Policy Briefing

Coming of age: communication's role in powering global health

Caroline Sugg

Sign up for our newsletter: www.bbcmediaaction.org

Contents

Front cover
To encourage their fellow villagers to improve sanitation, these men organised a procession featuring this model toilet mounted on a tricycle. The image forms part of a storytelling project that showcases efforts to improve sanitation across India
BBC MEDIA ACTION

Executive summary

HIV. Ebola. Polio. These figure among the major public health challenges faced in the last half century in low- and middle-income countries. The most effective responses to these diseases have been fiercely debated, yet the role of communication is rarely at the centre of this debate.

This is surprising. Never before has communication offered such potential to accelerate progress towards a healthier world. Even in the poorest parts of the globe, technology is enabling "always on", networked communication, and fast flows of information. More people own radios, televisions and phones than ever before and media channels are proliferating. At the same time, people working with communication to improve health have access to unprecedented evidence about the approaches that are most effective.

Through a careful review of the evidence, this paper illuminates how communication has been a consistent current running through many major health developments of recent years. Whether by influencing individual behaviour, galvanising community action, shaping social expectations or informing the way in which health services are provided, communication has been at the heart of public health. It has the potential both to mitigate health crises and to exacerbate them.

This critical interplay between human health and communication has now been recognised in assorted global and national health policies on paper. However, when it comes to funding allocation and the ways in which health programmes are implemented on the ground, clear deficits can be seen. Too often, health communication is poorly funded, under-utilised and badly planned, bolted on to programmes as an apparent afterthought. This needs to change if progress towards a healthier world is to be accelerated.

In addition to the limited funding for well-planned health communication efforts, programmes have not consistently integrated lessons learned from past practice. Successful health communication programmes have shown the importance of underpinning interventions with sound behavioural analysis, rooted in socio-ecological understanding of change and new insights from behavioural science. They have also shown the need to move beyond the idea of health communication as top-down "messaging" to something that encompasses dialogue and respects the opinions of those most affected by particular health challenges. Too often, however, these key ingredients are missing.

There are many reasons why the global public health community has not fully seized the power of communication. These include the complexity of many of the issues being tackled by social and behaviour change communication (SBCC, see page 10 for a definition), debates around "what counts" as evidence, and the need for more effective learning and capacity strengthening in health communication.

Certain agencies and organisations are taking important actions to overcome these obstacles, but more needs to be done if communication's potential to help to achieve – as well as to undermine – global health goals is to be properly addressed and absorbed into development thinking. This briefing concludes with a series of recommendations for policy-makers, donors, health communication practitioners and academic institutions committed to better health and wellbeing for all.

ver si la comunicación para la salud ayuda a la salud global

Right A member
of BBC Media Action
staff in Sierra Leone
at work on the weekly
radio show *Fo Rod*
(Crossroads), which
helped people in
the country question
their leaders about
the response to Ebola

INFINITE PRODUCTIONS

Introduction

The 21st century has already witnessed huge strides in public health. More children are surviving to see their fifth birthday, the number of people dying from Aids each year has fallen and polio now seems on the verge of eradication.

Yet major challenges remain. There are still around 2 million new cases of HIV each year and changing lifestyles are driving a surge in heart disease, cancers and diabetes. Resistance to important drugs is growing and outbreaks of communicable diseases threaten our ever-more connected communities.

Many of these issues are targeted in Goal 3 of the new 2030 Agenda for Sustainable Development, which aims to ensure healthy lives and wellbeing for all.[1] Less clear is how progress towards this goal will be achieved. This paper argues that, alongside the obvious improvements needed in health services, drugs and technologies, well-planned and ambitious communication strategies will also play a critical role.

Health knowledge, attitudes, norms, behaviours and policies are all influenced by communication: the information we have, how we talk to each other, how leaders and health providers hear and respond to our needs and what is perceived as acceptable in our societies. And in a world of rapidly expanding access to communication devices, channels and online networks, our ability to communicate with one another is easier than ever before.

And yet, despite the demonstrated promise – and ubiquity – of communication as a tool for improving public health, not enough has been done to date to capitalise upon its potential, particularly in the poorest parts of the world.

This paper offers a spirited case for why donors, practitioners and developing country governments alike need to pay more attention to the role of media and communication in tackling global health. It does not claim to offer a scientific review of the entire corpus of evidence on health communication. Instead, drawing on an extensive review of the literature – as well as input from public health and health communication experts – it explains why communication has been relatively neglected within the field of public health, why this matters and how to rectify that problem.

The cost of underestimating the contribution of communication to health has never been higher. If public health were an engine, clinical services and health commodities would be critical components of that engine. But communication would be the oil that puts the engine's parts in motion. Without this oil, improvements in public health risk grinding to a halt.

The paper is organised as follows:

Part 1 shows how communication successes and failures have been part of the trajectory of major public health developments over the last 30 years and influenced health outcomes around the world.

Part 2 explores the extent to which social and behaviour change communication (SBCC) has been adopted as a priority in public health policy and programming.

Part 3 asks whether lessons learned about what elements make successful health communication approaches are being consistently applied in practice.

Part 4 examines the reasons for the ongoing under-prioritisation of health communication and identifies promising attempts to bring it more firmly into the heart of public health practice.

Part 5 suggests ways in which those working to accelerate progress towards better public health can maximise the potential of evidence-based health communication.

PART I

The case for health communication: examining the evidence

Some of the major public health successes and challenges of recent decades have been shaped by communication. Again and again, it is evident that health is influenced by the information people have, how they talk to one other, how communication shapes social norms and behaviour, and how people are able to advocate for the services they need.[2] The evidence presented here makes the case that communication – from interpersonal communication to work with mass media and new communication technologies – will be central to accelerating progress towards a healthier world.

Case studies in public health: the communication dimension

Ebola: communication and epidemic control

Communication and information were critical dimensions of the Ebola epidemic that enveloped Sierra Leone and the neighbouring countries of Guinea and Liberia in 2014. Here, the focus is on the case of Sierra Leone, where rumour and confused communication initially compounded the terrifying impact of that disease.

A report by the humanitarian organisation ACAPS notes how early messages communicated by the international community and the government, designed to change the way people behaved in response to the outbreak, were often inconsistent and counterproductive.[3] People with Ebola-like symptoms were asked to isolate themselves from their households when they had nowhere else to go, attend treatment centres that did not always exist, or call helplines that often did not function properly.[4] As journalist Mustapha Dumbuya recalls, "In just a matter of weeks, 16 of our family had died. I couldn't shake off the feeling that people were dying of ignorance. People had heard of Ebola but the information they were getting was conflicting. They just didn't know who to trust."[5]

Other messages ignored very human care-giving instincts and the power of long-held cultural practices such as washing, touching and kissing the dead body as part of a traditional burial. Simply instructing people what not to do pushed risky behaviour underground, where these cultural practices continued, hidden from the public gaze. This failure to grasp local customs was compounded by misconceptions spread through local media, which, in some places, relayed the population's belief that Ebola was caused by witchcraft, a hoax from the government or the result of a conspiracy by international organisations.

"Even enlightened, educated people were talking about witchcraft, saying my family was cursed," notes Dumbuya.[6]

By the end of 2014, however, public attitudes towards Ebola in Sierra Leone had shifted radically. People understood how important it was to change burial practices and to take sick relatives to treatment centres. People were taking the painful steps needed to protect themselves and their families. It is clear that the trajectory of Ebola began to change when a number of nationwide communication interventions were launched to inform and empower the public. Kathy Hageman, of the US Centers for Disease Control and Prevention, argues, "communication was the crux of the response to Ebola".[7]

What did this mean, in practical terms? First, it meant that community mobilisers, armed with insights from ethnographic research, went out to listen to and help affected communities take action against the disease. These individuals tried to allay people's fears directly. They spoke about what happened at treatment centres and explained why ambulances – which smelled suspiciously of chlorine and had strange-sounding sirens – were in fact a safe way of transporting ill relatives.[8] Leaders began to discuss relevant behaviour changes in their villages.

Local-language radio programmes also provided people with a platform to voice their needs, share their experiences and discuss how to rid their communities of Ebola. Journalists and talk show hosts were trained to provide accurate information about the transmission, prevention and treatment of the virus, using stories to

> **"I couldn't shake off the feeling that people were dying of ignorance. People had heard of Ebola but the information they were getting was conflicting. They just didn't know who to trust."**

Left In Freetown, Sierra Leone, a group of volunteers speaks to local people, informing them about Ebola during the first day of the national lockdown in 2014

SAMUEL ARANDA/PANOS

which people could relate. Dramas on the radio helped people feel empowered to take practical steps to protect themselves and others.[9]

Social media played a role too. WhatsApp gave the BBC dispensation to set up an Ebola special service, lifting the limit for a broadcast group beyond its usual cap of 250 people.[10] The social media service was able to post images, text and audio content from the World Health Organization (WHO), the Centers for Disease Control and Prevention, and the United Nations Children's Fund (Unicef), to 20,000 subscribers, most of whom were in West Africa. BBC Media Action made localised two-way versions of the service that allowed it to hear from ordinary people about their needs. By the end of 2015 when the outbreak waned, BBC Media Action's WhatsApp channel for Sierra Leone had more than 15,000 subscribers.[11]

In sum, poor communication fuelled the Ebola outbreak in its early months.[12] But communication also played a critical role in its containment, saving lives.[13] Massimo Altimari, a humanitarian expert working with Unicef, explains the significance of communication in the Ebola response for the wider humanitarian system: "There are a limited number of milestone emergencies that 'shake the system' and push for change…Biafra, the Ethiopian famine of 1983–5, the Rwandan genocide and, I'm sure, Ebola. The push that will come from Ebola is around communication and community engagement."[14] Kathy Hageman agrees, noting, "There are really sensitive windows of opportunity – make or break moments – for communication in emergencies. These are the moments where we can get people on board or we can scare them."[15]

The polio endgame: vaccines, supply chains and communication

The detection of two polio cases in Nigeria in August 2016 after two years without any cases being seen in the country is a reminder of how fragile progress against this disease can be. But with polio endemic in only two countries, and just 21 cases of polio seen in those countries in the first eight months of 2016, it looks as if this crippling disease will soon be relegated to history.[16]

The story of the rocky road to polio eradication is one of science, of vaccine development, supply chains and lab tests. But it is also a story of human communication. As a review of the evidence around polio eradication in India and Pakistan, published by WHO, concludes: "There is no vaccine against resistance or refusals that are rooted in social, cultural, religious and political contexts. No supply

> **"**Communication was the crux of the response to Ebola.**"**

> **"**There are really sensitive windows of opportunity – make or break moments – for communication in emergencies. These are the moments where we can get people on board or we can scare them.**"**

FAROOQ NAEEM/AFP/GETTY IMAGES

Above A Pakistani child who was displaced with his family by fighting during operations against the Taliban receives a polio vaccination

chain can overcome issues of gender-based decision-making in households… These challenges demand effective communication action."[17] Where attention has been paid to ambitious and localised communication strategies in support of polio eradication, great successes have been seen. But where the communication by those opposed to vaccination has been more compelling than that of the public health community, eradication efforts have at times been brought to their knees.

