Steps In Planning and Developing Health Communication Campaigns: A Comment on CDC's Framework for Health Communication

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Synopsis

This reviews the efforts of the Centers for Disease Control and Prevention to integrate effective health communication into its programs that are designed to change behaviors.

Although the 10-step framework for developing and implementing the Centers' health communication programs is both practical and comprehensive, it is suggested that a reversal of steps 2 and 3 is a more logical sequence, is more consistent with the literature and, more importantly, could avoid misapplications of the framework by less experienced practitioners.

Comment is also made on the dynamic nature of health communication planning and development, a point not made explicit in the Centers' framework.

A 1993 article in *Public Health Reports* by Dr. William L. Roper, then Director of the Centers for Disease Control and Prevention (CDC), outlined strategies and goals for the integration of effective health communication into CDC's prevention programs that are designed to change behavior (*1*). The operating framework for health communication is a 10-step model for the development, pre-testing, refinement, delivery, and evaluation of health messages for targeted audiences (see chart) (*1*).

The CDC model is similar to those used by health educators (*2–6*) and by commercial marketers for advertising campaigns (*7,8*). The CDC framework, however, differs in one important respect from many models in that steps 2 and 3 appear to be reversed. Whereas other models select and describe target audiences prior to setting communication objectives, in the CDC framework it appears that the communication objectives are set before the target audiences are identified, profiled, and selected. This appears inconsistent with the American Public Health Association's criteria for the development of health education programs (*9*), which assume that target groups are defined first and that the needs, preferences, beliefs, and attitudes of the target groups are taken into account in designing and implementing interventions.

In this paper, it is argued that CDC alter the sequencing of these two steps for three major reasons—(*a*) the overall program's behavior change objectives must be explicitly stated prior to the setting of communication objectives so as to guide the communication strategy development, (*b*) a consumer orientation demands that the target audience's current beliefs, attitudes, and behavior be understood prior to setting communication objectives, and (*c*) communication objectives must be consistent with the channels available to reach the selected target audiences, which requires prior knowledge of the target audience's information and entertainment habits (media exposure, for example).

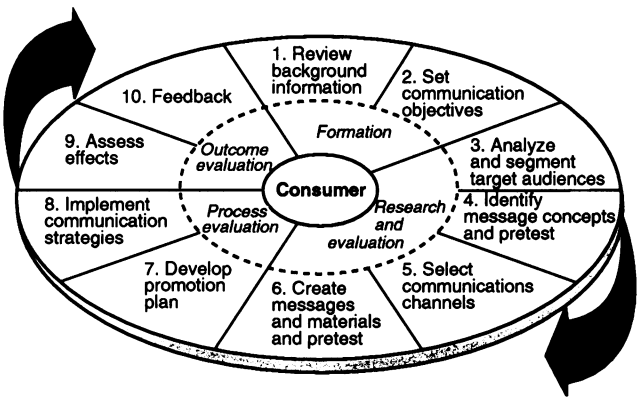
Linking Goals and Objectives

The early stages of any communication planning model should explicitly link the overall program's broad goals, specific outcome objectives, and individual behavior change objectives to the communication component of the program. Stating the behavior change objectives provides a clear focus for the literature review and formative research phases that lead to the development of communication objectives.

Although the CDC framework begins with a review of background information that includes a review of "any goals and objectives drafted for the overall prevention program" (*1*), the links with the overall program's objectives and the specific role and extent of the communication component of the program appear ill-defined.

Furthermore, there is no specific linking of the communication objectives with the overall behavior change objectives. This is somewhat surprising given CDC's clear expectation of "influencing individual behavior to reduce risks to health" (*1*), and the

CDC framework for health communication



emphasis on behavior analysis and objective-setting in health intervention frameworks such as PRECEDE (*10,11*).

Consider a comprehensive anti-smoking program. The program's overall goals might be better health, increased wellness, lower health care costs, and reduced morbidity and mortality. Specific objectives might include the reduction of smoking prevalence in the population from 28 percent to 20 percent in 5 years. These statements of what we want to achieve lead logically to the questions: "Who do we need to reach?" and "what do we want them to do?" (*2,12*).

Reducing the prevalence of smoking can be achieved by preventing the adoption of smoking or by persuading current smokers to quit (or both). A focus on prevention will target non-smokers, and particularly young children; a focus on cessation will target primarily adult smokers. Within each of these two broad segments are a number of different subsets defined by sociodemographics, lifestyles, beliefs, attitudes, and behaviors with respect to smoking, and by other risk factor indices (for example, degree of children's exposure to adult role models who smoke, degree of addiction of adult smokers, and so forth). It is clear that the communication objectives and communication strategy could vary markedly for these different audiences.

Similarly, the communication objectives clearly will vary by the type of behavior that is being targeted. For example, in Prochaska's change-stage model (*13*), smokers in the contemplation stage might be targeted actually to quit smoking, whereas smokers in the pre-contemplation stage might be targeted to undertake some intermediate behavior such as calling a telephone number for more information.

