Module 1 Unit 3

This is a **REQUIRED READING: PLANNING MODELS**

World Health Organization (2003). Mobilizing for Action:
Communication for Behavioural Impact. [4 p.]

World Health Organization
Mediterranean Centre for
Vulnerability Reduction (WMC)

Mobilizing for Action

Communication-for-Behavioural-Impact (COMBI)

Background

Communicable diseases account for a growing number of health burdens on families, communities and governments in the developing world. Together, HIV/AIDS, TB and malaria claimed 5.6 million lives in 2001. “Neglected” diseases such as lymphatic filariasis and leprosy that do not kill, also silently bleed the health and wealth of a nation causing high levels of suffering, disability and economic deprivation.

Effective prevention and treatment strategies have long been available for controlling these diseases. Yet this is only part of the equation. Along with improving health service provision and access, a continuing dilemma for health professionals has been finding effective ways to encourage the adoption of healthy behaviours at individual, household and community level.

Many different approaches have been useful in the past, ranging from health education (Information, Education and Communication) to development support communication for social mobilization. While there have been some successes, there has also been enormous frustration at not being able to achieve more at a faster rate. Public health programmes, as a consequence, struggle along - with modest behavioural impact.

Recently, WHO has begun applying an approach known as COMBI in the design and implementation of behaviourally-focused social mobilization and communication programmes for the elimination of leprosy in India and Mozambique, the prevention of lymphatic filariasis in India and Zanzibar, TB prevention and control in Bangladesh and Kenya, dengue prevention and control in Malaysia and malaria prevention and control in Afghanistan and Sudan. It is an approach well suited for achieving behavioural impact in the prevention, control and elimination of communicable diseases.

This document provides an introductory explanation of the COMBI approach and answers eight basic questions: What is COMBI? Why do we need COMBI? What are the key steps in designing a COMBI Plan? How different is COMBI from Health Education and Promotion? How can one tell if COMBI works? Is COMBI a good investment? Where has it been applied? How can one find out more?

What is Communication-for-Behavioural-Impact?

COMBI is social mobilization with a behavioural bite

COMBI is social mobilization directed at the task of mobilizing all societal and personal influences on an individual and family to prompt individual and family action. It is a process which blends strategically a variety of communication interventions intended to engage individuals and families in considering recommended healthy behaviours and to encourage the adoption and maintenance of those behaviours. COMBI incorporates the many lessons of the past 50 years of health education and communication in a behaviourally-focused, people-centered strategy. COMBI also draws substantially from the experience of the private sector in consumer communication.

Its methodology effectively integrates health education, information-education-communication (IEC), community mobilization, consumer communication techniques and market research, all directed sharply and smartly to specific, precise behavioural outcomes in health.

It recognizes that in health the ultimate goal is behavioural impact: someone doing something.

It stresses: we need information; we need education; we need persuasion; we need community involvement; we need an aroused society; we need a committed government; and we also need a consumer sensibility which focuses on consumer decision-making and behaviour, applied to healthy behaviours.

COMBI begins with the “people” (clients, beneficiaries, consumers – family members) and their health needs (or wants, or desires) and a precise focus on the behavioural result expected in relation to these needs, wants, desires. A COMBI mantra is: Do nothing – produce no T-shirts, no posters, no pamphlets, until one has a precise fix on the behavioural outcome desired.

COMBI is rooted in people’s knowledge, understanding and perception of the recommended health behaviour. The “market/community” is intimately involved from the outset through practical, participatory community research and situational analysis relating desired behaviours to expressed or perceived needs/wants/desires. This situational analysis 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 their perception of value of the behaviour to their lives.

People then participate in a reflection and analysis of the suggested healthy behaviour through a strategic blend of five integrated communication action areas in a variety of settings, appropriate to the “market” circumstances recognising that there is no single magical communication intervention.

The five integrated communication action areas

1. Public Relations/Advocacy/ Administrative Mobilization, for putting the particular healthy behaviour on the public and administrative/programme management agenda via the mass media: news coverage, talk shows, soap operas, celebrity spokespersons, discussion programmes; meetings/discussions with various categories of government and community leadership, service providers, administrators; official memoranda; partnership meetings.

2. Community Mobilization, including use of participatory research, community group meetings, partnership meetings, traditional media, music, song and dance, road shows, community drama, leaflets, posters, pamphlets, videos, home visits.