In terms of the positive contribution of communication, much was learned from India. When polio cases soared between 2005 and 2007, it was only by using locally owned, data-driven communication strategies to reach the poor and isolated communities where cases clustered that the disease was brought under control. A vast network of trained health workers and communicators fanned out across vast geographic areas

> **"**There is no vaccine against resistance or refusals that are rooted in social, cultural, religious and political contexts. No supply chain can overcome issues of gender-based decision-making in households… These challenges demand effective communication action.**"**

> **"** Communities have come together and decided that their children will no longer be crippled by polio. This has been the invaluable contribution of communications and social mobilisation. **"**

to talk with families, one by one. These conversations convinced parents of the need for repeated rounds of vaccination and helped to overcome suspicions that the polio vaccine did not work, made children ill and/or caused infertility. The support of religious and community leaders and the broadcast of public service announcements also helped to build trust in the vaccine and encourage families to vaccinate their children. These efforts played a major part in India being declared polio-free in 2014.[18]

But communication around polio can also cut the other way, allowing the virus to thrive. In Nigeria in 2012, messages disseminated by anti-polio vaccination campaigners via video and radio claimed that the polio vaccine was part of a deliberate Western plot to sterilise Muslims and to spread Aids, cancer and polio itself.[19] Rumour spread like wildfire in the north of the country, vaccination levels dropped and polio cases multiplied, reaching 122 by the end of the year. Violence and intimidation followed, and in 2013 13 vaccinators in Kano and Borno states were murdered.[20] That year, a report from the global Independent Monitoring Board charged with overseeing the Global Polio Eradication Initiative noted a "deep threat" caused by a "crippling under-emphasis on social mobilisation and communication".[21]

It became imperative to take action to tackle these issues and that is precisely what has happened within the polio community. Unicef increased the size of its teams working on polio communication and formed long-term partnerships with 25 organisations across the world (among them, BBC Media Action) to enable the quick turnaround of professional communication work on the ground. According to data from Unicef, the number of grassroots social mobilisers in polio endemic countries rose from about 12,000 in 2013 to over 35,000 in 2016. Emergency operation centres leading the fight against polio in Nigeria, Afghanistan and Pakistan now have dedicated cells for social mobilisation and communication, where health communication experts work closely alongside epidemiologists and clinicians.[22]

These investments have paid off. Dr Reza Hossaini, head of polio at Unicef, argues: "We've eradicated polio in nearly every country in the world because communities have come together and decided that their

children will no longer be crippled by polio. This has been the invaluable contribution of communications and social mobilisation."[23]

HIV and Aids: communication gaps cost lives

By 1990, 7.6 million people were living with HIV.[24] Without widespread access to effective treatment, growing numbers of people were dying and new infections increased inexorably.

In the early years of the global response, when sexual abstinence, avoiding risky sex or using condoms were the only ways to prevent sexual transmission of HIV, communication revealed itself as an important way of supporting these critical shifts in behaviour. Dr Bernhard Schwartlander, WHO representative in China and previously director of evidence, innovation and policy at UNAIDS, recalls how in the early days of HIV, communication and community engagement were central to achieving "massive changes in knowledge, attitudes and behaviour" that saved lives.[25]

Professor Peter Piot, the pioneering microbiologist who became the first executive director of UNAIDS, makes a similar point. He recounts how in the early days of the epidemic in the Democratic Republic of Congo, traditional theatre, dance and entertainment groups were effectively deployed to communicate with communities about HIV and condoms, contributing to containing prevalence of the virus in the capital city, Kinshasa.[26]

Uganda provides another important story of HIV communication. There, casual sex and HIV prevalence declined dramatically between the late 1980s and the mid-1990s – a trend not seen in neighbouring countries.[27] A rigorous study of data from seven sub-Saharan African countries revealed that high levels of "horizontal" communication between networks of friends and family in Uganda helped to prevent HIV transmission. Essentially, talking openly made people more aware that others were living with HIV and encouraged people to use condoms.[28] A 2003 report by the Panos Institute argues that this kind of person-to-person communication was supported by public debate on HIV, stimulated by the vibrant independent media sector in Uganda at the time.[29]

Further evidence comes from South Africa, where a study showed that awareness of Aids communication programmes had a statistically significant effect on HIV prevention behaviours, like condom use or abstaining from sex. The study also found that the practice of HIV prevention behaviours averted some 700,000 cases of HIV in the country by 2005, at a time when treating this many people with anti-retroviral therapy for just a year would have cost more than $280.6 million. The study's authors conclude that it is "very clear that every dollar allocated to effective HIV prevention programmes is highly cost-effective".[30]

Right A street vendor walks next to a billboard campaign against HIV and Aids in Abuja, Nigeria

PIUS UTOMI EKPEI/AFP/GETTY IMAGES

When it comes to HIV, the tragedy is that effective prevention programmes, rooted in lessons learned about what worked, were not scaled up at the rate required to bring the now global pandemic under control.[31] By 2001, when a major meeting was convened by the United Nations Population Fund (UNFPA) to reflect on the contribution of SBCC in preventing HIV, the number of people infected had soared to 29.5 million.[32] The experts brought together at that meeting argued that inadequate and inappropriate investment in HIV communication had allowed the pandemic to continue to spread.[33] Representatives from low- and middle-income countries consistently reported that communication programmes had been "targeted" at them by Western, expert-led campaigns and that they had been cast in the role as passive objects, rather than agents of their own change.[34] Surrounded by donor-funded billboards exhorting them to "Stop HIV" and radio jingles transmitting instructions to abstain from sex, people in their countries became infected with the virus in growing numbers.

Communication interventions addressing HIV continue to demonstrate that they can achieve a great deal. Results range from reducing stigma to encouraging young people to reconsider sexual risk and promoting the uptake of HIV testing, condom use and newer biomedical prevention interventions like voluntary medical male circumcision.[35] However, it is impossible not to conclude that, over time, failure to apply lessons about what works in tackling this disease through health communication at scale has cost lives.

Health communication: the broader evidence base

These three case studies shine a spotlight on the multi-faceted ways in which communication shaped the course of Ebola in West Africa, and polio and HIV globally. But evidence of communication's impact on other public health priorities also abounds.

Over 40 years of work on family planning programmes, for instance, has produced a wealth of evidence on the effect of communication on fertility behaviours.[36] Other studies show the impact of communication interventions on alcohol consumption and smoking, tobacco use and sexual risk-taking.[37] When it comes to child survival, a review of 78 mass media interventions concluded that these can positively impact a wide range of important behaviours including the use of oral rehydration therapy to treat diarrhoea, the early initiation of breastfeeding and hand-washing with soap.[38] Studies also point to the importance of communication programming for malaria.[39]

Turning to a country-specific example, in Ethiopia, the Minister of Health Dr Keseteberhan Admasu argues that "constant, thoughtful and consistent use of health communication" has been one of the key factors contributing to the great improvements in health seen in his country over the past 20 years. From family planning to reducing the spread of malaria and improving new-born and maternal health, communication has been effectively deployed to increase knowledge, shift attitudes and

> **"** Effective communication can truly save lives. **"**

cultural norms and encourage behaviour change. The minister concludes, "effective communication can truly save lives".[40]

Of course, as we saw with both Ebola and polio, examples of communication acting against the interests of public health are also rife. And cases like these can be expected to grow in low- and middle-income countries as access to the internet and social media expands, allowing, for instance, false rumours about vaccines to spread rapidly and to engender mistrust of health programmes.[41] Public health professionals will need to develop more effective and proactive communication strategies, as well as systems to effectively monitor rapidly growing digital information flows.[42]

The bottom line is that – for good and for ill – communication matters a great deal in public health. The next section of this paper will show that this critical interplay between communication and human health is now reflected in a range of important public health

GREG MARINOVICH/GETTY IMAGES FOR UNILEVER

Above Yvonne Chaka Chaka teaches children at Margaret Gwele Primary School in Soweto, Johannesburg, South Africa about the importance of washing their hands

policy statements. In practice, however, commitment to effective communication at a scale sufficient to accelerate improvements in health remains elusive.

PART 2

Social and behaviour change communication: a public health priority?

Communication in public health policy: an overview

The importance of communication is now widely recognised in global public health policy. Global and national health strategies and commissions exist on topics ranging from polio to malaria, and from HIV and Aids to maternal and child health. These highlight the importance of communication – often referred to as "social and behaviour change communication" (SBCC) – across a range of processes that shape health outcomes.

Malaria is a case in point. In 2012 the Roll Back Malaria Partnership – the global framework for co-ordinated action on malaria founded by the United Nations Development Programme (UNDP), WHO, the World Bank and Unicef – published its Strategic Framework for Malaria Communication at the National Level, 2012–2017. The framework states that "systematic communication… is increasingly understood as integral to malaria control programmes". It sets out numerous ways in which communication interventions can contribute to malaria programmes, leading to "improvements in specific prevention and treatment behaviour which… in turn have an impact on malaria morbidity and mortality". (See box on Health communication processes, page 11.) Major malaria donors, including the Global Fund, the Bill & Melinda Gates Foundation, the President's Malaria Initiative (PMI) and USAID, are all cited as recognising that greater urgency is needed in developing and carrying out effective communication around malaria.[43]

The Global Polio Eradication Initiative's Polio Eradication and Endgame Strategic Plan 2013–2018 similarly highlights the importance of communication in achieving its goals. Community engagement, through social mobilisation and communication, is one of the seven pillars of activity seen as central to interrupting endemic polio transmission. Citing the success of past communication strategies in "decreasing vaccine avoidance in all country programmes", this strategy highlights the need to tailor communication and social mobilisation activities to the

> **66** Systematic communication… is increasingly understood as integral to malaria control programmes. **99**

Below South Sudanese children are educated on the use of a long-lasting insecticide-treated net (LLIN) in Wau, a small city about 520km northeast of Juba, where the population is exposed to malaria

TONY KARUMBA/GETTY IMAGES

Social and behaviour change communication: what's in a name?

In health, the term "social and behaviour change communication" (SBCC) is used to describe work with communication that is aimed at achieving desired outcomes. SBCC practice recognises that many of the major individual and social determinants of health behaviour – like knowledge, attitudes and norms – are shaped by human interaction, in the form of communication between individuals and within communities. Public health policies can also be shaped by communication between leaders, ordinary people and groups that represent them.

