Introduction to Health Communication

USAID
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Ministry of Health & Population
وزارة الصحة والسكان

HEALTH COMMUNICATION CAPACITY COLLABORATIVE

Acknowledgments

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Introduction to Health Communication

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Contents

Course Description

This course is designed to provide an overview of health communication and education and their potential to influence the social and cultural norms that drive individual behaviors. Students will become familiar with the role of communication in health interventions—such as advocacy, education, persuasion, and counseling—and understand the steps to social and behavior change. They will also gain a basic understanding of a number of theories that are used to design health behavior change interventions.

Core Knowledge

By the end of this course the students should be able to:

- Recognize the influence of social and cultural norms on health behaviors, and discuss relationships between multiple factors—individual, community, environmental, policy—that affect health
- Define communication and explain its roles in health interventions
- Describe the communication process and identify types of communication, specifically, verbal and non-verbal, interpersonal and intrapersonal
- Illustrate various communication channels—such as mass media, community-based media, social media, digital media, and interpersonal communication—used in health communication interventions
- Discuss the steps to behavior change and ways to bring about normative change
- Identify the differences and similarities between health education and promotion; information, education and communication (IEC); and social and behavior change communication (SBCC)

Core Skills

By the end of this course the students should be able to:

- Describe the importance of communication as a social process and tool for improving health
- Analyze the complexities in changing harmful social norms

- Identify strategic approaches and steps to social and behavior change
- Explain basic communication theories at the individual, interpersonal, community and policy levels, and demonstrate examples of how they can be applied to health interventions

Course Overview

		Methods of Teaching/Training with Number of Total Hours per Topic				
ID	**Topics**	**Interactive Lecture**	**Field Work**	**Class Assignments**	**Research**	**Lab**
1	What is communication? Types of communication: verbal, non-verbal, mass, interpersonal, and intrapersonal	4			2	
2	Key health communication and health education terms and concepts	4			2	
3	Influence of social and cultural norms and other factors that influence health behaviors	4			2	
4	Four basic theories of communication: Social Learning Theory, Theory of Reasoned Action, Extended Parallel Processing Model, and Diffusion of Innovation	4			2	
5	Steps to behavior change	4			2	
6	Understanding communication channels	4			2	
TOTAL HOURS (36)		**24**			12	

Chapter 1

What Is Communication?

Objectives

- Define communication and explain its roles in health interventions
- Describe the communication process and identify types of communication
- Describe the importance of communication as a social process, including as a tool for improving health

Introduction

What is Communication?

Communication is social process that is essential to life and fundamental to survival (Stacks & Hockings, 1999). It permeates every level of society and influences how we think, act, and engage personally and professionally. It is derived from the Latin word, *communicare*, which means to impart or share (Merriam-Webster, 2017). One of the most important aspects of effective communication is the use of a common language to create a shared understanding of messages between the sender and receiver. This process can take many forms: face-to-face; through mediated communication, such as written letters and books; or via electronic platforms, such as computers.

Over the past 50 years, the media landscape and, consequently, the ability to communicate to mass audiences have greatly evolved. From radio and television to the invention of the internet and mobile technology, a range of platforms are now central to how and with whom we communicate.

Communication studies have proven applicable in a range of fields, including business, law, film, education, computer science, advertising, and health. In recent years, strategic communication and promotion have gained prominence in the field of public health. Today, both approaches draw on theories to understand human behavior and facilitate disease prevention (Rimal & Lapinski, 2009). This makes sense given that communication is essential for the exchange of information, coordination of social actions, and the encouragement of behavior, including the dissemination of messages to influence health and wellbeing.

Rimal and Lapinski (2009) refer to intervention efforts to change behaviors as "communicative acts" that often include both a function of information exchange and rituals of a social community. It is, therefore, important to understand the beliefs and value systems of a community when designing health communication or behavior change interventions, as different audiences may interpret messages in different ways.

Human communication is indeed complex. Its long history and varied processes have been studied across multiple fields and practices for many years, this is a testament to the significance of communication to human existence. From these investigations, De Fleur and Ball-Rokeach (1982) present five major perspectives through which human communication can be viewed:

- **Human communication is a semantic process**. It is dependent upon symbols and rules for their use that have been selected by a given language community.
- **Human communication is a neurobiological process**. Meanings for particular symbols are recorded in the memory functions of individuals. Thus, the central nervous system plays a key role in the storage and recovery of internal meaning experiences.
- **Human communication is a psychological process**. The meaning of words or other symbols to a given individual are acquired through learning. These meanings play a role in perceiving the world and responding to it.
- **Human communication is a cultural process**. Language is a set of cultural conventions. It is a set of postures, gestures, and symbols, and their arrangements have shared or agreed-upon interpretations.
- **Human communication is a social process**. It is the principal means by which human beings are able to interact in meaningful ways. Roles, norms, and social sanctions are understood through a system of shared values.

Definition of Communication

The way that we think about communication has evolved over the past 50 years. Kincaid (2002) described the history of modern notions about how communication contributes to the spread of new ideas and new behaviors:

- **1962**: No formal definition of communication was widely used, but diffusion was recognized as the process by which a new idea spreads from its source of invention to its adopters in stages through human interaction: people communicate a new idea to another person, who then shares it with others, and so on. With each sharing of the idea, individuals gain knowledge, become interested, and become motivated to try the new idea and eventually become adopters. The definition has five stages: **Awareness, Interest, Evaluation, Trial, and Adoption**.
- **1971**: Communication was defined as a process by which messages are transferred from a source to a receiver with effects; this is known as the Source-Message-Channel-Receiver (SMCR) model. Diffusion becomes a special subset of communication under this model: the diffusion of new ideas, new practices, and innovations occurs as information is shared through particular channels to particular audience members. Change under this definition has four stages: **Knowledge, Persuasion, Decision, and Confirmation**.

- **1983**: As scholars began to appreciate that communication was not linear and unidirectional, such as from a campaign to an audience, they began to define communication as a process of interaction through which information flows back and forth between communicators, rather than in one direction only from a source to a receiver. Under this perspective, communication is defined as a process of **convergence** in which participants create and share information with one another in order to reach a mutual understanding. It becomes a two-way process of information exchange (dialogue) rather than a one-way transfer (monologue) (Rogers & Kincaid, 1981). This realization led to small but profound changes in the definition of communication and diffusion and in the stages of change. Diffusion was defined as the process by which an innovation is **communicated** through certain channels over time among members of a social system. The practice of implementation was added to the previous four stages, resulting in the five-stage process: **Knowledge, Persuasion, Decision, Implementation, and Confirmation**.

- **1995**: By this time, the convergence perspective was widely accepted. Communication was defined as a process in which participants create and share information about a new idea with one another in order to reach a mutual understanding. Communication **networks** now consisted of interconnected individuals linked by patterned flows of information exchange. Social **systems** were believed to be composed of a set of interrelated units—such as families, neighborhoods, work units within a company, and so on—engaged in joint problem-solving to accomplish a common goal. **Horizontal and collective diffusion**—among peers and peer groups—occurred as well as **vertical and individual diffusion**—from the top down, such as from leaders to community members. The five stages from 1983 continue to be recognized: **Knowledge, Persuasion, Decision, Implementation, and Confirmation**.

