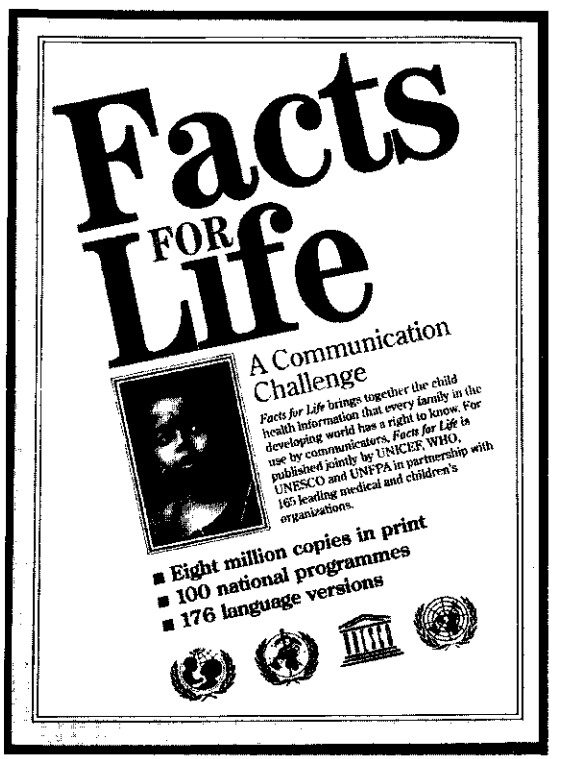
Facts for Life

Lessons from Experience



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Facts for Life: Lessons from Experience *is dedicated to the people whose communication skills and talents a*
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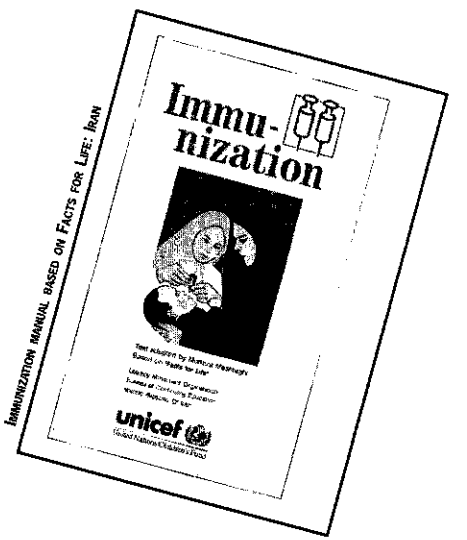


Contents

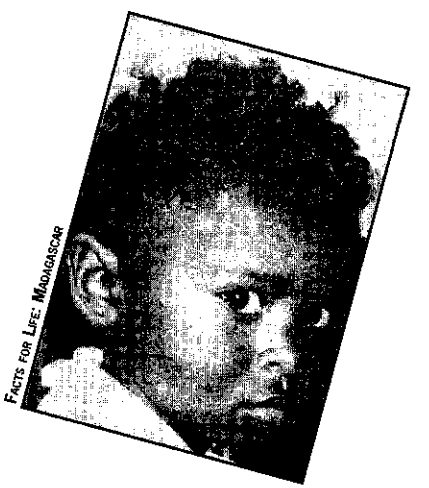
Introduction

Five years of using Facts for Life

In less than six years, some 12 million copies of *Facts for Life* have been printed and distributed in 213 different languages. The book is used in some 200 countries, most of which produced at least one local version. It qualifies as a significant publishing and marketing success. However, *Facts for Life* was not designed to top best-seller charts, but to make good the boast that appears on dust-jackets: 'This book changes lives'.

Facts for Life is designed to give children a better chance of life, health and physical and mental development, by putting knowledge into the hands of parents and communities and by presenting simple ways in which this knowledge can be turned into action. Some actions are things that parents can do themselves; others require efforts by local communities acting together; others imply significant changes in society.

The messages in *Facts for Life* derive in part from *The State of the World's Children*, the annual UNICEF balance sheet of the struggle for survival by families the world over. They have been repeated in different ways by many people and organizations. *Facts for Life* draws these messages together, makes them simple to understand, and links them to action and change.