SBCC practice encompasses a range of approaches and tools, including interpersonal communication, work with mass media and other information and communication technologies (ICTs) and social mobilisation.[44]

Work with communication to improve health has taken place under a number of different banners over time, including: health education; health promotion; information, education and communication (IEC); behaviour change communication (BCC); advocacy, communication and social mobilisation (ACSM); social marketing; communication for social change; and risk communication. The recent widespread adoption of SBCC as a name for this work reflects an increasing desire by practitioners to coalesce around shared language to describe their work.

la comunicación para el cambio de comportamiento no debe obviarse porque en todo determinante social del comportamiento de la salud de un individuo, individuo o política, la comunicación es el MEDIO ,interacción, lo que se comparte, el proceso de intercambio

specific "social, cultural and political context of each infected area".[45]

Likewise, the 2015 Lancet-UNAIDS Commission on Defeating AIDS also recognises a critical role for communication in the ever-evolving fight against the disease. The commission focuses attention on a framework for the Aids response that highlights both community mobilisation and mass media as social enablers of effective strategies. Behaviour change programmes (which routinely involve communication) are one of six basic programme activities, alongside biomedical approaches such as the prevention of mother-to-child transmission, male circumcision and treatment.[46]

Unicef has long prioritised communication across its work in the belief that "communication lies at the heart of sustainable development".[47] The organisation employs communication strategies across its work, on issues ranging from polio to Ebola and from exclusive breastfeeding to the prevention of HIV and Aids.[48] WHO has also highlighted the importance of integrating multidisciplinary interventions, including communication interventions, in order to achieve the health-related Sustainable Development Goals and its Global Strategy for Women's, Children's and Adolescent's Health.[49]

But while these examples of policy recognition might suggest that communication has truly gained a place at the heart of public health, a closer look at funding levels and health programming on the ground suggests that, all too often, this is not the case. Examples of successful health communication efforts abound, but there are also many indications that investments in this area are often too limited and mobilised too late to achieve maximum effect. It is to this issue that this paper now turns.

Policy versus reality: health communication commitments

Donor funding: too little, too haphazard

When it comes to international aid and development assistance, few donors systematically track and report spend on communication interventions.[50] However, in a recent book chapter on health communication, Elizabeth Fox, director of the Office of Health, Infectious Diseases and Nutrition at USAID, argues that global investments in this area have probably decreased over the last 10 years. This is both in comparison with investments in physical commodities, such as drugs, malaria nets or contraceptives, and in terms of overall health budgets. In the United States' aid programmes, for instance, health communication budgets did not keep pace with the sharp rise in overall health spending between 2000 and 2010.[51] And in 2016, as in 2010, only around 5% of the funds for the President's Malaria Initiative were allocated to health communication.[52]

Outside the United States, of the money dispersed by the Global Fund by the end of 2009, Fox notes that only 5% of malaria funding, 7% of HIV and Aids funding and 1% of tuberculosis funding was allocated to health communication. The last figure is a far cry from the recommendations set out in the Stop TB Partnership and WHO's 2006 Advocacy, Communication and Social Mobilisation to Fight TB: A 10-year Framework for Action, which argues that national tuberculosis control programmes would need to spend between 5% and 15% of their budgets on communication activities to achieve required effects.[53] Recent analysis from the Global Fund suggests that current disbursements for work on SBCC might be even lower than this.[54] Analysis of the disbursements made by global funding mechanism Gavi, The Vaccine Alliance between 2011 and 2015 also suggests that spending on creating demand for vaccines and for broader SBCC is low. Just under $72 million of the $5,944 million it disbursed in those years was allocated to these activities, a proportion of around 1.2%.[55]

Dr Nduku Kilonzo, executive director of the National AIDS Control Council in Kenya, agrees that international aid funding for health communication is limited. She notes that while communication has played a critical role in the country's response to HIV – from addressing stigma and discrimination in the early days of HIV to encouraging testing and male circumcision more recently – "there are now very limited resources

Health communication processes

Across a range of public health policies and strategies, recognised health communication processes include:

- Advocacy for policies that support health, from those on health service provision to those on the environment.
- Community dialogue about resource allocation, service provision and community action.
- Interactions between health workers and their clients.

- Information provision.
- The encouragement of healthy behaviours and the reduction of riskier ones; the shaping of broader social norms that influence how people behave in relation to their health. These might include gender norms or discrimination against certain groups.

globally available for social communication, despite an urgent need."[56] This stands in marked contrast with the money spent on communication in the private sector. As Dr Heidi Larson of the London School of Hygiene and Tropical Medicine notes, "If the public health world was prepared to pay just a fraction of what the private sector spends on communication, we'd be seeing a very different world right now."[57]

> **❝ If the public health world was prepared to pay just a fraction of what the private sector spends on communication, we'd be seeing a very different world right now. ❞**

The uncoordinated and haphazard nature of investments made in health communication by some individual donors is also cause for concern. Investments are often overseen by staff without specific expertise to interrogate the design of proposed interventions. Moreover, as Unicef argues, with multiple players working in health communication and "investment coming from national governments, development assistance donors, NGOs [non-governmental organisations], CSOs [civil society organisations] and the private sector", greater harmonisation of investments overall also remains a challenge.[58]

Communication deficits in health programming

The paucity of funding for health communication is paralleled by limitations in the extent to which communication is prioritised in the broader public health programmes designed and implemented by national governments, health partnerships and NGOs. As a discipline, health communication remains under-utilised, often incorporated into health programmes only as an afterthought.

A recent statement from WHO on social, behavioural and community engagement interventions for women's and children's health notes that, although communication and other multidisciplinary interventions for women's, children's and adolescents' health have been in use for decades, "policy makers often underestimate their value and their role in national strategies is weak".[59]

This weakness is evident in the work of the national ministries of health, which fund an important share of total health spending in low- and middle-income countries and which design the funding proposals submitted to major health financing institutions like Gavi and the Global Fund.[60] Health communication is

Right A man waits to be consulted at a donor-funded clinic that performs free HIV counselling and circumcision in Kenya's lakeside town of Kisimu

TONY KARUMBA/AFP/GETTY IMAGES

often neglected as an area of focus in their strategies, budgets and funding proposals. One senior country manager at Gavi, responsible for overseeing large funding allocations and himself a doctor and an epidemiologist, observes that, in the funding requests he reviews, less than 1% of budgets are allocated to communication. This is the case, he notes, "despite the critical importance of communication across vaccine programmes from advocacy to health worker training and community engagement. I am very surprised."[61]

Kojo Lokko, an expert in malaria with Johns Hopkins Center for Communication Programs, tells a similar story. He argues that, as funding for malaria expanded a decade ago, "SBCC was the last area to receive attention and it is still seen as an afterthought in ministries of health in countries affected by malaria." Despite policy statements made about the importance of "behaviours and effective communication… that doesn't translate into substantial investment in communication programming" by national governments, Lokko notes.[62]

When it comes to HIV, a recent report by UNAIDS on the global failure to bring down numbers of new HIV infections since 2010 maintains that "systematic implementation of behaviour and social change communication and demand generation has not taken place" within HIV programmes. The report goes on to note that many young people still lack the basic knowledge about how to protect themselves from the virus.[63] Dr Bernhard Schwartlander, the WHO representative in China, sees a similar problem in uptake of critical biomedical prevention methods like male circumcision.[64] He points to the low uptake of pre-exposure prophylaxis (or PrEP) in high-risk communities around the world, even though this method is scientifically proven and highly effective in preventing HIV transmission.[65] Schwartlander attributes this outcome to a failure to engage with communities in a way that encourages them to demand the tools that can protect them from HIV: "We are always talking about supply, we are not talking about demand. Demand – created

> "SBCC was the last area to receive attention and it is still seen as an afterthought in ministries of health in countries affected by malaria."

> "Demand – created through social communication and engagement – is always the weak part."

NOAH SEELAM/AFP/GETTY IMAGES

Left A medical volunteer administers a dose of injectable polio vaccine (IPV) to a child during a vaccination drive in Hyderabad, India

through social communication and engagement – is always the weak part."[66]

Analysis also suggests that as well as being too limited in scale, resources for communication interventions are often rolled out too slowly within major health programmes funded by donors and national governments. Sometimes, the real emphasis only appears to come as a last resort when other approaches are faltering. In the case of polio, for example, it seemed to take the terrible events in Nigeria and a report of the Independent Monitoring Board of the Global Polio Eradication Initiative in 2013 before investment in communication was reinvigorated and progress towards eradication resumed.[67]

> **"We advocated for an increase in beds for too long and everyone listened… Instead of asking for more beds, we should have asked for more sensitisation activities."**

Ebola illustrates a similar dynamic. While some agencies, such as the US Centers for Disease Control and Prevention, built communication into the heart of their responses to Ebola from the very beginning, others now recognise that they were too slow to do so. Claudia Evers of the medical charity Médecins Sans Frontières (MSF), which was one of the greatest contributors to the Ebola response in West Africa, has said that the charity made a "big mistake" during the early days of the outbreak by focusing too much on treatment rather than talking to people about the disease. Evers admits, "We advocated for an increase in beds for too long and everyone listened… Instead of asking for more beds, we should have asked for more sensitisation activities."[68] A recent report on effective communication in health crises funded by the Rockefeller Foundation views these communication deficits as a systemic problem, arguing that "there remains a lack of consistent and coherent communication among responders, within health systems and across the public domain".[69]

PART 3

Sound investments? Integrating lessons learned into health communication

Even when communication interventions are prioritised in public health, these often fail to reflect best practice, limiting impact.

Accordingly, this section attempts to pull together the collective wisdom on what works in health communication. Lessons from successful programmes cluster around five main areas. These include: (i) employing sound behavioural analysis to underpin communication interventions; (ii) moving beyond "messaging" to embrace the importance of dialogue and more nuanced approaches to social and behaviour change; (iii) emphasising local ownership and leadership of communication interventions; (iv) integrating communication more firmly with broader programmes to improve health; (v) employing socio-ecological models to understand and address the determinants of health.

> "All too often, implementers of health communication programmes still focus primarily on building knowledge through information provision, although it is widely known that this alone is rarely enough to shift behaviour and improve health."

Sound behavioural analysis

The first area of concern relates to the extent to which health communication programmes are built upon sound theory and solid research about the key determinants of health behaviours. A robust body of social and behaviour change theory now exists to inform health interventions, and the World Bank's 2015 World Development Report on Mind, Society and Behaviour emphasises the benefits of incorporating this "expanded understanding of human behaviour" into development programming, including on health.[70]

For example, some evidence-based theories explain the importance of factors that help to shape behaviour, such as "self-efficacy" and social norms, alongside knowledge and attitudes.[71] Others emphasise the importance of role models, explaining that people learn how to behave, in part, by observing and reflecting on the actions of others.[72] Further important insights suggest that social and behavioural shifts are rarely linear and are instead driven by numerous factors, thus requiring sustained and multi-pronged interventions to bring about change.[73]

Important things are now also known about different types of health behaviour: namely, behaviours that are daily habits compared with those that are practised less regularly. Evidence suggests, for example, that while a person's intentions to do something strongly influence non-habitual behaviours (like getting a child vaccinated), behaviours that are habitual (like wearing a seatbelt or using a condom) are predicted more by past behaviour than by planning or intention.[74] This observation has real implications for health communication strategies. For instance, it seems that habitual behaviours – like hand-washing or open defecation – may be shifted more readily by communication approaches that use disruptive visual cues, than by other types of communication. So, for example, stencilled footprints between latrine cubicles and sinks can vividly highlight the dissonance between people's healthy plans and their unhealthy actions, encouraging people to wash their hands after they use the toilet.[75]

> "Other people talk about something but only communities can talk about themselves and that is much more effective in communication."