Key Communication Principles [1]

- People make decisions about what they see, interpret, remember, and forget
- Action speaks louder than words
- Communication is influenced by context, and people receive messages from many sources
- Time and power relationships are critical dimensions of communication

Power relationships mean that access to and control over communication channels and the production of content will determine what is communicated to whom and with what effect. In earlier eras, when mass communication was highly centralized, public access to the means of production and dissemination was limited. In the current era, when mobile and digital technologies are widely available to people in communities, access to the means of production and dissemination is more decentralized; more people can make and disseminate messages.

[1] Used with permission: Johns Hopkins Center for Communication Programs (CCP). (2015). *Leadership in strategic health communication: Making a difference in health and development*. Workshop manual. Baltimore: CCP.

Key Ideas [2]

Relationship between perception and the communication process is best defined by these key points:

- What we do is more important than what we say; actions speak best.
- Communication is all about relationships and not just the delivery of messages.
- Communication does not happen in a vacuum. To understand human behavior, we need to understand both individual and social contexts.
- The key to effective communication is listening; this often includes listening to what is not being said.
- Our actions frame our words.
- We must understand communication from the audience's point of view.
- We communicate better when we understand how people see. How people see shapes what they know, what they know shapes what they believe, and what they believe shapes how they act.
- Context shapes what we see, and content is what we are interested in.
- People select what they see, they interpret selectively what they see, and they choose what they want to remember or forget. Principles of selective perception include filling in gaps when we lack information, selecting what we see in terms of our needs and perspectives, realizing that we best understand information that is well organized, and recognizing that how things are arranged helps determine what we see.
- We can "frame" a message in different ways. How we frame a message can change its meaning and impact.
- We should not see the world only through our mental models.

Types of Communication

- **Verbal** – Sharing of information through speech, language, or sound as a way to express ideas, concepts, and messages to one or more people
- **Non-verbal** – Actions, gestures, facial expressions, tones, silence, dress, color, and time
- **Written** – Communication that involves developing a message using the written word, such as letters and reports
- **Electronic** – Transfer of information either in whole or in part by wire, radio, electromagnetic, photo electronic, or photo optical systems

[2] Used with permission: Johns Hopkins Center for Communication Programs (CCP). (2015). *Leadership in strategic health communication: Making a difference in health and development*. Workshop manual. Baltimore: CCP.

- **Intrapersonal** – Communication within oneself, including thoughts and interpretation of messages
    - The process for creating messages is called encoding and the process for interpreting messages is called decoding. Encoding and decoding are translation processes that people use to make sense of messages and their meaning.
- **Instructive** – Involves teaching the skills and knowledge needed to perform an action
- **Directive** – Involves one-way influence or communication, including dissemination, promotion, and prescription
- **Non-directive** – Involves multiple ways of influence or communication, without the explicit goal of influencing another person; this includes dialogue, entertainment, counseling, and interpersonal interactions (Health Communication Capacity Collaborative [HC3], n.d.)
- **Interpersonal** – Communication between two people, either face-to-face or through some form of media, such as the telephone or social media

Chapter 2

Key Terms and Concepts in Health Communication and Health Education

Objectives

- Define key terms related to health communication and health education
- Explain the differences/similarities between health education and promotion, IEC, and SBCC

Introduction

This chapter aims to provide health educators with common terms and concepts in the field of health communication and education. These terms were developed and are used by international organizations that work in the fields of health promotion, health communication, health education, social marketing, and SBCC.

Most, if not all, of these terms and concepts will appear in or become relevant to course readings and study, implementation, and research activities. Review these terms for a basic level of understanding. Additional research may be needed to further explore and understand these concepts.

Key Terms and Concepts

Advocacy for health – A combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems support for a particular health goal or program (World Health Organization [WHO], 1995).

Alliance – An alliance for health promotion is a partnership between two or more parties that pursue a set of agreed upon goals in health promotion.

Burden of disease – The burden of disease is a measurement of the gap between a population's current health and the optimal state in which all people attain full life expectancy without suffering major ill-health (WHO, 2008). Burden of disease analysis enables decision makers to identify the most serious health problems facing a population. Loss of health in populations is measured in

disability-adjusted life years (DALYs), which is the sum of years of life lost due to premature death and years lived with disability. Burden of disease data provide a basis for determining the relative contribution of various risk factors to population health that can be used in health promotion priority setting. For instance, smoking, undernutrition, and poor sanitation are related to a number of major causes of morbidity and mortality and, therefore, each is a potentially important focus for health promotion. In addition, burden of disease studies can reveal disparities in health within populations that indicate underlying social inequities that need to be addressed.

Campaign – A goal-oriented attempt to inform, persuade, or motivate behavior change in a well-defined audience. A campaign provides benefits to the individual and/or society, typically within a given time period, by means of organized communication activities.

Capacity building – Capacity building is the development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health communication, education, and/or promotion in organizations; and the development of cohesiveness and partnerships for health in communities (Skinner, 1997; Hawe, King, Noort, Jordens, & Lloyd, 2001).

To achieve effective health communication, individual health educators must be competent; and to effectively implement health communication strategies, health educators must receive support from the organizations for which they work. At the organizational level, this may include training staff, providing resources, designing policies and procedures to institutionalize health communication, and developing structures for health communication planning and evaluation. The scope of organizational capacity building encompasses the range of policies and partnerships for health promotion that may be necessary to implement specific programs or to identify and respond to new health needs as they arise.

At the community level, capacity building may include raising awareness about health risks, strategies to foster community identity and cohesion, education to increase health literacy, facilitating access to external resources, and developing structures for community decision making. Community capacity building concerns the ability of community members to take action to address their needs as well as the social and political support that is required for successful implementation of programs.

Communication channels – Four categories of **communication channels** are used to reach intended audiences: interpersonal, community, mass media, and digital and mobile media.

- **Interpersonal channels** refer to one-to-one communication
- **Community channels** include community-based media, activities, and mobilization
- **Mass media channels** can reach large audiences quickly and include television, radio, newspapers, magazines, outdoor/transit advertising, and direct mail
- **Digital and mobile media channels** can not only reach large numbers of people, but also allow users to control the content and timing of that communication; they can be used for interpersonal (one-to-one) as well as mass (one-to-many) communication

Community – A community is defined as a specific group of people, often living in a defined geographical area, who share a common culture, values, and norms and are arranged in a social structure according to relationships that the community has developed over a period of time.

Members of a community gain their personal and social identity by sharing common beliefs, values and norms that have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group and share common needs and a commitment to meeting them.

Community mobilization – A process through which action is stimulated by a community itself or by others, and that is planned, carried out, and evaluated by a community's individuals, groups, and organizations on a participatory and sustained basis to improve health. In addition to improving health, the community mobilization process also aims to strengthen the community's capacity to address its health and other needs in the future. It is a participatory process of communities identifying and taking action on shared concerns.

Determinants of health – The determinants of health are a range of personal, social, economic, and environmental factors that determine the health status of individuals or populations.

Disease prevention – Disease prevention covers measures, such as risk factor reduction, to not only prevent the occurrence of disease, but also to arrest its progress and reduce its consequences, once established.[3]

Empowerment for health – In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health.