Messages carry authority

Facts for Life is jointly published by the World Health Organization (WHO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA). The second edition has the active support of 165 leading medical and children's organizations. The main global health and development bodies are speaking with one voice, and this makes *Facts for Life* authoritative in the eyes of doctors, teachers, planners and other professionals. This authority has been influential. In China alone, there are 4 million 'village doctors'; health workers with limited training and knowledge. *Facts for Life*

helps them and their counterparts in other countries to provide consistent and safe information on immunization, breastfeeding, drinking water, sanitation and many other topics. In sub-Saharan Africa, in Asia, in Latin America and in the Middle East, *Facts for Life* provides consistency of messages, which ensures that professionals are indeed speaking with one voice.

Facts for Life is also one of the few publications that has indeed penetrated communities throughout the world. Ghana, for example, reported that *Facts for Life* had become one of the most sought-after publications in the country, and is now the basic resource book for many organizations, both governmental and non-governmental. During research for this book, a volunteer health worker in a poor urban community in Manila apologized because her copy of *Facts for Life* was so well thumbed and tattered. Its condition was, in fact, evidence that *Facts for Life* was reaching its audience.

As well as being internationally validated, *Facts for Life* messages are 'action points', presented in non-technical language and illustrated with photographs of local people. The information has been taken out of the hands of the experts and demystified so that it can be shared with people in a form that can be easily understood and applied. This allows *Facts For Life* to be used as an organized and coherent platform for effective interventions with communities.

Transformed for local use

Having internationally agreed editions is not enough. Countries have transformed *Facts for Life* for national use, translating it into local languages, using local photographs and fostering a sense of national ownership, or alternatively integrating *Facts for Life* messages into local cultures and materials.

Even a national version is only a starting-point for the effective use of *Facts for Life*, because it is one of the basic truths of health education that information on its own is never enough. It has to be put into the right hands; training has to be given to those who are going to use it in their work, and messages have to be transformed so that they have impact with the people for whom they are intended.

Some of the results of this transformation can be seen in this book. Egyptian schoolchildren find story-books in their school libraries inspired by *Facts for Life*. In Uganda, parents and children have seen or taken part in a play about AIDS where *Facts for Life* was used to validate the content. In Brazil, messages from *Facts for Life* have been printed in tens of thousands on shopping bags. In Bangladesh, *Facts for Life* has been used to improve training for imams.

Who knows best about the problems of communities?

This book is not designed to promote *Facts for Life*. Its aim is to look critically at issues and lessons, so that individuals and teams in country offices and their co-workers in government departments and non-governmental organizations (NGOs) do not feel that only they come up against the same barriers and constraints. By looking at these issues *Lessons from Experience* can help people to perform more effectively and suggest some key ways that work with *Facts for Life* can be monitored and evaluated.

Today, UNICEF increasingly acts on the assumption that people and communities know best about their own lives and possibilities, and can usually define their own problems and agendas. Efforts are increasingly focused on helping development workers learn how to support communities. Accurate and relevant information is a vital component of this support, and relevance is as important as accuracy. If people confronting disease, malnutrition and poverty are to accept *Facts for Life* as a basis for action, then it must connect with their daily lives. If we are serious about empowerment, then *Facts for Life* must address the problems of parents, caregivers and communities.

From the examples in this book, it will be seen that *Facts for Life* reaches out to people in a variety of ways, in words and pictures, through mass media, face-to-face discussion, schools and community movements of all kinds. One of the themes of this book is that the way in which messages are conveyed is as important as their content, so that people are able to combine their life experiences with the knowledge base of *Facts for Life*, and are in control of the search for solutions.

The experiences reported here are rarely complete success stories because they are taken from life, and reflect its richness, contradictions, successes and mistakes. They are presented in the hope and expectation that we can learn from each other.

1. A Communication Challenge — but on whose agenda?

UNICEF: NICOLE TOUTOUNJI

A woman in northern Lebanon takes part in a 10-day training session to become a peace counsellor as part of the UNICEF-supported Education for Peace programme.