3. Sustained Appropriate Advertising, (in M-RIP fashion – Massive, Repetitive, Intense, Persistent), via radio, television, newspapers and other available media, engaging people in reviewing the merits of the recommended behaviour vis-à-vis the "cost" of carrying it out.

4. Personal Selling/Interpersonal Communication/Counseling, at the community level, in homes and particularly at service points, with appropriate informational literature and additional incentives, and allowing for careful listening to people's concerns and addressing them.

5. Point-of-Service Promotion, emphasising easily accessible and readily available solutions to health problems.

The key in planning COMBI programmes is to strive for an integrated approach with a judicious blending and selection of communication actions appropriate to the behavioural outcome desired, and not to believe that one single kind of communication intervention is all-powerful.

Why do we need COMBI?

The most fundamental challenge in confronting the major infectious diseases is this: having individuals (within the context of families and communities) adopt and maintain healthy behaviours. This is ultimately the end goal of our efforts against infectious diseases. This behavioural imperative hovers over all plans to scale-up the attack on communicable diseases and other diseases which keep the poor in poverty. But this challenge is often presumed to be met once "everything else is in place", once the health services are there and the health interventions are available. When multi-drug therapy (MDT) is readily and freely available, what could be easier than having someone with leprosy skin lesions come in to a clinic for free MDT? What is so difficult about regular swallowing of a few readily available, free drugs to rid oneself of TB?

But the deceptive simplicity of these expected behaviours plagues us. We do need to have quality health systems, trained staff, and health services and products in place. Many health behaviours are critically dependent on service and product availability. Yet, superb medical-technical solutions to health problems do not sell themselves, even when readily available. Fifty years of public health experience offer one example after the other of this problem. Whatever the healthy behaviours, they are elusive.

Knowing what to do is different from doing it

The foundation for having people adopt healthy behaviours is knowledge, once the behaviour and associated health services or products are within reasonable reach. An awareness/educational sensibility has so far informed strategies directed at achieving behavioural results in health.

Increased awareness and education about healthy behaviours have been notoriously insufficient bases for individual or family action, though they are essential steps in the process towards healthy behaviour practice. Regrettably, an informed and educated individual is not necessarily a behaviourally responsive individual. The health field abounds with examples of how "knowledge" in itself fails to prompt desired behavioural results. The almost banal theme needs repeating: Knowing what to do is different from doing it.

The leap into behavioural responsiveness requires the application of knowledge. It 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. This is the key mission as we aim for the practice of healthy behaviours in controlling and preventing major infectious diseases.

The strategic planning and execution of social mobilization and communication programmes for healthy behaviours begins with the fundamentals: One cannot act on a suggested healthy behaviour if one is not aware of and knowledgeable about it, and if one is not engaged in a full and fair appraisal of its merits in relation to the cost and effort involved in putting it into practice. This is the essence of "applying knowledge": engaged communication, based on knowledge, in order to assess recommended actions. Strategies for achieving behavioural impact will need to offer people frequent opportunities for engaging in a deliberate review of suggested behaviours, weighing their value in relation to the "burden" of carrying them out.

This kind of engaged communication is clearly more than a matter of audio-visual materials production. It is more than having posters, pamphlets and T-shirts. It is about empowering people, families and communities to have greater control over their lives and health. It calls for strategically designed, massive education, social mobilization and communication programmes, with a consumer communication sensibility, engaging people at all levels of the society through a wide array of media and in a variety of settings (in their homes, in clinics, at work, in church, in civic groups, in school, at community events).

But these communication programmes will need to go one step beyond the fair appraisal of healthy behaviours. Despite people's conviction about a course of action, they often need prompts and triggers which move them forward to adopting and maintaining healthy behaviours. All of us often need a trivial incentive to do the right thing. The opportunity to win a prize has prompted many to immunise their children in some polio campaigns.

Communication programmes for behavioural impact will need to engage individuals in examining recommended behaviours and to offer the incentives and tugs to action. In so many countries it is not unusual to have health service points with absolutely no promotional signs indicating what services are available. In many of these same countries, every little outlet for carbonated sugared water will prominently post massive signs.

If we are to have a more profound impact on controlling, preventing and eliminating communicable diseases, we need strategically planned, behaviourally focused social mobilization and communication efforts.

This is what COMBI offers.