Formative research – Research studies conducted during the initial stages of program and message development. It can include reviews of existing research studies, pretesting concepts and messages, or trying out a program on a small scale before full implementation.

Global health – Global health refers to the transnational impacts of globalization upon health determinants and health problems that are beyond the control of individual nations (Lee, 2003). Issues on the global health agenda include the inequities caused by patterns of international trade and investment, the effects of global climate change, the vulnerability of refugee populations, the marketing of harmful products by transnational corporations, and the transmission of diseases resulting from travel between countries. The distinction between global health problems and those that could be regarded as international health issues is that the former defy control by the institutions of individual countries. These global threats to health require partnerships for priority setting and health promotion at both the national and international level.

Health behavior – Any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting, or maintaining health, whether or not such behavior is objectively effective toward that end (Nutbeam, 1986).

Health communication – Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multimedia and other technological innovations to disseminate useful health information to

[3] Adapted from: World Health Organization (WHO). (1984). *Glossary of terms used in "Health for All" series, no. 1-8*. Geneva: WHO.

the public increases awareness of specific aspects of individual and collective health as well as the importance of health in development.[4]

Health communication is directed toward improving the health status of individuals and populations. Much of modern culture is transmitted by the mass and multimedia, which has both positive and negative implications for health. Health communication encompasses several areas including edutainment or entertainment-education, health journalism, interpersonal communication, media advocacy, organizational communication, risk communication, social communication, and social marketing. It can take many forms, from mass and multimedia communications to traditional and culture-specific communication, such as storytelling, puppet shows, and songs. It may also take the form of discreet health messages or be incorporated into existing media, such as soap operas.

Advances in communication media, especially in multimedia and new information technology, continue to improve access to health information. In this respect, health communication becomes an increasingly important element to achieving greater empowerment of individuals and communities.

Health education – Health education is comprised of consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills that are conducive to individual and community health.

Health education is concerned not only with the communication of information, but also with fostering the motivation, skills, and confidence (self-efficacy) necessary to take action to improve health. It includes the communication of information concerning the underlying social, economic, and environmental conditions impacting on health as well as individual risk factors and risk behaviors and use of the health-care system. Health education may involve the communication of information and development of skills which demonstrate the political feasibility and organizational possibilities of various forms of action to address social, economic, and environmental determinants of health.

Health literacy – Health literacy refers to the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health.

Health literacy implies the achievement of a level of knowledge, personal skills, and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions. It means more than just being able to read pamphlets and make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.

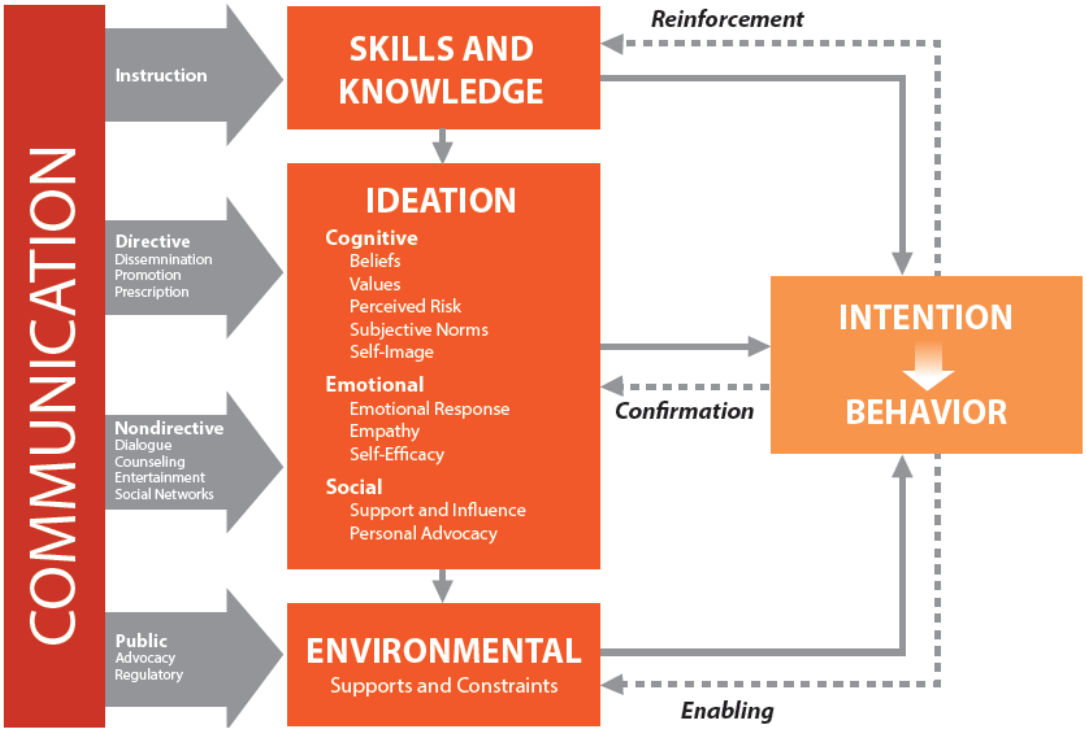
Health literacy is itself dependent upon more general levels of literacy. Poor literacy can affect people's health directly by limiting their personal, social, and cultural development as well as by hindering their development of health.

[4] Adapted from Cerqueira, M. T., & Coe, G. A. (1996). *Communication, education and participation: A framework and guide to action*. Washington, DC: Pan American Health Organization.

Health promotion – Health promotion is the process of enabling people to increase control over the determinants of health and, thereby, improve their health (WHO, 1986). Health promotion is a comprehensive social and political process. It embraces not only actions directed at strengthening the skills and capabilities of individuals, but also actions directed toward changing social, environmental, and economic conditions in order to alleviate their impact on public and individual health.

Ideation – Ideation refers to how new behaviors or ways of thinking are diffused through a community by means of communication and social interaction among individuals and groups. Behavior is influenced by multiple social and psychological factors as well as skills and environmental conditions that facilitate behavior.

In the ideational model of communication (see graphic below), instructive communication can teach the skills and knowledge needed to perform an action; directive (one-way influence) and nondirective (entertainment, counseling, and interpersonal) communication can affect ideational factors; and public communication, such as advocacy, can affect environmental factors. The model emphasizes how communication affects the intermediate outcomes that in turn determine behavior change.[5]



Source: Health Communication Capacity Collaborative (HC3). (n.d. c). Ideation: An HC3 research primer. Baltimore: HC3.

Indicator – An indicator is a statement of measure—such as the percentage of women ages 18-24 who had their first birth before age 18—used to track progress toward achieving objectives.

[5] Used with permission: Health Communication Capacity Collaborative (HC3). (n.d. c). *Ideation: An HC3 research primer*. Baltimore: HC3. Available from http://www.healthcommcapacity.org/wp-content/uploads/2015/02/Ideation.pdf

Information, education, and communication – Refers to a public health approach aimed at changing or reinforcing health-related behaviors in a target audience, concerning a specific problem and within a predefined period of time through communication methods and principles (WHO, 2014).

Key influencers – Key influencers are influential people in the primary audience's social network, such as friends, relatives, religious leaders, and traditional healers.