Many health communication programmes now benefit from basing their work in sound behavioural theory, but this is not uniformly the case. All too often, implementers of health communication programmes still focus primarily on building knowledge through information provision, although it is widely known that this is rarely enough on its own to shift behaviour and improve health.[76] Moreover, many programmes designed to shift habitual behaviours still focus only on building people's intention

Left A BBC Media Action staff member leads a workshop on behaviour change analysis

BBC MEDIA ACTION

to change.[77] While non-governmental organisations and national governments are ultimately responsible for the strategies of the health communication programmes they design, funders could play a more constructive role in interrogating the theoretical foundations and assumptions underpinning programme design. This would help to ensure that the communication organisations they fund have sufficient grasp of these important issues and that research is supported to ensure that drivers of behaviour are adequately understood and incorporated.

Beyond "messaging"

Related to sound behavioural analysis is the need to consistently embrace approaches to health communication that go beyond "messaging". While it is known that effective SBCC is a social process that encourages engagement, debate and reflection, too often the role of communication in health is seen as being one of conveying neatly packaged messages to promote behaviour change.

In all health communication, it is, of course, important to ensure that clear, consistent and technically sound information is provided to individuals and communities. In the Ebola response in Sierra Leone, for instance, the Ministry of Health's Messaging Review Committee was critical to ensuring that information shared with the media and community organisations was consistent, scientifically sound and culturally appropriate. Ultimately, a consolidated message guide was developed, shaped by how communities described their needs and fears. It provided ever-evolving guidance for all government, media and health communication practitioners involved with the response.[78] But as described in Part 1, the Ebola communication response went well beyond "messaging". Community dialogue, listening and discussion – both face-to-face and through the media – were essential to bringing about change.

> **Shift from persuasion and transmission of information by the 'know-it-all' to deliberation, debate and negotiation on issues that resonate with members of the community.**

Conflating communication and "messaging" is common in international development circles and can be harmful. It can blinker communicators to the need to embrace other approaches, such as role-modelling or storytelling, to provoke people to become open to new ways of thinking and embrace change. The communication-equals-messaging equation can also limit the potential to transform health by empowering communities. "Communication is not something that happens to people. You need to engage those that you want to reach in such a way that those communities take up the responsibility for communicating themselves," observes Dr Bernhard Schwartlander of WHO. "Other people talk about something but only communities can talk about themselves and that is much more effective in communication."[79]

> **Too often, health communication practitioners use local media in an instrumental way, simply buying airtime to broadcast pre-developed content, rather than engaging in collaborative initiatives that build on relationships with local audiences and leverage journalistic information-gathering networks.**

The Minister of Health for Ethiopia, Dr Keseteberhan Admasu, challenges health communication and public health professionals to make a "shift from persuasion and transmission of information by the 'know-it-all' to deliberation, debate and negotiation on issues that resonate with the members of the community."[80] Moving away from a message-focused understanding of communication can also unlock the potential role of local media and communication platforms in improving the responsiveness of health services, by holding leaders and decision-makers to account.[81]

Local leadership

A third criticism frequently launched against health communication practice relates to the failure to invest consistently in local and country-led communication strategies, networks and platforms. This criticism goes directly to issues of trust and credibility – both of which are considered to be vital components of effective and persuasive health communication. In Ethiopia, for example, the government's Health Extension Programme (with its specially recruited local health extension workers) and Health Development Army (a force of community-based volunteers) are cited as health communication platforms that work largely because they have that element of local authenticity.[82] In India, Nigeria, Afghanistan and Pakistan, vast networks of local social mobilisers have similarly proven critical to polio eradication.

But working effectively with these human networks requires investment – in salaries, of course – but also in training to improve interpersonal communication skills. Too often, communication skills, as well as sufficient knowledge to work effectively, are taken as a given and not monitored or developed effectively. This is an oversight that limits the impact that these networks can have on health.

Effective and scalable tools and approaches do exist to build these critical communication skills. BBC Media Action has developed mobile phone-based communication training tools in India, which the government is now rolling out to 1 million frontline health

Right Community health workers receive communication training in Bihar, India

BBC MEDIA ACTION

> **Communication got a seat at the public health table.**

workers across the country.[83] In Ethiopia, radio listening and discussion clubs have been used to strengthen both the knowledge base and communication skills of the volunteers who form the crux of the country's Health Development Army.[84] Similar efforts to support local communication networks elsewhere are critical.

In many contexts, local media organisations are also important partners that are not always engaged in the most effective ways. While many health communication interventions focus heavily on work with national (or even international) media, partnerships with local and community media can support the development of content that best reflects realities on the ground. Local media, too, is often well placed to establish genuine dialogue with the local communities it serves. Too often, health communication practitioners use local media in an instrumental way, simply buying airtime to support the broadcast of pre-developed content, rather than engaging in collaborative initiatives that build on relationships with local audiences and leverage journalistic information-gathering networks. This represents a failure to work with the local media to its fullest potential to communicate and connect around the health issues that matter most to populations around the world.[85]

Integration with public health programmes

Another problem relates to the failure of health communication and public health professions to integrate their work consistently. It is interesting to note that success with polio communication really started to come

about when – as Melissa Corkum, head of polio at Unicef in Afghanistan, puts it – "Communication got a seat at the public health table."[86] What she means is that health communication professionals began working in the same offices, alongside epidemiologists and logisticians, in a really integrated way, responding to detailed data about very specific and localised barriers to vaccine uptake and other communication needs. In a similar vein, one of the factors supporting successful communication around Ebola was the way in which communication experts, behavioural scientists and anthropologists worked alongside the doctors and engineers setting up health systems and infrastructures as part of these responses.[87]

Rather than following these models, health communication interventions are too often run in isolation from the public health programmes they aim to support. Health communication professionals may co-ordinate their efforts with each other through national health communication working groups, convened by ministries of health and the like; but, in many cases, that is about it. As Dr Bernhard Schwartlander of WHO frames the problem: "Traditional health promotion people… at times get stuck in their little cave. They tend to discuss their work in a rather theoretical way that might be absolutely correct, but doesn't really get you anywhere."[88]

> **Traditional health promotion people… at times get stuck in their little cave. They tend to discuss their work in a rather theoretical way that might be absolutely correct, but doesn't really get you anywhere.**

This lack of integration can lead to a variety of problems. These include a mismatch between the available health services and supplies and the demand created for them, as well as the failure to root interventions in valuable health data that could help those running communication

interventions better understand the challenges they are trying to address. It can also, of course, contribute to the marginalisation of communication practice within public health. Out of sight is often out of mind.

Some commentators note a valid need to retain a distance between communication interventions and government health systems in the particular situations where accountability issues are a priority concern. For example, when local media programmes are designed to play a role in holding government health service providers to account. However, Elizabeth Fox of USAID maintains that placing communication at the heart of public health may be the only way to really "analyse what works and what doesn't and to submit health communication programmes and results to a process of rigorous peer review".[89] This, she argues, is critical to driving ongoing improvement in health communication practice and an increased impact on public health.

> **"Our practice defies what we say. Most of what we do focuses on individual behaviour change and less on the social part, the community norms and the broader socio-economic-political sphere."**

Socio-ecological approaches

In public health, socio-ecological models are often used to support an understanding of the dynamic inter-relationships between the personal, interpersonal, social, economic, political and environmental factors shaping people's health. UNAIDS' 2010 guidance on HIV prevention, for example, emphasises that "individual action is shaped by immediate life conditions, including relationships, community and occupational groups and organizations, and by broader societal factors".[90] Similarly, analytical frameworks for studying the determinants of child survival describe the way in which variables in social, economic, cultural and health systems influence more proximal determinants of child health such as maternal age, levels of environmental contamination and nutrition.[91]

And yet, despite recognition of the wide range of factors influencing people's health within the broader public health community, health interventions – including communication programmes – rarely reflect a socio-ecological approach in their work.[92] A widespread critique of the "ABC" (Abstain, Be Faithful, Use Condoms) model of HIV prevention was that it was unrealistically "individualistic", giving too little attention to the "social, cultural and material factors that shape and constrain individual behaviours and put people at risk".[93] Lebo Ramafoko, CEO of Soul City – one of the most established NGOs working with SBCC approaches on the ground – agrees.[94] She notes that, although those working in the field pay lip service to socio-ecological models, "Our practice defies what we say. Most of what we do focuses on individual behaviour change and less so on the social part, the community norms and the broader socio-economic-political sphere."

Overall, it would seem that both greater and more strategic allocation of resources and closer attention to lessons learned will be critical if health communication is to achieve its full potential for public health. The following section explores some key reasons why this has not happened as effectively as it might have to date.