THE KEY STEPS IN DESIGNING A COMBI PLAN

WMC's technical staff and consultants trained in COMBI planning apply a process in developing a COMBI plan. The building blocks of a COMBI plan are outlined below. It assumes a prior understanding of a few basic communication and marketing principles.

What are the key steps in designing a COMBI plan?

Identifying the behavioural objectives

1. The overall goal: a statement of the overall programme goal that COMBI will help achieve. For example... To contribute to the elimination of Lymphatic Filariasis in [location] by the year 2020.

2. The behavioural objective/s: a statement of specific, measurable, appropriate and timebound behavioural objectives. For example... To prompt approximately 800,000 individuals (i.e. everyone other than pregnant women, new mothers of infants under a week old and children under 5 years of age) in [location] to accept the hand-delivered set of LF prevention pills (maximum 4) and to swallow these pills in the presence of a health worker/volunteer on October 27th, 2001.

3. The situational market analysis vis-à-vis the precise behavioural goal: a "consumer oriented" exploration of the factors influencing the attainment of the behavioural objectives that will inform the strategy and the communication mix.

The first mantra:

Do nothing- produce no T-shirts, no posters, no leaflets until you have a clear specific behavioural goal

The situational market analysis

COMBI uses state-of-the-art participatory research techniques adapted from marketing, communications, anthropology, and sociology to identify behavioural issues amenable to communication solutions.

The situational market analysis involves listening to people and learning about their perceptions and grasp of the offered behaviour(s) through tools such as TOMA (Top of the Mind Analysis), and DILO (Day in the Life Of). Their sense of the costs (time, effort, money) in relation to their perception of value of the behaviour to their lives is explored through a Cost vs Value calculation.

Other tools such as the Force Field Analysis helps community members, field staff, local experts, and the COMBI specialist to analyse the social, political, ecological, moral, legal, and cultural factors that could constrain or facilitate adoption of the behaviour.

The situational market analysis also examines where and from whom people seek information and advice on the particular health problem and why they use these information sources. The concept of positioning (used extensively in the advertising world), also helps the development of appropriate messages and communication approaches. Areas that require further investigation are also highlighted.

Finally, issues not substantially amenable to communication solutions, such as the ready availability of services, are documented so that appropriate organizational change or political action can be taken.

The communication strategy and mix

4. The overall strategy for achieving the stated behavioural result: a description of the general communication approach and actions which need to be taken to achieve the behavioural results in light of #3 above and the communication issues identified and presented as follows:
(a) Re-state Behavioural Objective.
(b) Set out "Communication Objectives" which will need to be achieved in order to achieve behavioural result(s).
(c) Outline Communication Strategy: a broad outline of the proposed communication actions for achieving communication and behavioural results in terms of the five communication actions listed in #5.

5. The COMBI Plan of Action: a description of the integrated communication actions to be undertaken with specific communication details in relation (but not exclusive) to:

Public Relations/Public Advocacy/Administrative Mobilisation
Community Mobilisation
Personal Selling (Interpersonal Communication)
Advertising
Point-of-Service Promotion

The second mantra:

Do nothing until an appropriate situational market analysis is carried out in relation to the expected behavioural outcomes

Implementation, monitoring and evaluation, budgeting

6. Management and implementation of COMBI: a description of how COMBI will be managed specifying the multidisciplinary planning team, including specific staff or collaborating agencies (e.g., local advertising firms and research institutions), designated to coordinate communication actions and other activities such as monitoring. Also included are any technical advisory groups or government body from which the management team receives technical support or to whom it should report.

7. Monitoring implementation: a description of the process indicators to be used in tracking the reach and effect of the communication actions, including a description of how monitoring data will be gathered, shared and used.

8. Assessment of behavioural impact: details of the behavioural indicators to be used, methods for data collection, analysis and reporting.

9. Calendar/Time-line/Implementation Plan: a detailed workplan with time schedule for the preparation and implementation activities required to execute each communication action as described in #5.

10. The budget: A detailed listing of costs for the various activities described in #5, 6, 7 and 8.

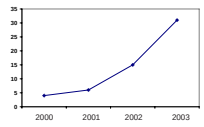
For further information see the section on 'How can one find out more?'

Is this different from Health Education and Promotion?

Yes and no. COMBI integrates principles and techniques of health education and promotion. While health education and promotion may be dedicated to behavioural outcomes stated implicitly, COMBI focuses on and is informed by behavioural outcomes that are made explicit. While health education and promotion emerges from an "educational" sensibility, COMBI springs from a consumer communication sensibility, recognising that behavioural results call for an educational and information base coupled with a marketing orientation. COMBI also begins with the underlying principle that nothing is to be assumed. Instead, the real barriers and constraints that prevent people from choosing to adopt healthy behaviours are discovered.