ACTION POINTS

- ***Facts for Life*** **contains accurate and relevant health information but it is more than a health manual.**
- ***Facts for Life*** **is designed to help people communicate health information in a way most likely to result in change.**
- **By emphasizing the communication challenge, *Facts for Life* puts the emphasis on the dynamic of change, rather than simply on giving information.**
- **Communities have their own agendas and are experts on their own problems, and often on their own survival.**
- **People in communities act on their beliefs, attitudes and knowledge, and this 'social knowledge' is deeply held.**
- **People in communities should be encouraged to focus on their own experiences, to identify problems and actions that lead to solutions. *Facts for Life* has the potential to introduce new scientific information into that process.**
- **The communication challenge is to bring this scientific knowledge in *Facts for Life* to communities, in a way which helps them to address problems.**
- ***Facts for Life*** **messages have limited value if used as ready-made solutions to pre-defined problems. They are tools for communities, not a set of commandments.**
- **If *Facts for Life* is introduced in this positive way and integrated into the work of UNICEF and its partners, then programmes will produce more effective results.**

A communication challenge

Facts for Life is subtitled *A Communication Challenge* to impress on us that it is not simply a health resource book, but that communicating about health is the main objective. *Facts for Life* sets out to communicate ideas related to the promotion of health and child and family welfare and the prevention of ill health and disease. It challenges society to communicate the child health information "that every family in the world has a right to know". Among those targeted in this challenge are the owners and editors of mass media, ministries of education, principals of schools and teacher training colleges, teachers and teaching unions, NGOs, religious leaders, political parties, employers, trade unions and health workers.

This is a daunting task that requires a worked-through communication strategy, and the first step in this strategy is to have a clear idea of what it is we are trying to achieve. What is the aim of the communication, and how do we know when we have done it successfully?

These are questions to which it once seemed there were simple answers. The aim was to communicate messages designed to bring about change, and change was designed to eliminate dangerous practices and introduce beneficial ones. The communication challenge was how to bring new information to communities that were not fully aware of the risks to their children, or how to avoid those risks. Today, the communication challenge seems more complex, because we know that pouring information into communities does not in itself bring change, and also because the very objective of 'bringing about change' in communities seems inadequate, even arrogant.

Communities have their own agendas for action

Communities have survival skills. Their history is one of defining the problems that put them under threat and finding solutions to ensure they are not wiped out. Sometimes, these solutions bring profound benefits to the community in improved child survival, improved food security and improved family income. But the world is a harsh place and sometimes even the most determined families and communities have only 'least worst' options.

Those seeking to communicate health information do well to remember that every community that survives does so because of its ability to learn from experience and to transform knowledge into action. In putting forward suggestions for community action we need to find a place on the community's own agenda for action.

Listening builds trust

To reach your audience or community, it is very useful to know what it believes and how it behaves with respect to health and sickness. You will need to ask people about their problems and elicit their opinions and views. It is very important to listen carefully to their answers. They will help you to decide what to communicate. Listening helps to build trust. Listening helps you to identify priorities.

Ugandan Facts for Life, vol. 1, page 3

Most people involved in development work know this at one level or another. They have experienced interventions that succeed and interventions that fail. Often, however, we fail to understand — or even to ask — why communities will take some actions but not others, why some new piece of knowledge is accepted or ignored.

Scientific and social knowledge

Messages from *Facts for Life* are examples of *scientific knowledge*. That knowledge has been internationally validated and put together in such a way that it can be understood by people who do not have academic or scientific backgrounds. Although information on breastfeeding, immunization, AIDS, birth spacing and other matters is designed to be easy to read and understand, it is based on the facts: a distillation of scientific knowledge that parents and communities have a right to know, and want to know.

Scientific knowledge is what we are used to learning in school and college. It is factual, validated and presumed true (at least until someone comes along with a better set of facts).

There is another sort of knowledge that communities use in their everyday life. We can call this *social knowledge*. In rural communities, this includes such things as which plants are safe to eat, which wells are the most likely to last out the dry season and when crops should be planted. In urban communities, it might include knowledge of how to dispose of human and household waste, where the boundaries between communities are located and where cheap food or work can best be obtained. In all communities, it is likely to include social knowledge of how children should be brought up, who should be listened to and who can be politely ignored. This sort of knowledge is passed from person to person, and from generation to generation, and is more or less taken for granted. It depends on the beliefs of a community, and may become codified into a set of customs that are relatively inflexible on such questions as who should help a mother to give birth, who has responsibility for child-rearing and for housekeeping and providing food.