Long-term identity – A long-term identity refers to a unique set of associations that represent what the product, service, or behavior stands for in the minds of the audience.

Media advocacy – The strategic use of mass media to advance a social or political policy initiative. It attempts to reframe community-based public dialogue and to increase support for public health policies from the public in general and from community policy and decision makers specifically.

Outcome evaluation – A type of evaluation that determines whether a particular intervention had the desired impact on the intended audience's behavior, that is, whether the intervention made a difference in knowledge, skills, attitudes, beliefs, behaviors, and health outcomes. It is sometimes also called impact or summative evaluation. While an impact or summative evaluation typically focuses on measuring the magnitude of changes caused by a communication program, an outcome evaluation also tries to determine *how and why* those changes occurred.

Positioning – In the context of strategic design, positioning means presenting an issue, service, or product in such a way that it stands out from other comparable or competing issues, services, or products and is appealing and persuasive. Positioning creates a distinctive and attractive image that ideally makes a perpetual foothold in the minds of the intended audience.

Program – A plan or system under which action may be taken toward a goal. In the context of our course, the term "program" refers to a broad health-related effort with long-term goals, perhaps national in scope, that is usually generated or at least endorsed by the government. A health program may include various projects and strategies focusing on issues such as health-care service delivery, service provider training, commodity supply, clinic infrastructure, communication, and research of topics such as family planning, HIV/ AIDS, integrated health services, and child immunization.

Project – A specific plan or design scheme.

Public policy advocacy – The effort to influence public policy through various forms of persuasive communication. Public policy includes statements, policies, or prevailing practices imposed by those in authority to guide or control institutional, community, and, sometimes, individual behavior.

Segmentation – This process involves dividing the audience into smaller groups of people who have similar communication-related needs, preferences, and characteristics. Each audience segment requires tailored messages that will be meaningful to the audience members. Segmentation entails subdividing an overall population into similar subgroups in order to better describe and understand each subgroup, predict behavior, and formulate the appropriate messages and programs to meet specific needs.

Self-efficacy – Perceived self-efficacy refers to beliefs that individuals hold about their capability to carry out action in a way that will influence the events that affect their lives (Bandera, 1994). Self-efficacy beliefs determine how people feel, think, motivate themselves, and behave. This is demonstrated in how much effort people will expend and how long they will persist in the face of obstacles and aversive experiences.

Social capital – The resources embedded in social relations among persons and organizations that facilitate cooperation and collaboration in communities.

Social and behavior change communication – A framework that uses communication to positively influence social dimensions or determinants—knowledge, attitudes, norms and cultural practices—of health and wellbeing. Strategies used in SBCC include advocacy, interpersonal communication, mass media, and digital programming to influence both individual and societal change.

Social marketing – Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the behavior of target audiences in order to improve the welfare of individuals and society.

Social marketing strategies are concerned first with the needs, preferences, and social and economic circumstances of the target market (Andreason, 1995). This information is used to ensure the most attractive benefits of a product, service, or idea are offered and to address any barriers to the acceptance of that offering (Maibach, 2003). While communicating with members of the target market about the relative advantages of what is offered is one element of social marketing, it is also important to address issues of price, access, environmental support, and the marketing of competing products. Effective social marketing, therefore, may include efforts to address the economic and regulatory environment. Success of a social marketing strategy is determined by its contribution to the wellbeing of the target market or society as a whole (Maibach, 2003).

Social norms – Social norms are unwritten rules that dictate what behaviors are acceptable within a society or individual group (Mato-Santiso & Rey-Garcia, 2015).

Strategic approach – A strategic approach is the overarching direction that guides the choice of messages, channels, tools, management components, and indicators to achieve desired goals.

Strategic communication – Strategic communication is a systematic process based on data, ideas, and theories and integrated by a visionary design. Its aim is to achieve verifiable objectives by affecting the most likely sources and barriers to behavior change, with the active participation of stakeholders and beneficiaries.

Strategic communication tools – Strategic health communication and education messages can be shared through various channels. These channels can include advocacy, advertising, promotion, interpersonal communication, event creation and sponsorship, community mobilization, and publicity as well as entertainment vehicles, such as television and radio programs, folk dramas, songs, or games, that simultaneously entertain and provide educational messages.

Strategy – A strategy is a careful plan, method, or policy of achieving a goal. A health communication strategy includes a description of the situation, the audience, behavior change objectives, the strategic approach, key message points, channels, management, and evaluation plans.

Chapter 3

Factors That Influence Health Behaviors

Objectives

- Explain the influence of social and cultural norms on health behaviors
- Highlight relationships among multiple factors—individual, community, environmental, and policy—that affect health

Introduction

It is generally accepted that "interventions on social and behavioral factors should link multiple levels of influence, including the individual, interpersonal, institutional, community, and policy levels" (Glanz, Rimer, & Viswanath, 2008). Ecological models are used to develop behavioral-intervention approaches based on this idea and focus on the "nature of people's transactions with their physical and sociocultural surroundings" or environments (Glanz, Rimer, & Viswanath, 2015). Storey, Figueroa, and Kincaid (2005) explain further:

> Ecological models view health in broad social and biological contexts, identifying various determinants and their interactions in a way that suggests how interventions occurring at different points in the life course or addressing different determinants would…contribute to improving health and wellbeing. The ideal choice of intervention strategies would, therefore, not just implore people to change, but help them make appropriate health decisions by building healthy, participatory communities and effective health care delivery systems, supported by enlightened health policy (p. 4).

The **social ecological model** (SEM) is a framework for understanding the multiple levels of a social system and the interactions between individuals and the environment within this system. Individual and group behaviors within the SEM are influenced by multiple social and psychological factors as well as skills and environmental conditions that facilitate behavior.

The **ideation** theoretical framework is useful for understanding how new ways of thinking and new behaviors are diffused through a community by means of communication and social interaction among these groups. The factors of ideation are grouped into three categories:

- **Cognitive** – which addresses individual's beliefs, values, and attitudes; how they perceive what others think should be done; what they think others are actually doing (social norms); and how the individual thinks about him/herself (self-image)

- **Emotional** – which includes how an individual feels about the new behavior (positive or negative) and how confident they feel they can perform the behavior (self-efficacy)
- **Social** – which involves interpersonal interactions that are meant to convince someone to behave in a certain way or persuade others to adopt the behavior (personal advocacy).

Combined, these factors "affect behavior similarly to how multiple risk factors affect the probability of getting a disease" (HC3, n.d. d).

Below is an article that summarizes how SBCC and health communication can be used to influence social norms at multiple levels of influence and, ultimately, to change behaviors around health in a positive way.

In-Class Reading

Ask students to read the summary below regarding the social ecological model and facilitate a discussion on the topic.

