest in such joint enterprises.



People’s networks in South Africa, Thailand and Indonesia

There are hundreds of examples of health programmes mobilizing “people networks” resulting in dramatic behavioural impact. Many polio immunization and leprosy elimination programmes have been successful as a result of the involvement of people’s networks.



A strong community network became the key to the success of DOTS for TB control in Sanderton, South Africa. It began with a group of women who came together, recognized that there was a problem, and began working to tackle it as a group. The mainstay of the initiative is the 75 volunteer “treatment supporters” who have been trained since the programme started in 1996. A central map with little flags marks the location of patients currently being treated and is a visual reminder that once patients begin treatment they are followed through until completion of the entire regimen. When the programme began only 4% of patients were covered but now it includes virtually 100% of TB patients in the district and the documented cure rate among the initial group of patients is well over 80%. These volunteers now also carry out general health promotion including the distribution of condoms to protect against HIV and sexually transmitted infections.

Thailand used the existing infrastructure of village committees at the district and subdistrict levels to plan and implement leprosy elimination work. These committees of local people – called the tambon council – were supported by a working group of government officers from four key ministries. Health communicators were trained to deal with common health problems and recognize when to refer people for more specialized treatment. Leprosy was successfully added to the list of health problems to be addressed.

The Dokter Kecil programme in Indonesia is an example of how children can be motivators and promoters of better health in their families and communities. Children are selected to work as “little doctors” and are given about 20 hours of training in class. Their responsibilities include setting a good example by following a healthy lifestyle, active participation in environmental health, and communicating messages on diarrhoea, immunization and nutrition. The programme started as a pilot project 10 years ago and is now used throughout the country.

Immunization in Bangladesh

Many innovative and effective social mobilization campaigns have been conducted in Bangladesh. The following account is of a major child immunization communications programme which UNICEF and the Government of Bangladesh embarked upon in 1986. The result of this initiative was that by 1991, roughly 65% of children in the target age group were fully immunized.

One of the first elements of the communication programme was the search for a symbol which people would recognize easily. The Moni symbol was designed. Moni is a term of endearment for children of both sexes and a character was drawn to suit the term. Six arrows, representing the six vaccine-preventable diseases and a ring for protection were added. Moni became one of the most successful elements in communication of the Expanded Programme on Immunization (EPI). It was placed just about everywhere to raise awareness and prompt behavioural responses.

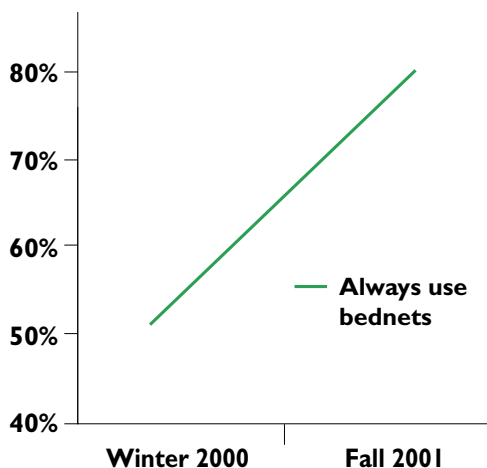
Print and electronic media were used extensively. National immunization weeks received massive press coverage and the Government provided three minutes per day of prime commercial time on radio and television. The Government also fostered intra- and interministerial collaboration of an unprecedented kind. Celebrities from Audrey Hepburn to Bangladeshi movie and television stars to popular cricket and soccer players lent their voices of support for EPI.

But what was truly remarkable was the extensive community mobilization and active support of an enormous number of partnering groups from local civic groups, to the Rotarians, CARE, Boy Scouts, Girl Guides, other social clubs, a variety of NGOs such as BRAC and World Vision, among others. And it was in these community actions that the many varied opportunities for “engaged communication” with families allowed for discussion of the merits of immunization, and where people’s fears and concerns were discussed.



The value of healthy behaviour campaigns

Use of bednets in Blantyre district, Malawi following BITNET campaign



Source: PSI, Malawi 2001

Local initiatives blossomed and played a major role. Boat sails, elephants, buses, rickshaws and many more vehicles and partners carried EPI banners. Vaccinators were supported in their interpersonal interactions with flip charts and flash cards, and EPI bookmarks for students. Village theatre and folk poets promoted EPI.

The private-sector joined with superb cause-related marketing actions. Dhaka Match Industries put the Moni logo on the back of 20 million matchboxes sold every month. This was followed by half a dozen other companies joining in support, linking the EPI logo to their products and services.

Social marketing in Malawi and the United Republic of Tanzania

Social marketing (distribution, promotion and sale) of subsidised insecticide-treated nets (ITNs) in selected districts of Malawi and the United Republic of Tanzania has demonstrated that even the poor (earning less than US\$ 1 per day) will bear the cost (US\$ 4) of the purchase of a net if they are effectively engaged in a fair appraisal of this healthy behaviour. In the United Republic of Tanzania project the number of infants by district with insecticide-treated net rose from less than 10% in 1997 to more than 50% 3 years later. In Malawi, the percentage of houses with at least one net increased from 14% to 30% in urban areas and from 5% to 17% in rural areas within 9 months of the launch of the marketing effort. In both cases, extensive and intensive marketing communication based on market research and using a mix of traditional media, persistent mass media advertising, point-of-sale promotion, wall paintings, vigorous brand promotion, incentives to sellers, radio dramas, among other communication interventions, all played a vital role in engaging consumers in this healthy behaviour.

Sometimes personal selling or peer counselling alone can be the best way to achieve behavioural impact. In the private-sector, there are numerous products sold purely by

personal, door-to-door sales (e.g. Amway, Avon Cosmetics, Herbalife, Tupperware). A 1996 study in Bangladesh highlighted how home-based visits by community-based peer counsellors can transform breastfeeding behaviour. Prevalence of exclusive breastfeeding at 5 months reached 70% in the intervention group using community-based peer counsellors compared to 6% in the control group where there was no home-based counselling.

Massive programmes for engaging millions in a fair and full appraisal of healthy behaviours will cost millions. If we recognize that this is an enterprise which goes far beyond poster production there has to be a major global and national commitment to funding these initiatives in a far more substantial way than has ever been done.

Each of the major global infectious diseases have their own proven bio-medical tools to combat the diseases; and considerable social capital exists for behaviourally-focused mobilization. What is needed is commitment to a strategic model which blends the body of existing knowledge based on research and good practices from both private and public sectors into powerful, dynamic vehicles for social change and precise behavioural impact.