We can illustrate the difference between scientific and social knowledge by asking: "*Which water is good to drink in this community?*" A scientific answer details the number of microbes per millilitre and whether the water has been treated or boiled. An answer based on social knowledge is more likely to focus on how the water tastes, how clear it appears and whether the source has been traditionally regarded as clean and pure. This is true in all communities — whether they get water from a river or a pump, or whether they have running water in every room. People think they know which water is safe to drink.

Wells in India — agreeing to differ

The Indian Market Research Bureau surveyed 7,900 water users. Four out of five had access to a handpump, but only one third used it as their main water supply. In some cases, this was because the pump was too far from their home. However, users judged water by look, smell and taste and sometimes chose polluted water. A quarter of those interviewed believed that they would be able to see germs in impure water, and fewer than one person in five understood the link between impure water and diarrhoea and cholera.

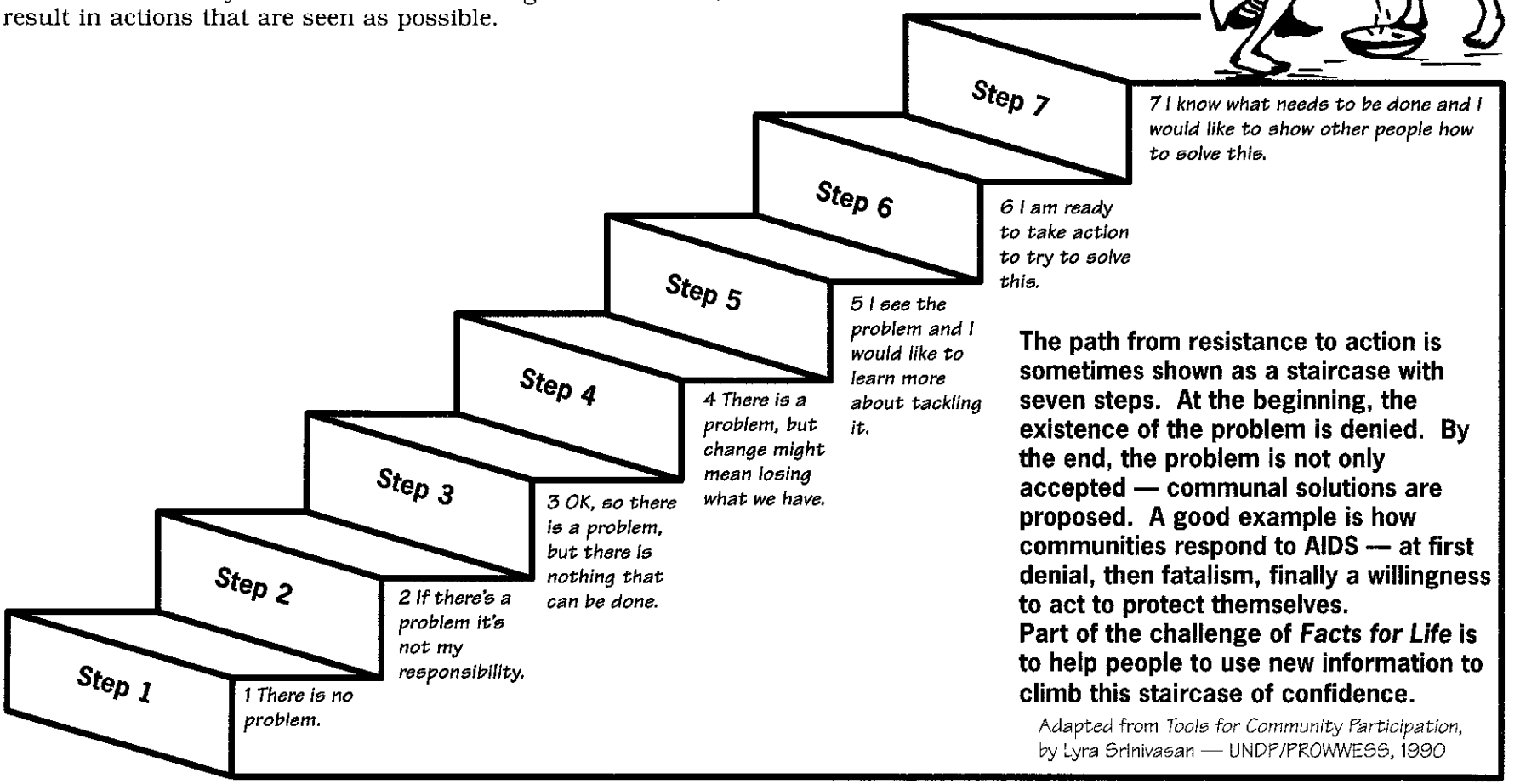
Two thirds of the women interviewed judged water by whether it 'cooked well'. The Bureau also talked to the water sector experts who were introducing a safe water programme. They had no concept of the 'cookability' of water and little idea of what people knew or believed about pure and impure water. The water experts were however, baffled as to why their wells were not being better used.