A Social Ecology Model of Communication for Social and Behavioral Change:

A Brief Summary[6] by D. Lawrence Kincaid, Maria Elena Figueroa, Doug Storey, & Carol Underwood, Johns Hopkins Bloomberg School of Public Health

As a result of extensive research and program experience over the last fifty years—especially in the fields of population and health communication, much is already known about SBCC (Figueroa, Kincaid, Rani, & Lewis, 2002; Kincaid & Figueroa, 2007). The primary challenge is to further increase our knowledge of how individuals behave within their own social contexts and learn how some are able to overcome social constraints and barriers to change, and then apply that knowledge to implement more effective communication programs for health and development. Social and behavior change are best understood within a **social ecological** framework that takes into account the interconnected influences of family, peers, community and society on behavior. Social ecology is "the study of the influence of the social context on behavior, including institutional and cultural variables" (Jamison, et al, 2006; Powell, Mercy, Crosby, Dahlberg, & Simon, 1999; Sallis & Owen, 2002). Because the social ecology model of communication and behavior change presented in Figure 1 is itself embedded in the physical environment and infrastructure and the communication process that affects it, it is also a general ecological model of behavior and change.[7] Ecology, as derived from the biological sciences, describes the complex interrelationships among organisms and the environment in which they are embedded.

[6] Used with permission: Kincaid, D. L., Figueroa, M. E., Storey, D., & Underwood, C. (2007). *A social ecology model of communication, behavior change, and behavior maintenance*. Working paper. Baltimore: Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.

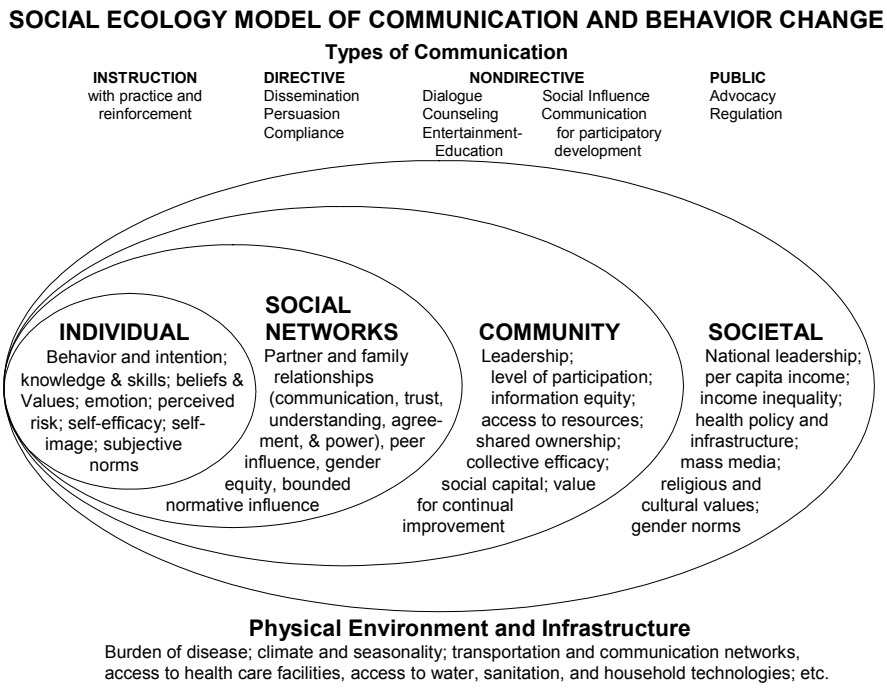
[7] Adapted from: Kincaid, D. L., Figueroa, M. E., Storey, D. & Underwood, C. (2007). *A social ecology model of communication, behavior change, and behavior maintenance*. Working paper. Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health; and from Powell, K. E., Mercy, J. A., Crosby, A. E., Dahlberg L. L., & Simon, T. R. (1999). Public health models of violence and violence prevention. In L. R. Kurtz, (Ed.), *Encyclopedia of violence, peace, and conflict* (pp. 175-187). San Diego, CA, USA: Academic Press.

The social ecology model of communication takes a **systems approach** to analysis rather than a reductionist approach. It describes the complexity, interrelatedness and wholeness of the components of a complex adaptive system rather than just one particular component in isolation from the system in which it is embedded. The two-key system features of the social ecology model of communication and behavior change are the assumption of **embeddedness**, a state in which one system is nested in a hierarchy of other systems at different levels of analysis, and **emergence**, in which the system at each level is "greater than the sum of its parts."

One of the primary advantages of a social ecology approach is that many of the sources of resistance to change at one level can be found in obstacles that exist not only at that level but also at higher levels of analysis. Communication programs for behavior change—usually defined at the individual level alone—are often less effective than they should be because they may ignore obstacles to change in the systems in which individuals are embedded. Those individuals often cannot ignore the constraints that exist in their social networks, communities and institutions, and in society at large.

The social ecology model of communication is a meta-model or *meta-theory* in the sense that each level shown in the model encompasses theories of change for that particular level. Thus, the ideational model of communication and behavior change fits into the individual level; interpersonal relationship theory and bounded normative influence theory fit into the social network level; the communication for participatory development model applies to the community level; and theories of mass media effect fit into the societal level. The main contribution of the ecology model is to emphasize how higher levels facilitate or constrain and act as barriers to change at lower levels of analysis. This suggests that interventions for planned change should address all four levels to be effective.

Figure 1



There are qualities of individuals that cannot be understood without knowledge of their peer networks, family relationships, partner relationships, community relationships and societal norms. Change at one level may be facilitated or obstructed by conditions within and at higher levels of analysis. Communication is a process that can be used to overcome barriers at each level and help facilitate change. For example, a study of adolescent girls in South Africa revealed that concerns about sexual health did not influence the decision to delay or abstain from sex and deviate from prevailing social norms as much as their concerns about becoming "targets of resentment by their sexually active peers" and fears about social isolation and exclusion (Kahn, 2005). By applying the principle of "bounded normative influence" in this context, abstaining from sex would be more likely to occur if girls could form or join new supportive peer groups in which abstinence is already the norm and is seen as a means to independence, self-control and better relationships with others.

Research shows that social norms are often misconstrued (O'Gorman, 1988). News, entertainment, and even advertising in the mass media can help overcome pluralistic ignorance about the actual behavior in society. Committed national leaders can use mass media to convey policy/legal changes that support change, as well as using them to reinforce change that has already occurred (among "positive deviants") and advocated by others, thereby increasing the likelihood that such changes will be sustained and increased. Local leaders and community institutions can emulate this leadership by showing similar public support and providing access to the information and resources needed for change: from bed nets to antiretroviral therapy treatment centers, from water treatment products and condom distribution to programs to prevent violence against women. Communication helps cultivate or shift perceptions about what is normative, thereby motivating change and the maintenance of existing behaviors.

Figure 2

Interaction between Individual and Social Change

Social Change \ Individual Change	NO	YES
NO	Maintenance of status quo	Limited health improvement
YES	Increased potential for health improvement	Self-sustained health improvement

The model also implies that individual change that is facilitated and supported by social changes at higher levels is more likely to be self-sustaining. Individuals who go against prevailing norms, who attempt to change without the support and complementary change

in their spouse/partner and other family members, and who defy local community leaders are expected to find it difficult to maintain new behavior even if highly motivated to change. A good example of societal level constraints on community leaders is the case of the traditional chief in KwaZulu Natal, South Africa, who reached the conclusion that the AIDS epidemic was so severe in his village that everyone should be tested for HIV infection. His plan was soon sidetracked by political pressures from the upcoming national and provincial election. The model raises the question of what this leader would have done if the leaders of his party and national leaders publicly encouraged local leaders to advocate HIV testing in their communities.