Right Media and communication can affect the broader social factors that influence health. BBC Media Action's health drama in Bangladesh, *Ujan Ganger Naija* (Sailing Against the Tide) explores the effect of early marriage on its heroine Anika (pictured, right)
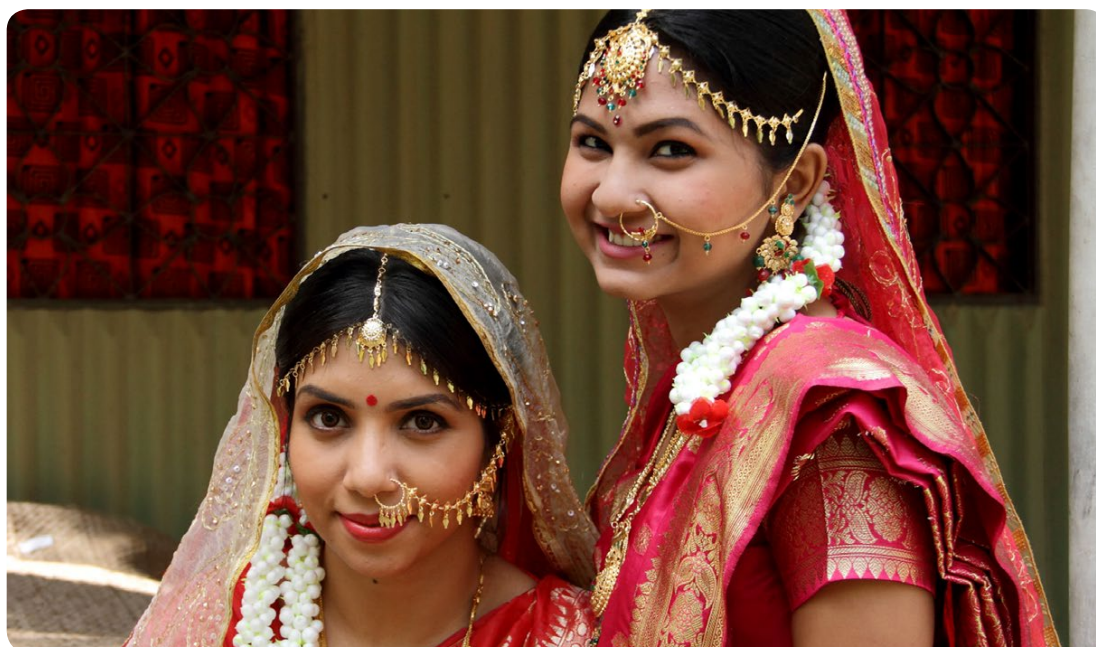
Policy versus practice: picking apart the paradox

This section attempts to unpick the paradox between the demonstrated role of communication in shaping health, which is now reflected in many public health policies, and its continued under-prioritisation and uneven application in practice. Four inter-related factors help to explain this paradox: (i) the dominance of science in public health; (ii) the complex nature of "messy human change" in an era of quick wins; (iii) evidence debates in the field of health communication; and (iv) the failure of SBCC to coalesce as a field and build an effective brand. While progress is being made in each of these areas, challenges remain.

Paradigm clash? The dominance of science in public health

Whether created by international aid agencies or developing-country governments, public health programmes are largely designed and managed by professionals trained in biomedical scientific disciplines. Leaders tend to come from epidemiology, medical, nursing or pharmaceutical backgrounds that focus on understanding and preventing disease and curing the sick. They bring a deep professional familiarity with the measurable, provable and predictable tools of their trade – such as drugs, vaccines and contraceptives.

The health communication community, in contrast, comes from the social and behavioural sciences, which are steeped in an understanding of context. The people designing and implementing communication programmes often have a background in anthropology, sociology, media – or indeed in civil activism. As USAID's Elizabeth Fox puts it, "Health communicators… cannot come to the table with a tried and true set of interventions that are proven to work. Their first reactions tend to be more questions than solutions. Their data and numbers are softer and less convincing than those of their medical colleagues." All this contributes to "lowering the

prestige" of health communication in the eyes of the public health community.[95]

While health communication has slowly emerged as a distinct academic discipline, few university-accredited health communication programmes exist outside the United States. This may also add to the low regard in which health communication is held by those with medical and public health qualifications. A recent report from academics at Imperial College London and Università della Svizzera italiana despairs of the fact that "anyone can call themselves a health communicator or health communication expert, despite not having the certifiable necessary skills and know-how."[96]

This issue is slowly being addressed. In the United States, there are now many health communication programmes offered at schools of public health and medicine as well as at schools of media and communication. There is less on offer elsewhere in the West and few universities in low- and middle-income countries have robust academic health communication programmes. However, at a meeting held in Rwanda in 2011, representatives from 15 universities in nine African countries reported rising interest in the creation of masters' programmes on health communication.[97] An interesting model to replicate may be the Masters of Public Health (MPH) programme at the University of Witwatersrand's School of Public Health in South Africa. With the support of the USAID-funded C-Change programme and Soul City, SBCC has been available as an area of study in this programme since 2010, in addition to the five fields traditionally offered.[98] This integration of health communication within mainstream public health education appears to be a promising approach.

The low regard in which health communication is held within public health programmes in many low- and middle-income countries may also be the result of the relatively limited attention that has been paid to long-term and effective capacity building for local health communication agencies and professionals, particularly those working within government. Many donor-funded health communication programmes have relied heavily on international organisations or technical assistance from developed countries in an effort to deliver quick results in line with donor timeframes. With some notable exceptions, local

> **"Health communicators… cannot come to the table with a tried and true set of interventions that are proven to work. Their first reactions tend to be more questions than solutions."**

> **"With some notable exceptions, local health communication capacity strengthening has not been sustained or systematic."**

Right Preparing oral rehydration solution in Dhaka, Bangladesh. The International Centre for Diarrhoea Disease Research (ICDDR) developed the oral rehydration formula which the WHO adopted as its international standard

HARD RAIN PROJECT/MARK EDWARDS

health communication capacity strengthening has not been sustained or systematic. A recent study of HIV communication capacity building, for instance, found limited documentation of SBCC capacity needs or systematic approaches to address them.[99] Too often, capacity building is delivered as an add-on to projects more focused on the speedy delivery of health communication interventions.

When combined with a high turnover in government staff in these countries, this lack of capacity has contributed to a situation where the planning and delivery of health communication within ministries of health is often limited in scope and strategy.[100] This, in turn, creates a vicious circle leading to further underinvestment and limited respect for this area of work. As more and more public health investments are tied directly to strategies developed by governments in low and middle income countries, there is clearly a risk that health communication practice may dwindle unless the development of local capacity receives more focus.

"Messy" human change in the age of quick wins

The complex and sometimes unpredictable nature of the social and behaviour change that health communication experts grapple with can itself be off-putting to public health specialists. This is especially the case given

evidence showing that some health behaviours may be shifted rapidly with small policy tweaks, such as the provision of financial incentives or by manipulating the ways in which choices are presented to people (choice architecture).[101] But bringing about important health-related social and behavioural changes often requires more time and effort.

The polio sector recognised the importance of communication and social mobilisation earlier than many other health programmes. But, as Michel Zaffran, head of the polio programme at WHO, acknowledges, "As epidemiologists we often like to focus on quantifiable, known variables: Where is the virus circulating in the environment? How many children have been paralyzed? How many more have been missed by vaccination teams? It is a lot more difficult to understand – and act on – people's attitudes, perceptions, and the complex interaction between behaviour, culture and social context."[102] The multitude of factors – emotional, economic, religious, social, political – underpinning a father's refusal for his child to be vaccinated, for example, can indeed be challenging to analyse and address.

This complexity – and the unpredictability of how long it will take for change to occur – can be problematic for public health funders and policy-makers under pressure to show quick results. Reflecting on the stunning success of face-to-face communication efforts to drive the uptake of oral rehydration therapy in Bangladesh, the

renowned American surgeon, writer and public health researcher Atul Gawande concludes that, even when they are successful, investments in human-led change – approaches that involve "sandals on the ground", as he puts it – can be unappealing in terms of the effort involved. "In the era of the iPhone, Facebook, and Twitter, we've become enamoured of ideas that spread as effortlessly as ether… We prefer instructional videos to teachers, drones to troops, incentives to institutions. People and institutions can feel messy and anachronistic. They introduce, as the engineers put it, uncontrolled variability."[103]

According to Rafael Obregon, head of communication for development at Unicef, it is precisely this predilection for quick solutions that limits investment in the kinds of communication interventions that have delivered results in the past: "The foundations and donors that invest significantly in this area… naturally may want immediate results. They are looking for the kind of interventions about which you can say, 'you intervene here and get this result'. In the area of public health, for instance, it's often influenced by a biomedical approach. Communication interventions that don't work in this way often don't get given the time, space and investment to show impact."[104] The current interest in "fail fast" approaches, inspired by the practices of Silicon Valley, compounds the pressures on social and behaviour change interventions.[105]

In addition to the fact that quick fixes for complex health problems may not always be feasible, communication programmes often require implementation over generations and lifecycles. Each generation of mothers needs to be given support to breastfeed their babies. New cohorts of young people becoming sexually active for the first time need advice that extends beyond their first sexual encounter.

Thus, it will be important for the health communication community to engage continuously with leaders in public health to ensure that the human and social processes underpinning health are acknowledged and addressed, notwithstanding the long-term and ongoing effort involved. However, in order for that to happen, evidence showing that it is indeed possible to bring about lasting social and behaviour change must be at their fingertips.

Evidence debates: quantity and quality

This brings up the thorny issue of the evidence base supporting investments in health communication. Many public health professionals perceive the overall quantity of evidence around health communication to be poor compared with that available for other types of health intervention. As a recent paper from WHO notes, when assessing social, behavioural and community engagement interventions for women's and children's health, there

is a "fundamental misalignment and gaps between the evidence that is needed and the evidence that is available for these interventions".[106]

This evidence gap is partly due to the failure of donors and health communication practitioners alike to demand investment in rigorous evaluative research. As anyone involved in seeking funding for health communication interventions will attest, there is demand from donors for ever-more robust evidence proving that change can be attributed to health communication interventions. But, as Elizabeth Fox of USAID points out, "The donor community rarely sets the bar very high on measuring actual changes in behaviours as the result of health communication programmes."[107]

Time and time again, focus is instead given to numbers and easily quantified measures of success. Lebo Ramafoko, CEO of Soul City, notes that, although the organisation's current funders do require repeated "proof that what we do works", they prioritise research on HIV that counts the number of people reached by its interventions over and above research that examines social impact within communities.[108] According to Ramafoko, qualitative research that can be used to measure the latter is not seen as "real research" by funders. Many studies do compare the health behaviours of people exposed to an intervention with people who are not exposed, but these studies are not always set up to allow for the kind of rigorous analysis that would conclusively determine the causal impact of interventions.

If anything, funding for the evaluation of communication interventions may actually have declined over time, rather than increased. A recent systematic review on the impact of mass media interventions on child survival in low- and middle-income countries found only 11 studies meeting their inclusion criteria in the period 2000–2010, compared with 17 from the 1980s. Only two qualifying studies were apparently published between 2010 and 2014.[109] WHO cites challenges in building the evidence for social, behavioural and community engagement interventions, including "a lack of measures, tools, and frameworks to capture the broader development and transformational contributions such as equity, sustainability, gender, social and household dynamics, empowerment, human rights, etc."[110]

There are also important gaps within the health communication evidence base. The lack of extensive research on how communication works in different contexts to address specific diseases like malaria is a case in point.[111] Communication for improved maternal health is another under-researched area. Evidence reviews also suggest that there is a lack of data that

> "Approaches that involve 'sandals on the ground', can be unappealing in terms of the effort involved."

Right BBC Media Action staff carry out health research with a group of local women in India

BBC MEDIA ACTION

explains how communication shapes the social factors underlying behaviour, such as "norms, trust, solidarity, power inequalities in households, neighbourhoods and societies".[112] Unanswered questions also remain about how best to scale up social and behaviour change efforts that have proven successful in a given community, and how to sustain communication-led changes over time.[113] Accumulating more evidence about cost-effectiveness is critical too, so that clearer – if not definitive – answers can be given to funders of health programmes when they rightly ask about the returns they can expect from their investments in health communication.