***Communication in Water Supply and Sanitation*, published in 1994 by the International Water and Sanitation Centre, Netherlands**

Transforming knowledge into action

Facts for Life messages advocate actions that require change in people's beliefs and ways of doing things. Not everybody is readily open to change. When the social knowledge of the community and the scientific knowledge from outside are brought together and result in positive action by a community in addressing a problem, the new basis for action is sometimes called *transformative knowledge*. It doesn't matter what it is called — so long as we recognize the importance of this process of fusing together the knowledge and beliefs of communities with the new information. If new information is to be used by communities in this way it must be relevant to their priorities, it must be introduced in a way that makes it interesting and accessible, and it should result in actions that are seen as possible.

Seven steps on the road from resistance to action



The path from resistance to action is sometimes shown as a staircase with seven steps. At the beginning, the existence of the problem is denied. By the end, the problem is not only accepted — communal solutions are proposed. A good example is how communities respond to AIDS — at first denial, then fatalism, finally a willingness to act to protect themselves.
Part of the challenge of *Facts for Life* is to help people to use new information to climb this staircase of confidence.

Adapted from *Tools for Community Participation*, by Lyra Srinivasan — UNDP/PROWWESS, 1990

Common communication approaches

Informing:	*The new idea is introduced and made familiar.*
Educating:	*The new idea, its strengths and weaknesses are explained.*
Persuading:	*Appealing to the audience to accept the new idea.*
Entertaining:	*The attention of the audience is drawn to the new idea.*

UNDP Guidelines for Planning Communication Support, 1986

There are many ways for individuals to receive new information, and their attitude to that information is likely to be influenced by the way it is communicated.

- They could see or hear something on television or radio, unrelated to their own lives.
- They could be approached with a message by someone they do not really know or really trust, and thus receive a message that is unlikely to move them to action.
- They could see friends or neighbours doing something differently that seems to be making their lives better, and be interested and curious but unsure how to proceed.
- They could come to know something through personal experience, so that a new practice becomes an everyday routine, or a threatening situation becomes manageable.

The last of these is the most profound form of knowing something. How do we reach the point at which old attitudes are challenged and knowledge is transformed into action?

How do people learn?

Most adults do not learn the things they really believe from books or television. They are more likely to learn from sharing experiences with others in a similar situation. The process of discussing a problem and seeking a solution is itself a learning process, and it is in that process that *Facts for Life* can be most useful.

This changes the focus of interaction with a community. Instead of presenting a new set of facts, as in *Facts for Life*, and saying, "Here is information you should act on," the focus is on the experience of communities and their problems. The emphasis is on *problems* rather than needs, because it is not clear that asking people about needs elicits the same response. If asked what they need, people list items or services they know about — a well, a means of transport, a health centre. If these things alone really did provide answers, then successful development would really be happening, not something under discussion. 'Things' are almost never the whole answer, and may not be available or sustainable solutions. But when people are asked to discuss their problems, they often identify what they see as obstacles to improving their lives. A community may list diarrhoea, children dying, the isolation of the community and its lack of access to clean water. In searching for solutions they may come up with answers that more directly involve the community, such as protecting a water source, or training a village health worker, or

supporting an economic group that plans to open a shop nearby. They identify problems rather than felt needs, and transform the problem by solving it in a way that is effective and appropriate. Of course, part of the answer may still be a well, or a four-wheel-drive vehicle, but identifying problems opens a wider range of possibilities, and allows people to focus on what they can do rather than simply on acquiring hardware.