Chapter 4

Four Basic Theories of Communication

Objectives

- Explain basic communication and behavior change theories
- Provide examples of how these theories can be applied to health interventions

What is a Theory?

A theory is an explanation of a process or phenomenon based on systematic observation. It can also be seen as a narrative or story that describes a sequence of connected events or characters, bounded in space and time, containing implicit or explicit suggestions about decisions, motives, barriers, and facilitators associated with an event. A theory can be used as a way to think about the audience and identify the things that influence behavior. It can be used as a tool for guiding programs and research, by helping researchers ask:

- Why do people act the way they do?
- What factors are most likely to encourage or facilitate desired health behaviors?
- Are there other things to consider?

To that end, a program can use communication to overcome barriers to protective action or response.

Four major theories are commonly used in health communication and in social and behavior change communication. They include: Social Learning Theory, Theory of Reasoned Action, Extended Parallel Processing Model (EPPM), and Diffusion of Innovations. Some of these theories focus more on the individual level change while others can be used to better understand how behavior change takes place at the social/structural level (see table on the next page).

Theory	Emphasis	Type of Change Needed
Reasoned Action (Planned Behavior)	Cognition, rational processes	**More Individual**  **More Social and Structural**
Extended Parallel Processing Model	Interaction between cognition and emotion	
Social Learning Theory	Social judgment/comparison and social influence	
Diffusion of Innovations	Social structural factors	

Source: Storey, J. D. (2017). Johns Hopkins Center for Communication Programs.

Social Learning Theory

Social Learning Theory suggests that people can learn new behaviors by observing others. It emphasizes the reciprocal relationship between social characteristics of the environment, how they are perceived by individuals, and how motivated and able a person is to reproduce behavior they see happening around them. The theory was developed by Albert Bandura in 1977, based on his studies of how children perceive aggressive behavior from watching others. He determined that people learn and decide how to act by:

- observing the action of others;
- observing what happens to people when they take an action;
- evaluating these consequences for their own life;
- rehearsing, then attempting to reproduce those actions themselves;
- comparing their experiences with what happened to the other people; and
- confirming their belief in the new behavior.

Social Learning Theory can be used in almost any health communication program that aims to influence social behaviors. It is especially useful when a particular behavior is difficult to describe but can be explained through demonstration or modeling.

How Can You Use Social Learning Theory?

- Identify motives for action
    - What personal and social incentives affect learning and behavior?

- Identify compelling message characteristics
    - What models will be appealing and compelling?
    - How should the behavior be visually represented?
    - How can you stimulate/reinforce rehearsal?
    - How can trials be encouraged?
    - How can feedback be provided?
    - How can incentives for performance be provided?
- Identify reinforcing activities
    - How can mediated learning be reinforced through other program activities?

Social Learning Theory is rooted in three main concepts: modeling, efficacy, and parasocial interaction.

- **Modeling** – Provides messages by showing someone performing a desirable behavior. It is most effective when modeling a positive outcome. Modeling requires four cognitive stages: attention, retention, reproduction, and motivation.
    - **Attention** – Individuals must pay attention to the model to learn something new.
    - **Retention** – Individuals must be able to store new information about the modeled behavior and review it later.
    - **Reproduction** – Individuals have to re-enact the new behavior in order to practice and master it themselves.
    - **Motivation** – Individuals need to be properly motivated to perform the new behavior themselves.
- **Efficacy** – Describes a feeling of personal empowerment or confidence in one's ability to perform a particular behavior.
- **Parasocial interaction** – Takes place when people begin to identify with and think of fictional characters as if they were real people.

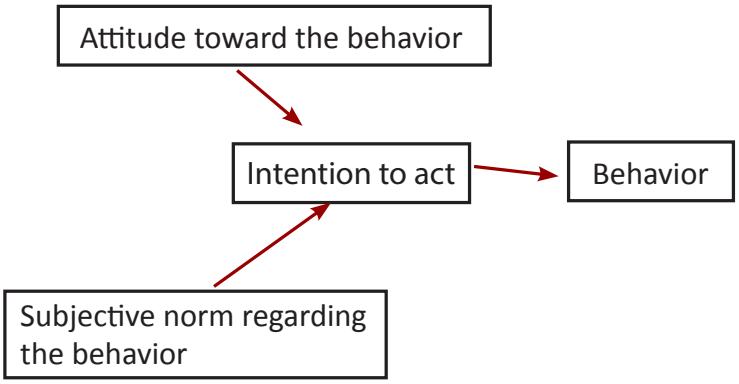
Theory of Reasoned Action (Planned Behavior)

The **Theory of Reasoned Action** suggests that people make decisions thoughtfully. Fishbein and Ajzen developed the theory in 1975, stating that behavioral decisions are based on three types of beliefs:

- **behavioral beliefs** – what people expect will happen to them if they choose a particular action;
- **normative beliefs** – what they think other people do or want them to do; and

- **control beliefs** – what makes it harder or easier to act.

A **belief** is information about a person, object, or issue, which may be factual or opinion. An **attitude** is a positive or negative feeling about a person, object, or issue. People base their intentions to act on two main things: their attitudes toward the behavior—whether performing the behavior is a good thing or a bad thing to do—and their subjective norms regarding the behavior—whether people around them are performing it and think others should, too.



Source: Storey, J. D. (2017). Johns Hopkins Center for Communication Programs.

The Theory of Reasoned Action should be used to design interventions that target health-enhancing individual behavior that may be socially unacceptable, such as condom use, smoking cessation, voluntary testing, and other behaviors that warrant individual decisions but have varying levels of social acceptability.

Individuals are more likely to intend to have healthy behaviors if they have positive attitudes about the behaviors, believe that subjective norms are favorable toward those behaviors, and believe they are able to perform those behaviors correctly. Intention will be stronger when a person has more than one of the previously beliefs.

Many external factors or barriers may contribute to why an individual does not perform a behavior even when they have the intention to do so. It is important to understand barriers to positive behaviors and consider additional skills that individuals might need in order to successfully take action toward changing their behavior.

How Can You Use the Theory of Reasoned Action?

- Identify motives for action
    - What are the advantages and disadvantages of a behavior?
- Identify messages that can change attitudes
    - Change beliefs about consequences of action
    - Change evaluations about consequences of action
    - Change subjective norms
    - Change motivations to comply with subjective norms

- Identify target audiences
    - Primary audience (those who would benefit from attitude change)
    - Secondary audience (significant others of those you want to influence)

Extended Parallel Processing Model [8]

The **Extended Parallel Processing Model** (EPPM), also known as Threat Management or Fear Management, describes how rational considerations (efficacy beliefs) and emotional reactions (fear of health threat) combine to determine behavioral decisions. More specifically, the degree to which a person feels threatened by a health issue determines his or her motivation to act, while one's confidence to effectively reduce or prevent the threat determines the action itself. Developed by Witte in 1994, the EPPM Model has four key variables: two related to beliefs about threat and two related to beliefs about efficacy.