Importantly, it is not only the quantity and scope of research conducted that has acted as a barrier to greater investment in health communication, but also disagreements about what constitutes a robust and appropriate way to assess impact. A particular issue here relates to the fact that the experimental study designs that are typically used to measure the impact of biomedical health interventions and highly valued by the public health community have not generally been used to analyse health communication efforts.[114] Scholars Danielle Naugle and Robert Hornik explain why, arguing that certainly for mass media interventions, "policy interest is in campaigns that operate on a large scale and over time, rather than in the tightly controlled and focussed interventions that

are well studied with randomized controlled designs".[115] As a result, the health communication community often finds itself in a double-bind – driven to deliver sustained interventions at scale that do not lend themselves to the exacting evidence standards of the day.

Increasingly, health communication practitioners are deploying quasi-experimental research designs to assess impact. Interrupted time series analysis and studies that use statistical controls like propensity score matching to reduce the potential bias of confounding variables are allowing practitioners to make claims of plausible attribution. More and more, these approaches – combined with qualitative research that can help to contextualise quantitative findings – are seen to represent best practice in health communication evaluation. But they are still rated less highly than experimental research in the formal grading processes used in mainstream public health.[116] A recent paper from WHO notes that "frameworks evaluating evidence for global health interventions, including GRADE (Grading of Recommendations Assessment, Development, and Evaluation)… do not adequately consider complex, multidisciplinary interventions".[117] Not surprisingly, these interventions are then rarely included in important public health guidelines on recommended interventions.[118]

Social and behaviour change communication: strengthening the field, building a brand

One explanation for the low prioritisation of effective health communication in health stems from the "field" of SBCC itself. A symposium on social and behaviour change hosted by BBC Media Action in 2014 recognised the existence of a vibrant and active global community of practitioners, researchers and activists working in health communication. Nonetheless, this meeting concluded that the SBCC community had fundamentally failed to coalesce as a field, despite a growing recognition of the importance of social and behaviour change within both international development and public health. Participants argued that it was essential to develop a stronger and more collaborative health communication community with the capacity and mechanisms to better collate, analyse and apply lessons learned to drive forward advances in practice.[119]

Promising efforts are now being made to support the development of the health communication field. These include the recently redesigned Communication Initiative, an online space with over 88,000 members. Focusing on a range of development issues including public health, this network provides knowledge-sharing opportunities for those working in communication and media for development and in SBCC.[120] Springboard for Health Communication Professionals is another active online network through which health communication knowledge, experiences and resources are shared.[121] The Health Communication Capacity Collaborative at Johns Hopkins Center for Communication Programs is also playing an active role in bringing together communication professionals around specific public health priorities such as Zika and malaria.[122]

In 2016, for the first time ever, a major summit – the International Summit on Social and Behavior Change Communication – was held with support from a number of funders, including USAID, Unicef and the Bill & Melinda Gates Foundation.[123] Arranged by the Health Communication Capacity Collaborative, the summit brought together the global community of SBCC organisations and more than 700 practitioners, researchers and funders for talks, discussions and workshops to "consider the way forward in elevating the science and art of SBCC". A second, follow-on summit is likely to be held in 2018.[124]

All these developments are promising and will serve to strengthen the SBCC field. But challenges remain. Efforts to build up the field and learn more about what works in health communication are hindered by the lack of guidelines or standard protocols for reporting on interventions, so that research findings can be understood and shared. Such standards for women's and children's health interventions are currently being developed by WHO, in consultation with a wide range of programme funders and implementers.[125] Once finalised, it will require effort to integrate these standards into everyday practice and extend their application to other areas of health.

There is also a problem in the way the health communication field packages and presents its work. Ironically, failures in communication about health communication have been a factor in holding back the field. As pointed out in Part 2, health communication has had many labels over the years, which is a problem in itself. It can seem as if there are many competing disciplines in operation, causing confusion for those working in mainstream public health.

In recent years, new approaches to social and behaviour change, such as behavioural economics or human-centred design, have also made it more difficult for SBCC to effectively distinguish itself as a coherent and cutting-edge field. These new tools have caught the attention of the international development and public health communities, who, hungry for new thinking, are drawn to apparent paradigm shifts that promise to transform the apparently slow pace of development.

In reality, helpful new theories and insights offered by these approaches are already being incorporated into health communication practice. Indeed, concepts popularised by behavioural economics – such as those focused on encouraging commitments as a tool to counteract people's lack of willpower or those recognising the way in which people discount the benefits of new behaviours if they aren't immediately realised – easily lend themselves to behavioural communication interventions. Good health communication practice has in fact adapted and grown to reflect these new approaches. However, in failing to communicate this effectively, the field can seem amorphous and outmoded in comparison with newer, narrower schools of thought.

PART 5

Future directions: advancing health communication, accelerating change

Major public health developments have shown that communication and human health are deeply entwined. This paper has argued that this relationship should be better reflected in public health funding and programming, harnessing advances in access to communication technologies and ever-growing evidence about the nature of effective health communication. It concludes with a set of recommendations for policy-makers, donors and health communication practitioners committed to better health and wellbeing for all.

Health policies, programming and funding: Health policy-makers and donors alike should systematically consider the importance of communication in the health programmes they plan and fund. Major health agencies should ensure that their strategies incorporate sound and up-to-date consideration of SBCC. Funders should seriously consider supporting these strategies where they are compelling. Recognising the complexity of much social and behaviour change, donors should consider supporting longer-term, multi-pronged approaches to SBCC. Shifts in attitudes or gender norms may be considered as valid measures of impact for shorter-term health communication grants, provided these are linked to a credible longer-term theory of change.

Applying lessons learned: Policy-makers, donors and health communication practitioners should be rigorous in applying lessons learned from past health communication to their programmes. Donors should ensure that their staff are familiar with the health communication evidence base and lessons learned from past programmes, so that they are equipped to plan and evaluate proposals for new communication interventions effectively. Health communication practitioners should strive to integrate their efforts with broader public health programmes. This will involve lobbying harder for a seat at the "public health table" in the settings where they are working, rather than operating in isolation. Donors should emphasise the importance of this in the programmes that they fund.

Right A community health worker in Freetown, Sierra Leone, uses *Welbodi Tok* (Health Talk), an audio-visual aid, to share information with a mother on topics ranging from the treatment of diarrhoea, to breastfeeding and good hygiene

BBC MEDIA ACTION

Building the evidence: Ongoing investment is required to bring together public health and health communication experts to agree appropriate evidence standards for health communication. Current efforts by WHO to propose evidence standards for the measurement of interventions on women's and children's health are promising, and consideration should be given to adopting the standards agreed across other technical areas. Building on WHO's current work on women's and children's health and the USAID/Unicef summit on child survival, SBCC evidence mapping efforts should also be prioritised and expanded to new areas.

Donor support for research efforts to fill evidence gaps – for instance, on cost-effectiveness and sustainability or in under-researched areas such as communication around maternal health and malaria – will be critical to build and sustain the field going forward. Health communication practitioners should also be more insistent on the need for funding to enable stronger evaluations, and open to holding their work to higher standards of scrutiny, including external review. Research partnerships between health communication practitioners and academic institutions, and more extensive publication of research findings, would help to support the further development of the field.

Strengthening the field: Current efforts to build the health communication field and encourage strategic coalescence and mutual learning should be accelerated. Sector-wide meetings are essential, as are platforms for encouraging greater interaction between practitioners, with emphasis placed on peer learning and more rigorous peer review of programmes and research. These steps alone may not be enough to ensure that the health communication field coalesces in order to achieve maximum impact and undertake advocacy, knowledge management, strategic development and evidence generation more effectively. Unicef's current interest in establishing a global mechanism to support improved integration of communication into development practice is a promising step towards creating an institutional "home" for health communication. Finally, health communication professionals would benefit from investigating compelling ways of packaging and promoting their work, using language that speaks clearly to current priorities in the public health, development and behavioural science disciplines.

Capacity strengthening: A further important step in building the health communication field will be giving greater prominence to health communication capacity strengthening – particularly in government health agencies and civil society organisations. The health communication sector would benefit from agreeing key milestones and measures of success, and showing greater commitment to this area. Further integration of health communication in academic public health programmes and other university courses should be an area of greater focus in coming years.

The stories of lives saved from Ebola, of progress towards polio eradication, of the challenges still faced in ending Aids – and many more highlighted in this paper – reveal that it is imperative to get health communication right, and the terrible consequences of getting it wrong. We know far more about what works in health communication than is currently put into practice. As evidence grows, ignoring lessons learned from the past is inexcusable. By working together to take the steps outlined above, health policy-makers, funders and practitioners can capitalise on the promise offered by health communication to save lives and promote wellbeing around the world.

List of experts consulted

Anonymous, behaviour change expert, major philanthropic organisation

Anonymous, senior country manager, Gavi

Massimo Altimari, humanitarian expert, Unicef

Melissa Corkum, head of polio, Unicef Afghanistan

Mustapha Dumbuya, journalist

Elizabeth Fox, director, Office of Health, Infectious Diseases and Nutrition, USAID

Sherine Guirguis, senior communications manager, polio eradication, Unicef

Kathy Hageman, chief, Epidemiology and Strategic Information Branch, US Center for Disease Control and Prevention, Zambia

Dr Reza Hossaini, head of polio, Unicef (via correspondence with the External Relations team at the WHO)

Dr Nduku Kilonzo, executive director, National AIDS Control Council, Kenya

Dr Heidi Larson, associate professor, London School of Hygiene and Tropical Medicine

Kojo Lokko, senior technical advisor, Johns Hopkins Center for Communication Programs

Thaddeus Pennas, senior technical advisor, FHI360

Dr Bernhard Schwartlander, WHO representative, China

Anissa Sidibe, senior programme manager, vaccine implementation, Gavi

Michel Zaffran, director, polio eradication, WHO

Endnotes

1   United Nations (2015) *GOAL 3: Ensure healthy lives and promote well-being for all at all ages* [online]. Available from: https://sustainabledevelopment.un.org/sdg3 [Accessed 19 August 2016].

2   Social norms are the written and unwritten "rules" shaping how people behave. They include our understanding of what other people do and our perception of what we think other people think we should do.

3   ACAPS (2015) *Ebola outbreak, Sierra Leone: communication: challenges and good practice* [online]. Available from: http://www.acaps.org/sites/acaps/files/products/files/v_sierra_leone_communication_challenges_and_good_practice_dec_2015_2-ilovepdf-compressed_ul.pdf [Accessed 19 August 2016].

4   Wilkinson, S. (2016) *Using media and communication to respond to public health emergencies: lessons learned from Ebola*. BBC Media Action [online]. Available from: http://downloads.bbc.co.uk/mediaaction/pdf/practicebriefings/ebola-lessons-learned.pdf [Accessed 12 August 2016].