In this process, someone bringing new information has to act as a facilitator, not an instructor, helping communities to identify those important problems they can do something about, and ensuring that people in communities have access to relevant and timely information. There is nothing magical about *Facts for Life* that would ensure that it always, in all circumstances, contains the information people need. Because *Facts for Life* is drawn from experience and has been tested in many different settings, we can be confident that some of its prime messages will prove useful and that some supporting actions will be adopted or adapted. However, people do not adopt ready-made answers without question. The panel on this page shows some questions people are likely to ask about new information.

The relationship between knowledge and action

The relationship between knowledge and action is complex. People may be willing to try something different from what they have done before, or they may resist new ways of doing things, depending on how deeply their beliefs and customs are held, and how significant a problem is in their lives. Some actions require deep understanding of problems and solutions. Others simply require minor shifts in routine.

The campaign for universal immunization has been the most successful global health campaign ever, in terms of people reached and affected. Over the course of a decade, immunization levels in many countries rose from negligible levels to over 80%. Millions of children were protected from fatal diseases. The effort to mobilize communities and provide services was enormous. However, once communities could see that immunization did protect children, there was a clear incentive to support the campaigns. The action required by parents — taking children to a clinic two or three time in the first months of life — is important and significant, but does not involve a complex change of attitude, except where immunization challenges cultural taboos. Many parents have a poor idea of how immunization works, yet, so long as they continue to take their children to clinics, this lack of knowledge will not adversely effect the programme. Of course, better understanding by mothers may make the programme more sustainable, because they then understand the importance

Ready-made answers questioned

People do not adopt ready-made answers without question. Here is one way of describing how we react to new ideas and innovation; together with some questions communicators might ask themselves.

Those receiving new information may ask:	Communicators might ask themselves:
What will other people say?	*Is this information culturally appropriate?*
How it is like what I already know or do?	*What do people already think and do about this?*
How complicated is it?	*Can we explain this simply? Is it feasible and sustainable?*
How much will it cost?	*Is this 'low-cost' solution affordable, compared to competing claims on their money?*
Will I see any good results?	*What assessment can we suggest, so people can check that things are improving?*

Adapted from *Communication of Innovations*, by Everett Rogers

of completing a course of vaccinations and they will continue to bring their babies even when there is no outbreak of disease. However, the important thing is for parents to believe that immunization works and that their children should be immunized.

Some changes require a more sophisticated level of knowledge. Parents in malarial areas are encouraged to make sure that their children sleep under impregnated mosquito nets. Parents need to know about the link between the mosquito and malaria, and to be committed to a regular routine. Parents may try this way of protecting their children, but this knowledge and practice will only become part of the social fabric if they see that their children are in fact protected, and that rates of malaria fall. This in turn suggests that the knowledge of the link between the mosquito and malaria must be applied in other ways — that rubbish is cleared from around the house, and pools where mosquitos breed are targeted. One action alone, even a correct action, on its own, may not make the difference.

Some chains of action are complex and require deeper conviction. Parents are encouraged to feed young children five times daily and to enrich food to prevent malnutrition. Parents need to know that not all cases of malnutrition are obvious, to know how to check on the progress of their children and to know which foods provide good nutrition. Nutrition campaigns simplify this by introducing weighing and measuring systems so that parents can check the progress of their children on growth charts, and by setting up some forms of communal feeding so that parents can learn more about the kinds of food that help their children to grow strong and healthy. Even so, the changes that result can be profound. Increasing the frequency of meals may be difficult if the mother works away from home. Mothers may set up day-care centres where children can be looked after, and this in turn may encourage cash-generating schemes to allow the women to meet the costs. To follow through this chain of actions, mothers must be convinced of the need to change feeding habits taught to them by their mothers and grandmothers.