- **Threat variables** (emotional reaction determines motivation)
    - **Perceived severity** – How serious is the threat or consequences?
    - **Perceived susceptibility** – Can it happen to me? How likely is it that is can happen to me?
- **Efficacy variables** (cognitive reaction determines response)
    - **Response efficacy** – Does the solution work? How well?
    - **Self-efficacy** – Can I do it? How confident do I feel that I can do it?

	Efficacy Determines Reaction		
Threat Motivates Action		**High Efficacy** Ability and Effectiveness	**Low Efficacy** Inability and Ineffectiveness
	High Threat Vulnerable to Serious Harm	**Control Danger** High motivation to take protective action	**Control Fear** Denial, defensive avoidance, counter-arguing
	Low Threat Invulnerable Trivial Threat	**Control Danger** Low motivation, may be some protective action	**No Response** No fear of risk

Source: Storey, J. D. (2017). Johns Hopkins Center for Communication Programs.

The approach above can be used to guide segmentation of audiences. Reviewing the above table, if a person feels a high level of threat, but a high level of efficacy, they are more likely to take

[8] Used with permission: Health Communication Capacity Collaborative (HC3). (n.d. e). *The extended parallel processing model.* Available from http://www.healthcommcapacity.org/wp-content/uploads/2014/09/Extended-Parallel-Processing-Model.pdf

protective action. On the other hand, if a person feels a high level of threat and low efficacy, then they would be less likely to take action or might not feel the need to respond to the threat at all. These individuals would likely need to be educated about risk perception and what to do in the event of a threat.

When to Use the Extended Parallel Processing Model

The EPPM is useful in health communication or education campaigns when a health issue poses a real or perceived threat to personal health. It is important to note that it is the blend of perceived risk and perceived efficacy that causes risk reduction behavior. Fear messages alone without efficacy messages can result in maladaptive fear control, rather than protective danger control.

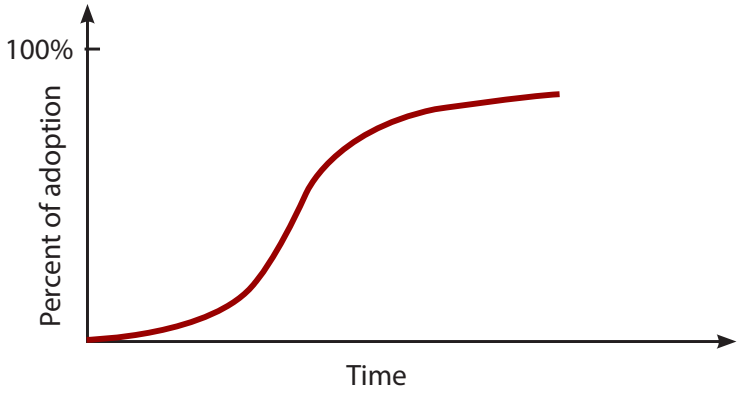
How Can You Use the Risk Perception Attitude Framework?

- Identify how the audience thinks of the health issue
    - Is it considered serious?
    - Do they feel threatened? Fearful or unconcerned?
- Identify what people think are viable and effective solutions
    - What solutions will work?
    - Which solutions can they do?
- Identify messages that address threat and efficacy
    - Increase perceived seriousness of threat
    - Increase perceived susceptibility to threat
    - Increase knowledge of solutions
    - Model response behaviors

Diffusion of Innovation [9]

The Diffusion of Innovation is a research model that describes how a new idea, product, or positive health behavior spreads through a community, social structure, and networks over time. Developed in the 1940s and 1950s by Ryan and Gross and then expanded upon by Rogers (1962), the model identifies several factors that influence how quickly an idea or behavior is adopted. The adoption of a new idea or behavior, or the diffusion of an innovation, depends on the perceived characteristics of the innovations, communication channel, time, and the social network or system.

[9] Used with permission: Health Communication Capacity Collaborative (HC3). (n.d. a). *Diffusion of innovations*. Available from http://www.healthcommcapacity.org/wp-content/uploads/2014/03/diffusion_of_innovations_kim.pdf



The diffusion S-curve shows how innovations are diffused through a social system. It illustrates how people are initially slow to adopt new behaviors, but as the behavior becomes better known and accepted, more people quickly start to practice it. More popular innovations will have steeper curves, while those innovations that are slow to be adopted will have flatter curves.

Factors That Influence How Quickly an Idea is Shared in a Community

- Communication channels – such as media, community meetings and word of mouth can influence how individuals access information and what types of information they access.
- Opinion leaders – they are often seen as gatekeepers and may be "significant others" for people within a network. As trusted members of the community, they can serve as guides for adopting a particular behavior. They can also prevent diffusion of an innovation if they reject it.
- Social structure – can determine whether a community is open to integrating innovations or if there are community gatherings where people come together to exchange and discuss information. Understanding the community environment can also help implementers identify opinion leaders and select the best channels of communication.
- How people perceive an action can help to determine its appeal.
    - Relative advantage – Does it offer any advantage over the current behavior?
    - Compatibility – Is the new behavior compatible with current behaviors, beliefs and values?
    - Complexity – How difficult is the new behavior to perform?
    - Triability – Can it be tried without too much risk before making a decision?
    - Observability – Are there opportunities to see what happens to others who adopt this behavior?

The Diffusion of Innovation is best used for interventions that have a limited amount of time to make an impact on entire communities. It works best when applied to issues that can be influenced by prominent members of society or spread through traditional methods of communication.

How Do You Apply the Diffusion of Innovation?

- Identify what the audience thinks of the innovation
    - Relative advantage, complexity, etc.
- Identify people who are key network members
    - Who is an opinion leader?
- Identify messages that address concerns about the innovation
    - Show the benefits
    - Show how to do it in simple terms
    - Show what happens if you do it
    - Show how new behavior fits with or grows out of current practices
    - Motivate or provide opportunities to try
    - Encourage discussion

Chapter 5

Steps to Behavior Change

Objectives

- Describe the steps to behavior change

Steps to Behavior Change

Armed with theories, models, and frameworks that focused on the audience—as individuals, clients, and customers—and on exchanges between providers and clients, "health communicators began turning to theories of communication and behavior change that emphasize **process**. These theories help to explain the process that individuals go through as they exchange information and as they interpret and react to different messages" (Piotrow, Kincaid, Rimon, & Rhinehart, 1997).

Various models of behavior change process have been developed over the years, including the Stages of Change, or the Transtheoretical Model. The Stages of Change Model includes five stages that describe an individual's readiness to act on a new behavior—pre-contemplation, contemplation, preparation, action, and maintenance of new behavior—that have been applied to behaviors such as smoking, drug addiction, and weight loss.