5   Email correspondence with Mustapha Dumbuya, August 2016.

6   Ibid.

7   Phone interview with Kathy Hageman, June 2016.

8   Ibid.

9   For more about BBC Media Action's work with local radio in Sierra Leone, see: BBC Media Action (2016) *Kicking out Ebola* [online]. Available from: http://www.bbc.co.uk/mediaaction/where-we-work/africa/sierra-leone/sierra-leone-ebola-response [Accessed 19 August 2016].

10 A broadcast group on WhatsApp is similar to a group chat except that contact details of users are not shared with others in the group.

11 See: Wilkinson, *Using media and communication to respond to public health emergencies: lessons learned from Ebola*.

12 Perry, H. et al. (2016) Community health worker programmes after the 2013–16 Ebola outbreak. *Bulletin of the World Health Organization,* 94:7, 551–553.

13 ACAPS, *Ebola outbreak, Sierra Leone: communication: challenges and good practice*.

14 Interview with Massimo Altimari, January 2016, London.

15 Phone interview with Kathy Hageman.

16 Global Polio Eradication Initiative (2016) *Polio this week as of 17 August 2016* [online]. Available from: http://polioeradication.org/polio-today/polio-now/ [Accessed 18 August 2016].

17 Obregon, R. et al. (2009) Achieving polio eradication: a review of health communication evidence and lessons learned in India and Pakistan. *Bulletin of the World Health Organization,* 87:8, 624–630.

18 Ibid.

19 Independent Monitoring Board of the Global Polio Eradication Initiative (2013) *Eighth report: October 2013*.

20 Centers for Disease Control and Prevention (2013) *Progress Towards Poliomyelitis Eradication – Nigeria, January 2012-September 2013* [online]. Available from: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6249a5.htm [Accessed 18 August 2016].

21 Independent Monitoring Board of the Global Polio Eradication Initiative, *Eighth report: October 2013*.

22 Email correspondence with Sherine Guirguis, senior communications manager, polio eradication, Unicef, May 2016.

23 Email correspondence, with Sherine Gurguis, Unicef, May 2016.

24 World Health Organization (2009) *Global epidemic data and statistics* [online]. Available from: http://www.who.int/hiv/data/global_data/en/ [Accessed 18 August 2016].

25 Phone interview with Bernhard Schwartlander, June 2016.

26 Piot, P. (2012) *No time to lose: A life in pursuit of deadly viruses*. New York: WW Norton & Company.

27 Unfortunately, Uganda's early successes against HIV were not sustained and prevalence rates among adults aged 15–49 stood at an estimated 7.1% in 2015. See: UNAIDS (2015) *Uganda HIV/AIDS estimates* [online]. Available from: http://www.unaids.org/en/regionscountries/countries/Uganda [Accessed 10 August 2016].

28 For instance, among men aged 15–24 in Uganda, of those who knew someone with Aids, nearly 20% used condoms, compared with less than 5% of those who didn't. See: Low-Beer, D. and Stoneburner, R.L. (2004) Social communications and AIDS population behaviour changes in Uganda compared to other countries. *African Journal of AIDS Research*, 3:1, 1–13.

29 Scalway, T. (2003) *Missing the Message: 20 years of learning from HIV/AIDS*. The Panos Institute.

30 Kincaid, D.L. and Parker, W. (2008) *National AIDS Communication Programmes, HIV Prevention Behaviour, and HIV Infections Averted in South Africa, 2005*. Johns Hopkins Health and Education South Africa.

31 In the early days of the epidemic, community mobilisation, behavioural change and condom use were employed "to successfully prevent HIV – even in the absence of biomedical interventions or effective therapy" (Piot, P. et al. (2015) Defeating AIDS – advancing global health. *The Lancet*, 386:9989, 171–218).

[32] The 2001 meeting called by UNFPA was held in Nicaragua and organised with the Rockefeller Foundation, the Panos Institute and Unesco. See: World Health Organization, *Global epidemic data and statistics*.

[33] Unesco (2001) *Communication for Development Roundtable Report, Focus on HIV/AIDS Communication and Evaluation*. New York: United Nations Population Fund.

[34] Ibid. Personal correspondence with James Deane (2016), director of policy and insight at BBC Media Action and organiser of the Nicaragua roundtable in his former role as executive director of the Panos Institute. See: Scalway, *Missing the Message: 20 years of learning from HIV/AIDS*. Panos London. Available from: http://panoslondon. panosnetwork.org/wp-content/files/2011/03/missing_ messagedleYq6.pdf [Accessed 23 September 2016]

[35] See, for instance: LaCroix, J. et al. (2014) Effectiveness of mass media interventions for HIV prevention, 1986–2013: A meta-analysis. *Journal of Acquired Immune Deficiency Syndromes*, 66:Suppl 3, S329–240; Noar, S.M. et al. (2009) A 10-year systematic review of HIV/AIDS mass communication campaigns: Have we made progress? *Journal of Health Communication*, 14:1, 15–42; Health Communication Capacity Collaborative (2015) *Impact of Health Communication on Voluntary Medical Male Circumcision* [online]. Available from: https://www. malecircumcision.org/resource/impact-health- communication-voluntary-medical-male-circumcision [Accessed 18 August 2016]; Vidanapathirana, J. et al. (2005) *Mass media interventions for promoting HIV testing*. Cochrane Database of Systematic Reviews [online]. Available from: http://www.ncbi.nlm.nih.gov/ pubmed/16034948 [Accessed 18 August 2016].

[36] Hornik, R. and McAnany, E. (2001) Mass media and fertility change. In Casterline, J. (ed.) *Diffusion Process and Fertility Transition: Selected Perspectives* (pp. 208–239), Washington DC: National Academic Press.

[37] See: Snyder, L. (2007) Health communication campaigns and their impact on behaviour. *Journal of Nutrition, Education and Behaviour,* 39: Suppl 2, S32–40; Wakefield, M. et al. (2010) Use of mass media campaigns to change health behaviour. *The Lancet,* 376:9748, 1261–1271.

[38] Naugle, D. and Hornik, R. (2014) Systematic Review of the Effectiveness of Mass Media Interventions for Child Survival in Low- and Middle-Income Countries. *Journal of Health Communication*, 19: Suppl 1, 190–215.

[39] Data from Senegal, for instance, indicates that intensified communication interventions and major nationwide advocacy efforts, coupled with an expansion of bed net distribution, the introduction of rapid diagnostic testing and health system strengthening, contributed to a 30% reduction in under-five mortality between 2001 and 2010, saving the lives of more than 26,800 children. See: Mouzin, E. et al. (2010) *Focus on Senegal.* Roll Back Malaria Progress and Impact Series [online]. Available from: http://archiverbm. rollbackmalaria.org/ProgressImpactSeries/report4.html [Accessed 18 August 2016].

[40] Admasu, K. (2016) Address to the inaugural Social and Behavior Change Communication Summit 2016 [online]. Available from: http://www.moh.gov.et/ [Accessed 8 June 2016].

[41] See, for instance: The Vaccine Confidence Project (2015) *The State of Vaccine Confidence.* London: London School of Hygiene and Tropical Medicine.

[42] KYNE and News Deeply (2016) *Effective public health communication in an interconnected world: enhancing resilience to health crises.* Final Report of the Rockefeller Foundation Bellagio Center Convening: October 21–23 2015 [online]. Available from: https://assets. rockefellerfoundation.org/app/ uploads/20160419105316/News-Deeply-Public-Health- Communication-v3-LOW-RES.pdf [Accessed 18 August 2016].

[43] Roll Back Malaria Partnership (2012) *Strategic Framework for Malaria Communication at the National Level 2012–2017*. Geneva: Roll Back Malaria Partnership [online]. Available from: http://www.rollbackmalaria.org/ files/files/globaladvocacy/docs/BCCstrategicFramework. pdf [Accessed 18 August 2016].

[44] Unicef defines social mobilisation as "a process that engages and motivates a wide range of partners and allies at national and local levels to raise awareness of and demand for a particular development objective through dialogue". See: Unicef (June 2015). *Social mobilization* [online]. Available from: http://www. unicef.org/cbsc/index_42347.html [Accessed 10 August 2016].

[45] Global Polio Eradication Initiative (2013) *Polio Eradication and Endgame Strategic Plan 2013–2018*. World Health Organization [online]. Available from: http://www.polioeradication.org/Portals/0/Document/ Resources/StrategyWork/PEESP_EN_US.pdf [Accessed 18 August 2016].

[46] Piot, *Defeating AIDS – advancing global health*.

[47] Unicef (n.d.), *Communication for Development* [online]. Available from: http://www.unicef.org/cbsc/ [Accessed 18 August 2016].

[48] Unicef (n.d.), *Communication for Development: the big picture* [online]. Available from: http://www.unicef.org/ cbsc/index_42328.html [Accessed 18 August 2016].

[49] World Health Organization (2016) *Social, Behavioural and Community Engagement Interventions for Women's and Children's Health: A WHO Roadmap for Building, Reporting, Assessing, and Applying Evidence*.

[50] The content of this section is based on the best data available and on conversations with experts. The author was unable to obtain any further data from funders of health programmes than is presented here.

[51] Fox, E. (2012) Rethinking Health Communication in Aid and Development. In Obregon, R. and Waisbord, S. (eds.) *The Handbook of Global Health Communication*. Chichester: John Wiley & Sons, Inc.

52 Correspondence with Julie Wallace, chief, Malaria Division, Global Health Bureau USAID, September 2016. For 2016 the President's Malaria Initiative (PMI) allocated approximately 4.8% of its budget specifically for work on SBCC. USAID notes that these figures slightly underestimate PMI's support for SBCC as they do not include funding tied to its Indoor Residential Spraying (IRS) Programs as the community mobilisation and sensitisation work carried out as part of IRS cannot be disentangled from the cost of the integrated package of support provided to countries. Likewise, there might be some support for fully integrated SBCC activities missed in this tracking, for example improved interpersonal communication or counselling resulting from improved healthcare provider practices brought about through support for strengthening malaria case management.

53 World Health Organization and Stop TB Partnership (2006) *Advocacy, Communication and Social Mobilization to Fight TB: A 10-Year Framework for Action* [online]. Available from: http://www.stoptb.org/assets/documents/resources/publications/acsm/tb-advocacy.pdf [Accessed 18 August 2016].

54 In email correspondence with the author in August 2016, the Global Fund reported that in disbursements approved for 2014–2019, $66 million was allocated to "information, education, communication/behaviour change communication", from total allocations of over $10 billion, ie. 0.66%. These figures may underestimate the disbursements made as the Global Fund notes that SBCC is "not always specifically detailed in countries' budgets" and since figures do not include countries and regional initiatives that were funded early under the fund's new model which launched fully in 2014. (Early applicants were Myanmar, Zimbabwe, El Salvador, Kazakhstan, the Philippines, the Democratic Republic of the Congo and three regional initiatives.) Even taking into account these caveats, the proportion of funding specifically allocated to IEC/BCC activities appears surprisingly low.