Some actions require high levels of knowledge and commitment by whole communities. One example is action to prevent diarrhoea. Protecting wells and disposing of sewage demand an understanding of the risk from human waste, and require changes to ingrained customs. Many sanitation campaigns fail because communities do not see them as viable or relevant. The campaigns are often expensive. They ask people to change the habits of a lifetime but may not lead to quick and visible improvements in health, because the level of diarrhoeal disease depends on many factors, not all of which can be changed at once.

Social pressure can inhibit change

It is not only a sense of conviction that people need. Often, there is a conflict between what people would like to do and the social pressures they feel they are under. Women may 'know' that breast is best for their baby but feel under strong social pressure to stop breastfeeding because they feel this will make them less attractive, or because using powdered milk is seen as a social step-up. Many young people 'know' that smoking is bad for them but are insulated from the arguments for stopping because they are in a circle of friends who smoke.

Campaigns to improve the health and development of communities succeed when they help people reach a new level of understanding and help them adopt a series of actions that are both possible to sustain and effective. Campaigns that fail need to fail at only one of these stages, and the more complex the change in thought and actions the more carefully such interventions need to be planned and introduced.

Is this approach at odds with the Facts for Life package?

This approach, advocating that communities define their own agendas and discuss their own experiences, may appear to be at odds with *Facts for Life*, which, after all, is a series of internationally agreed prime messages on pre-selected issues. In fact, these approaches are complementary rather than contradictory because *Facts for Life* has come out of years of experience and has in that sense been validated by communities. *Facts for Life* topics have been selected as the problems most likely to perpetuate ill health and to continue the cycle of poverty, and the actions proposed are those most likely to encourage children to grow up with good health.

Facts for Life is the basis for scientific knowledge covering a wide range of common problems to which communities seek solutions. Because *Facts for Life* has been validated, it is authoritative, and because it has been sensitively assembled, its messages are sympathetic to community knowledge and support community experiences and beliefs. *Facts for Life* seeks to broaden debate and discussion and open people to the possibility of reconsidering and challenging common assumptions. Is it true that children who drink from one source become sick more often that those who drink from another? Is it true that children who have been immunized have fewer serious preventable illnesses? In short, *Facts for Life* is a tool for engaging in dialogue, not a set of commandments.

Monitoring and evaluation

Evaluating the success of health and communication campaigns should be part of the initial process, not an afterthought. The first step is to ensure the correct identification of a relevant and practical problem of real concern to the communities involved. The existing state of knowledge, beliefs and customs of community members on the issues must be known for successful evaluation to be possible. A knowledge, attitude and practice survey could be one way to assess whether the right topics have been selected.

Questions to determine whether the correct issues have been identified for action

How was this problem identified as a priority?

How highly does this problem rank in the perception of the community?

Have previous attempts been made to tackle the problem, and what was their outcome?

What beliefs do community members hold about this problem, and about any suggested solutions?

Has the community discussed possible solutions? How viable are these?

What new scientific knowledge might communities need to know?

What possible actions might be suggested?

How deeply will these actions challenge existing customs and beliefs?

2. A Strategy for Communicating Facts for Life

UNICEF: NANCY MCGIRR

Family life, Perguin, El Salvador.

ACTION POINTS

- **A strategy to communicate *Facts for Life* successfully is a strategy to mobilize communities and policy makers.**
- **The ultimate audience for *Facts for Life* is parents, families, carers for children and communities.**
- **Many partners — formal and informal — must be enlisted if *Facts for Life* is to be brought to this ultimate audience.**
  - **Formal communicators include mass media, schools, colleges, teachers, trainers and health professionals.**
  - **Informal communicators include community workers, community leaders, religious leaders and entertainers.**
- **All programme areas should be reviewed for opportunities to use or apply *Facts for Life*.**
  - **The communication strategy will target influential people to act as advocates for *Facts for Life*.**
  - **It will target legislators to improve the framework for communities and policy makers to improve resources.**
  - **It will develop interpersonal communication within communities, by giving trainers information, and by training them in a participatory approach.**
- **The objective is long-term sustainable effort — not a series of episodic high-intensity campaigns.**

A strategy to communicate

The ultimate audience for *Facts for Life* is parents, others who care for children, and all those who have influence within communities. The messages of *Facts for Life* are communicated in many different ways and by many different people. The mass media bring them to the attention of millions of people, including policy makers and other influential groups. Other communicators may concentrate on specific audiences and groups of people. Artists and playwrights, religious leaders, poets and storytellers have communicated *Facts for Life* by transforming the material in innovative ways. The objective, however, is not just to achieve an impressive list of supporters who are communicating, but to devise a strategy that forms a coherent whole.