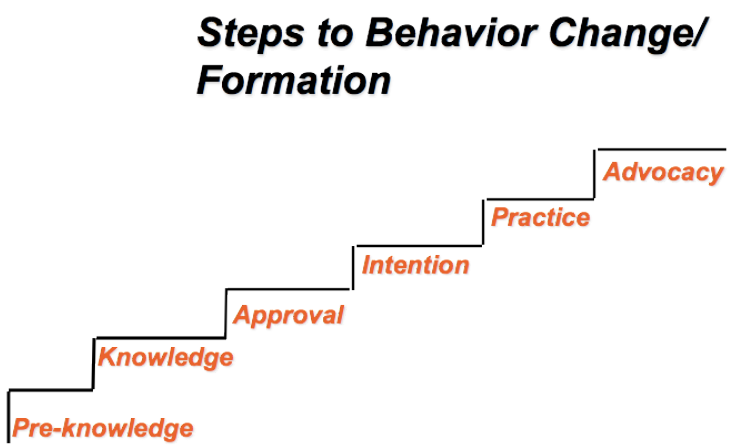
Steps to Behavior Change – Adapted from the Diffusion of Innovations and the Input/Output Persuasion models, this model was developed as a social and behavior change framework to demonstrate how individuals and groups move from knowledge to sustained behavior change and advocacy. The model is enriched by social marketing concepts and is flexible enough to incorporate other theories within each of the steps or stages as appropriate. The model consists of six major stages of change: **pre-knowledge, knowledge, approval, intention, practice, and advocacy**.

- **Pre-knowledge** – The individual is unaware of the problem and has no sense of personal risk.
- **Knowledge** – The individual understands the issue and their personal risk.
- **Approval** – The individual agrees that a specific behavior will reduce personal risk of contracting disease, discusses issues with personal networks (family, friends, peers), and believes that their family, friends, and community, especially their peers approve of risk-reduction practices.

- **Intention** – The individual intends to reduce risk, plans to practice a specific behavior, and plans to not undertake specific risky practices.
- **Practice** – The individual actively practices risk reduction.
- **Advocacy** – The individual experiences and acknowledges the benefits of risk reduction, advocates the practice to others, and supports peers to practice the same.

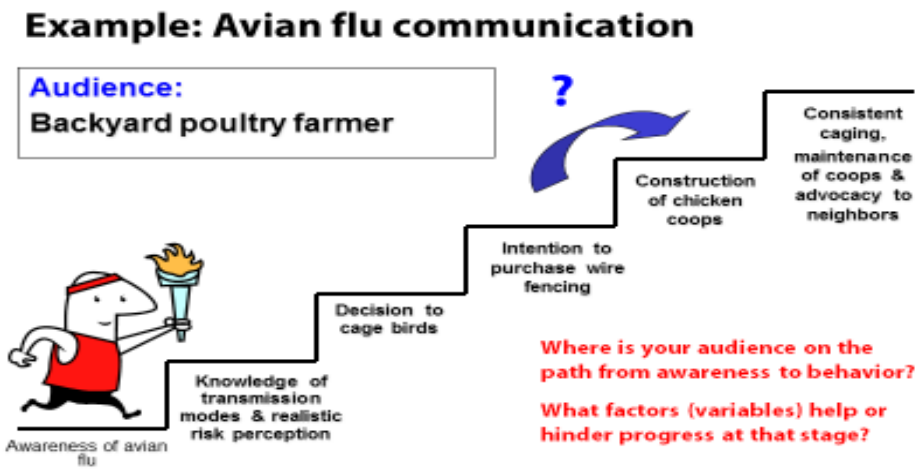
The Steps to Behavior Change Framework assumes that:

- Not all individuals go through each step of the process in the same order, at the same speed or at the same time
- Emphasis can shift to later steps as knowledge and approval reach high levels
- Many factors influence behavior change, including social norms and public policies (Lozare, Storey, & Bailey, 2016)
- The final stage of behavior change is advocacy through public acknowledgement, promotion by satisfied user, and support for behavior change programs



Source: Johns Hopkins Center for Communication Programs (2015)

On the next page is an example of the Steps to Behavior Change that illustrates what the audience is doing and thinking at each stage. This example also illustrates how important it is to identify where your audience is so that you can determine how best to use communication to move them to the next stage.



Source: Storey, J. D. (n.d.) Johns Hopkins Center for Communication Programs.

Chapter 6

Understanding Communication Channels

Objectives

- Describe various communication channels—such as mass media, community-based media, social media, digital media, and interpersonal communication—used in health communication interventions
- Provide tips on how to choose the correct channel for an audience

Introduction

Various communication channels are helpful in reaching individuals and communities. Health communicators have defined communication channels as modes of transmission that enable messages to be exchanged between "senders" and "receivers." The various types of communication channels are:

- **Interpersonal channels** include one-to-one communication, such as provider to client, spouse to spouse, or peer to peer.
- **Community-based channels** reach a community, defined as a group of people within a distinct geographic area, such as a village or neighborhood, or a group based on common interests or characteristics, such as ethnicity or occupational status. Forms of community communication are:
    - Community-based media, such as local newspapers, local radio stations, bulletin boards, and posters
    - Community-based activities, such as health fairs, folk dramas, concerts, rallies, and parades
    - Community mobilization, which is a participatory process of communities identifying and taking action on shared concerns
- **Mass media channels** reach a large audience in a short period of time and include:
    - Television
    - Radio

- Social Media (Facebook, Twitter, YouTube, Instagram, LinkedIn, etc.)
- Newspapers
- Magazines
- Outdoor/Transit Advertising
- Direct Mail
- Internet

There is no one perfect channel. Each channel has inherent strengths and limitations due to its nature. A blend of channels can be used to capitalize on inherent strengths, allowing for greater impact. Using multiple channels can also have a cumulative and reinforcing effect, increasing the effectiveness of the messages communicated. The table below provides examples of general strengths and limitations for various channels (HC3, n.d. c).

Channel	Strengths	Limitations
Interpersonal Communication Community dialogue, peer-to-peer, health provider-client, and inter-spousal and parent-child communication	• Tailored and personalized • Interactive • Able to explain complex information • Can build behavioral skills • Can increase intention to act • Familiar context – enhances trust and influence	• Lower reach • Relatively costly • Time-consuming
Community/Folk Media Community drama, interactive storytelling, music, community events, video group discussions, mobile video units, talks and workshops, door-to-door visits, demonstrations, and community radio	• Stimulates community dialogue • Motivates collective solutions • Provides social support for change • Can increase intention to act • Reaches larger groups of people	• Less personalized than interpersonal communication • Time-consuming to establish relationships • Relatively costly • May have less control over content

Channel	Strengths	Limitations
Mass Media and Mid-Media Radio, TV, print, film, and outdoor posters and billboards	• Extensive reach • Efficient and consistent repetition of message • Capacity to model positive behaviors • Sets the agenda – what is important and how to think about it • Legitimizes norms and behaviors	• Limited two-way interaction • Available only at certain times • Relatively impersonal
Digital and Social Media Mobile phones, SMS, Facebook, Internet, Twitter, e-toolkits, web sites, e-forums, blogs, YouTube, and chat rooms	• Fastest growing and evolving • Potential to mobilize youth • Highly tailored • Interactive • Quickly shares relevant information in a personalized manner • Flexibility to change and adapt as needed	• Program may have less control over content • Requires literacy • Limited reach and accessibility • Can lack credibility

Choosing the right channel depends a lot on the purpose of a program or intervention and the expected outcomes. As noted in the table above, different channels can be used to achieve different results. For example, they can be used to inform and educate, persuade and promote, increase intention to act, impact skills, encourage behavior change, reinforce behavior change, and/or nurture advocacy. Formative research and learning more about the audience can help determine which channel is best to use for an intervention.

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