Delineating precisely what behaviors are required of a segment of the target audience to meet the program's specific objectives provides a clear direction for formative research (and the eventual communication objectives) by asking the questions, "What are the target audiences' current knowledge, beliefs, and attitudes that underlie their current behavior?" and "What knowledge, beliefs or attitudes do we need to create, maintain, or negate to get the target audience to behave in the way we want them to?" (*2,12*). Answers to these questions provide the basis of the communication strategy.

Knowledge, Beliefs, and Attitudes

CDC's framework defines communication objectives as promoting "changes in awareness, knowledge, attitudes, beliefs, and, if appropriate, changes in certain behaviors" (*1*). This definition itself needs modifying. Communication objectives include behavioral intentions but, by definition, do not include behavioral changes that are separate behavioral objectives. Given CDC's definition, it is clear that communication objectives can be set only after current awareness, belief, and attitude levels are measured in the selected target audiences. For example, with respect to the adoption of exercise, in some target groups, awareness of exercise as a health issue may be high, but attitudes toward adoption of exercise may be negative. In this case, the awareness objective is simply to maintain awareness and the emphasis will be on attitude change objectives. In another target group, awareness and favorable attitudes may both be high, but intention to try exercise may be low. The emphasis for this group will be on motivating trial (that is, increasing intentions to exercise).

The prior identification, description, and selection of target audiences before setting communication objectives is even more clear when current behaviors and attitudes form the primary bases of segmentation (*14,15*). For example, target audiences may be defined on the basis of their current behavior (regular exercisers, occasional exercisers, nonexercisers) and their current attitudes to exercise (positive, neutral, negative) (*12,16*). In these cases, setting communication objectives before selecting target audiences is not logical.

Channels of Communication

Step 2 in the CDC framework includes selecting channels of communication before the target audiences are described (*1*). Again this is not logical. A knowledge of the target audiences' information and media habits is necessary to select appropriate

channels for communication. More often than not this leads to the exclusion of various channels as inappropriate for reaching various target audiences.

Overall, then, it is argued that the CDC framework as it appears could be misleading to those inexperienced in developing health communication, since it implies that communication objectives are set before the target audiences are defined and before the actual behavior changes required by the target audience(s) to meet the overall objectives are explicitly described. Communication objectives should only be set after these have been defined.

Planning and Development

Health communication planning is an iterative process, especially within steps 4 to 6 of the CDC framework. Although the steps in this and other models are shown in sequence, some step decisions are made simultaneously or recursively. For example, in typical models, the target audience's information and entertainment habits are measured and communication channels tentatively selected or excluded at this stage before the messages are developed. If an audience profile shows that they are infrequent TV viewers or never read brochures, then these channels are excluded from further consideration when developing potential messages.

Similarly, to achieve the desired communication objectives, it might be that visual modeling of behaviors is required. Maybe television is too expensive, print is inadequate, and face-to-face group meetings would be avoided by the target audience. This may lead to development of alternative high visual-imagery messages on radio or in popular songs, or, if these are not viable, to revision of the original communication objectives.

References

1. Roper, W. L.: Health communication takes on new dimensions at CDC. Public Health Rep 108: 179–183, March–April 1993.
2. Egger, G. J., Donovan, R. J., and Spark, R.: Health and the media: principles and practises for health promotion. McGraw-Hill, Sydney, Australia, 1993.
3. Frederiksen, L. W., Solomon, L. J., and Brehony, K. A., editors: Marketing health behavior: principles, techniques, and applications. Plenum, New York, 1984.
4. McKee, N.: Social mobilization and social marketing in developing communities: lessons for communicators. Southbound, Penang, Malaysia, 1992.
5. Novelli, W. D.: Applying social marketing to health promotion. *In* Health behavior and health education, edited by K. Glanz, F. M. Lewis, and B. K. Rimer. Jossey-Bass, San Francisco, 1990, pp. 342–369.
6. Smith, W. A., and Elder, J.: Applied behavior change: a framework for behavior change interventions and research. Academy for Educational Development, Washington, DC, 1992.
7. Colley, R. H.: Defining advertising goals for measuring advertising results. Association of National Advertisers, Inc., New York, 1961.
8. Rossiter, J. R., and Percy, L.: Advertising and promotion management. McGraw-Hill, New York, 1987.
9. An Ad Hoc Work Group of the American Public Health Association: Criteria for the development of health promotion and education. Am J Public Health 77: 89–92 (1987).
10. Green, L. W., and Kreuter, M. W.: Health promotion planning: an educational and environmental approach. Mayfield, Mountain View, CA, 1980.
11. Windsor, R. A.: Planning and evaluating health education methods for pregnant smokers. HYGIE 5: 38–43 (1986).
12. Donovan, R. J., and Owen, N.: Social marketing and mass interventions. *In* Advances in exercise adherence, edited by R. K. Dishman. Human Kinetics Books, Champaign, IL, pp. 241–282.
13. Prochaska, J. O.: Assessing how people change. Cancer 67: 805–808 (1991).
14. Rossiter, J. R.: Market segmentation: a review and proposed solution. Aust Market Researcher 11: 36–58 (1989).
15. Sheth, J. N., and Frazier, G. L.: A model of strategy mix for planned social change. J Marketing 46: 15–26 (1982).
16. Donovan, R. J., and Francas, M.: Understanding communication and motivation strategies. Aust Health Rev 13: 103–114 (1990).