55 Gavi (2016) Data for commitments, approvals & disbursements in XLS format [online] Available from: http://www.gavi.org/results/disbursements/ [Accessed 12 August 2016].

56 Phone interview with Nduku Kilonzo, June 2016.

57 Phone interview with Heidi Larson, June 2016.

58 Unicef (2016) *Background Note: Maximizing the Role of Communication for Development/Social and Behaviour Change Communication for Development and Humanitarian Results.*

59 World Health Organization, *Social, Behavioural and Community Engagement Interventions for Women's and Children's Health.*

60 Government health spending as a share of total health spending is lowest in South Asia at 33.2% and sub-Saharan Africa at 36.3% but 50% or more in all other regions. See: Dieleman, J. (2016) National spending on health by source for 184 countries between 2013 and 2040. *The Lancet*, 387:1037, 2521–2535.

61 Phone interview with senior country manager at Gavi, June 2016.

62 Phone interview with Kojo Lokko, June 2016.

63 UNAIDS (2016) *Prevention Gap Report*. Geneva: UNAIDS.

64 Phone interview with Bernhard Schwartlander.

65 Pre-exposure prophylaxis (PrEP) is the use of anti-retroviral medication by people who are HIV negative to protect them from infection. It is intended for use by people substantially at risk from acquiring HIV.

66 Phone interview with Bernhard Schwartlander.

67 Independent Monitoring Board of the Global Polio Eradication Initiative (2013). *Seventh report: May 2013.*

68 Hussain, M. (2015) MSF says lack of public health messages on Ebola 'big mistake' [online]. *Reuters.com.* Available from: http://www.reuters.com/article/us-health-ebola-msf-idUSKBN0L81QF20150204 [Accessed 18 August 2016].

69 KYNE and News Deeply, *Effective public health communication in an interconnected world.*

70 World Bank (2015) *World Development Report 2015: Mind, Society and Behaviour.* Washington, DC: World Bank.

71 "Self-efficacy" means the belief in one's own ability to do something. See: Fishbein, M. and Cappella, J. (2006) The role of theory in developing effective health communications. *Journal of Communication,* 56, S1–S17.

72 Bandura, A. (1977) *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

73 See, for instance: Resnicow, K. and Page, S. (2008) Embracing chaos and complexity: a quantum change for public health. *American Journal of Public Health*, 98:8, 1382–1389.

74 Ouellette, J. and Wood, W. (1998) Habit and intention in everyday life: The multiple processes by which past behavior predicts future behavior. *Psychological Bulletin,* 124:1, 54–74.

75 Neal, D. (2016) *The habitual brain: Advances in creating sticky and disruptive behavior change*. Presentation at the inaugural International Social and Behavior Change Communication Summit 2016 [online]. Available from: http://www.comminit.com/sbcs2016/content/habitual-brain-advances-creating-disruptive-and-sticky-behavior-sbcc-summit-2016-keynote [Accessed 10 July 2016].

76 Webb, T. and Shearan, P. (2006) Does Changing Behavioral Intentions Engender Behaviour Change?: A Meta-Analysis of the Experimental Evidence. *Psychological Bulletin*, 132:2, 249–268.

77 Neal, *The habitual brain: Advances in creating sticky and disruptive behavior change.*

[78] For more information on the importance of co-ordination of communication messages in Ebola, see: Wilkinson, *Using media and communication to respond to public health emergencies: lessons learned from Ebola*.

[79] Phone interview with Bernhard Schwartlander.

[80] Admasu, Address to the inaugural Social and Behavior Change Communication Summit 2016.

[81] KYNE and News Deeply, *Effective public health communication in an interconnected world*.

[82] Admasu, Address to the inaugural Social and Behavior Change Communication Summit 2016.

[83] Dutt, P. (2016) Technology Saving Millions of Lives [online]. Available from: http://www.huffingtonpost.co.uk/priyanka-dutt/technology-saving-millions-of-lives_b_9058016.html [Accessed 30 June 2016].

[84] BBC Media Action (2106) *How listening groups are adding value to the Ethiopian Health Development Army and impacting the wider community*. BBC Media Action [online]. Available from: http://downloads.bbc.co.uk/mediaaction/pdf/research-summaries/listening-groups-ethiopia-august-2016.pdf. [Accessed 18 August 2016].

[85] KYNE and News Deeply, *Effective public health communication in an interconnected world*.

[86] Phone interview with Melissa Corkum, May 2016.

[87] Phone interview with Kathy Hageman.

[88] Phone interview with Bernhard Schwartlander.

[89] Fox, Rethinking Health Communication in Aid and Development.

[90] UNAIDS (2010) *Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections: A UNAIDS Discussion Paper*. Geneva: UNAIDS.

[91] Hill, K. (2003) Frameworks for studying the determinants of child survival. *Bulletin of the World Health Organization*, 81:2, 138–139.

[92] Sugg, C. and Senthilingam, M. (2014) *Debates in Change: Symposium Reports and Conclusions*. BBC Media Action [online]. Available from: http://www.bbc.co.uk/mediaaction/publications-and-resources/policy/briefings/debates-in-change-symposium-report [Accessed 20 August 2016].

[93] Hankins, C. (2004) From a vicious circle to a virtuous circle: reinforcing strategies of risk, vulnerability and impact reduction for HIV prevention. *The Lancet*, 364(9449):1915–1916.

[94] Ramafoko, L. (2016) *The Good, the Bad and the Ugly: Reflections on 20 years of proving what we do matters*. Presentation at inaugural Social and Behavior Change Communication Summit 2016 [online]. Available from: http://www.comminit.com/global/content/good-bad-and-ugly-reflections-20-years-proving-what-we-do-matters [Accessed 20 August 2016].

[95] Fox, Rethinking Health Communication in Aid and Development.

[96] Suggs, L.S. et al. (2015) *Communication Health Messages: A framework to increase the effectiveness of health communication globally*. Report of the WISH Communicating Complex Health Messages Forum 2015 [online]. Available from: https://www.imperial.ac.uk/media/imperial-college/institute-of-global-health-innovation/public/Complex-health-messages.pdf [Accessed 20 August 2016].

[97] Obregon, R. and Waisbord, S. (2012) Capacity Building (and Strengthening) in Health Communication: The Missing Link. In Obregon, *The Handbook of Global Health Communication*.

[98] Obregon, Capacity Building (and Strengthening) in Health Communication.

[99] Lettenmeir, C. et al. (2014) HIV Communication Capacity Strengthening: A Critical Review. *Journal of Acquired Immune Deficiency Syndromes*, 66: Suppl 3, S300–S305.

[100] Fox, Rethinking Health Communication in Aid and Development.

[101] Sunstein, C. and Thaler, R. (2009) *Nudge: Improving Decisions about Health, Wealth and Happiness*. New Haven & London: Yale University Press.

[102] Personal correspondence with WHO, May 2016.

[103] Gawande, A. (2013) Slow ideas: some innovations spread fast. How do you speed the ones that don't? [online] *New Yorker*, Annals of Medicine, 29 June. Available from: http://www.newyorker.com/magazine/2013/07/29/slow-ideas [Accessed 18 August 2016].

[104] Interview with Rafael Obregon, January 2016, London.

[105] "Fail fast" is an approach to running organisations or developing products that embraces experimentation, with the understanding that some ideas will develop and grow and others will fail and be abandoned. See, for instance: Babineaux, R. and Krumboltz, J. (2013) *Fail Fast, Fail Often: How Losing Can Help You Win*.

[106] World Health Organization, *Social, Behavioural and Community Engagement Interventions for Women's and Children's Health*.

[107] Fox, Rethinking Health Communication in Aid and Development.

[108] Ramafoko, *The Good, the Bad and the Ugly: Reflections on 20 years of proving what we do matters*.

[109] Naugle, Systematic Review of the Effectiveness of Mass Media Interventions for Child Survival in Low- and Middle-Income Countries.

[110] World Health Organization, *Social, Behavioural and Community Engagement Interventions for Women's and Children's Health*.

[111] Roll Back Malaria Partnership, *Strategic Framework for Malaria Communication at the National Level 2012–2017*.

[112] Waisbord, S. (2014) Where Do We Go Next? Behavioral and Social Change for Child Survival. *Journal of Health Communication*, 9: Sup 1, 216–222.

113 Ibid.

114 Experimental study designs include, for instance, randomised control trials (RCTs) used to test the efficacy of new pharmaceutical products and other health interventions. When it comes to health communication, Development Media International has conducted a rare RCT to study the effects of its child survival radio campaign in Burkina Faso, where the unusually localised media market made it feasible to try to create control and intervention groups for research. The final results of the trial are awaited. For more information about the campaign's midline results, see: Sarrasat, S. et al. (2015) Behaviour Change After 20 Months in Addressing Key Lifesaving Family Behaviours for Child Survival: Midline Results From a Cluster Randomized Trial in Rural Burkina Faso. *Global Health: Science and Practice*, 3(4), 557–576.

115 Naugle, Systematic Review of the Effectiveness of Mass Media Interventions for Child Survival in Low- and Middle-Income Countries.

116 For more information, see: http://www.gradeworkinggroup.org.

117 World Health Organization, *Social, Behavioural and Community Engagement Interventions for Women's and Children's Health*.

118 An extensive evidence review was carried out in 2014 under the leadership of USAID and Unicef. This involved more than 200 professionals and resulted in a special edition of the *Journal of Health Communication*, which opened with a statement that "the evidence represented… compares favourably to evidence in clinical research fields of biomedical interventions" (Fox, E. and Obregon, R. (2014) Editorial: Population-Level Behaviour Change to Enhance Child Survival and Development in Low- and Middle-Income Countries. *Journal of Health Communication*, 19: Supp 1, 3–9). Yet a year later, a WHO review of social, behavioural, communication, structural and economic interventions for women's, children's and adolescents' health still concluded that these types of interventions face "difficulties in establishing a strong evidence base" and that "the research available did not fit well with current assessment process standards" (World Health Organization, *Social, Behavioural and Community Engagement Interventions for Women's and Children's Health*). This seeming contradiction reflects unresolved debates over what counts as evidence of impact.

119 Sugg, *Debates in Change: Symposium Reports and Conclusions*.

120 For more information, see: http://www.comminit.com/global/spaces-frontpage.

121 For more information, see: https://healthcomspringboard.org.

122 See: the Zika Communication Network; http://www.zikacommunicationnetwork.org and the Roll Back Malaria Communication Community of Practice group: https://healthcomspringboard.org/groups/roll-back-malaria-task-force-knowledge-management.

123 See: http://sbccsummit.org.

124 Ibid.

125 World Health Organization, *Social, Behavioural and Community Engagement Interventions for Women's and Children's Health*.

Acknowledgements

BBC MEDIA ACTION

UKaid
from the British people