Where is COMBI being applied?

COMBI planning is taking place in over 30 countries



Health Programme	Countries where COMBI Planning and Implementation are taking place
Dengue	**Belize** (planning), **Brazil** (planning), **Cambodia** (pre-implementation), **Costa Rica** (pre-implementation), **Cuba** (planning), **Dominican Republic** (pre-implementation), **El Salvador** (planning), **Guatemala** (implementing), **Honduras** (planning), **Indonesia** (pre-implementation) **Lao People's Democratic Republic** (implementing), **Malaysia** (implemented 2001), **Myanmar** (pre-implementation), **Nicaragua** (implementing), **Panama** (planning), **Philippines** (planning), **Thailand** (planning)
HIV/AIDS	**Moldova** (planning), **Sudan** (planning), **Ukraine** (planning)
Leprosy	**India** (implemented 2002), **Mozambique** (implementing)
Lymphatic Filariasis	**India** (implemented 2002,2003), **Kenya** (implemented 2002, 2003) **Myanmar** (planning), **Nepal** (implemented 2003), **Philippines** (implemented 2003), **Sri Lanka** (2002, 2003), **Tanzania** (planning), **Uganda** (planning), **Zanzibar** (implemented 2001, 2002, 2003)
Malaria	**Afghanistan** (pre-implementation), **Ghana** (pre-planning), **Sudan** (pre-implementation)
TB	**Bangladesh** (planning), **India** (implementation), **Kenya** (implementation)

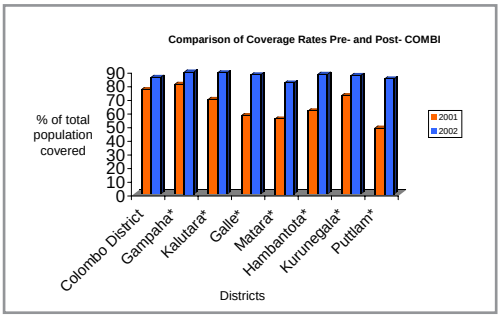
How can one tell if COMBI works?

COMBI's impact is defined by the behavioural results specified from the very outset. Once these have been established, the social science research methods of tracking surveys, sample surveys, field observation and in-depth interviewing allow for measuring the achievement of specific behavioural results. The essential pre-requisite, however, for measuring impact is having clear behavioural outcomes as programme goals.

In Johor Bahru, Malaysia, a three-month COMBI Programme resulted in 85% of households in sampled areas carrying out the desired behavioural task over a 12-week period. Three months later, 70% were still maintaining the checks.

In the state of Bihar, India, COMBI contributed to early case detection of leprosy by improving the number of people self-reporting with skin lesions. The proportion of skin cases attending clinics rose by 69% with the number of female skin cases rising by 73%.

COMBI has also supported over 40 million people to participate in Mass Drug Administrations, motivating over 75% of entire populations to prevent lymphatic filariasis in 6 COMBI-supported countries. Sri Lanka and Kenya both attained over 80% of the total populations, meaning that over 90% of those eligible for treatment had complied.



Is COMBI a good investment?

Beyond delivering behavioural results, COMBI's investment value lies in the following: social mobilization will be more strategically targeted from the outset; existing resources will be better utilised; the true constraints and problems affecting behavioural outcomes will be pinpointed; relevant experts will be used much more appropriately; monitoring and evaluation will be more focused and there will be greater understanding and co-operation on the social mobilization outcomes between partners.

COMBI draws in diverse individuals and groups from communication specialists, researchers, volunteers, and businesses to name just a few, thereby, encouraging public-private sector partnerships and invigorating existing health programmes. Local branches of pharmaceutical companies such as GlaxoSmithKline and global advertising agencies such as Grant McCann Erickson (Sri Lanka), Ogilvy & Mather (India) and Saatchi & Saatchi (Kenya) have all been strong partners in many national programmes. COMBI certainly gives value for money and more. At the global level, individual philanthropists are supporting COMBI precisely because, above all, it delivers the expected behavioural outcomes.

How can one find out more?

For more information on how COMBI may be applied to behavioural goals in confronting communicable diseases, please contact:

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