A communication strategy amounts to a developed and coherent overview of what consistent messages should be given to which target audiences in a specified variety of ways. The aim of a communication strategy should be to create the conditions for behaviour change. It encompasses advocacy with opinion formers, a methodical approach to mass media, keeping open channels with partners and allies and extensive use of interpersonal media with trainers and communities. A communication strategy for a country office will be broader than *Facts for Life*, but *Facts for Life* programme communication is a critical part of implementing the communication strategy. *Facts for Life* is both a major part of 'what' is being communicated and, when linked to a participatory approach, a tool for empowerment.

Bringing sectors together

When *Facts for Life* was published, the then UNICEF Executive Director James Grant said its unique strength lay in the ability to bring sectors together[1].

"All programme areas should be reviewed for opportunities to use or apply Facts for Life *— basic education, literacy, women and development, water and sanitation, child care and so on.* Facts for Life *will fulfil its potential only to the extent that its contents are widely communicated and become part of the basic stock of health knowledge of every family and community caregiver."*

Basic principles and targets

Facts for Life was launched with a strategy document that set some basic principles:

- *Facts for Life* initiatives should be through country-level cooperation.
- *Facts for Life* is intended to promote informed actions by parents, community leaders and local caregivers, conducive to maternal health and the survival and development of children.

Communication — built in, not stuck on!

Communication succeeds when it is planned with a comprehensive strategy. There must be research, clear objectives, identification of different audience groups, careful message design and choice of channels, and monitoring and feedback. Multimedia approaches that use different communication channels in a co-ordinated and mutually reinforcing way give the best results. The last-minute addition of a 'communication component' too often consists only of a budget to make project publicity materials or to produce some audiovisual aids, and is not cost-effective. A critical mass of staff, equipment and activities is needed to make an impact.

Communication, a Key to Human Development, by Colin Fraser and Jonathan Villet, FAO, 1994

The place of a communication strategy

***A communication objective** is a target that specifies the intended audience, the type of change that is expected, when and where the communication activity is to take place and finally, what criteria will be used to measures its degree of success.*

***A communication strategy** is a combination of methods, messages and approaches by which the planner seeks to achieve the communication objectives.*

UNDP Guidelines for Planning Communication Support, 1986

Achieving management objectives

A UNICEF conference in Amman in 1992 identified a number of objectives and management constraints related to Facts for Life (FFL).

Objective: Integrate FFL into planning
Problems: Lack of coordination between communication and programme sectors. Lack of cooperation between programme sections. Lack of clarity about the importance of FFL. Other perceived priorities. Too many goals. Difficulty in monitoring and evaluation.

Strategy: Use situation analysis to examine knowledge gaps on FFL issues.
Action Points: *Present FFL as a resource to meet the information needs of people. Include FFL in sectoral plans and activities. List FFL issues in research objectives. Highlight the role of FFL in achieving goals of the summit. Include FFL in national plans of action. Feedback evaluation of FFL usage to show its usefulness.*

Objective: Improve communication strategy
Problems: Lack of communication skills and useful experts. Lack of effective distribution. Assumption that FFL is the 'answer to all'. Superficial interpretation of FFL. Lack of effective monitoring and evaluation. Lack of objectivity in assessment. Top-down process. Difficulties in reaching the poorest, and in changing behaviour.

Strategy 1: Incorporate mechanisms for monitoring and evaluation as part of the communication strategy.
Action Points: *Define objectives. Select indicators (process or outcome). Establish baselines. Improve tracking of distribution.*

Strategy 2: Strengthen UNICEF and counterparts.
Action Points: *Identify capabilities of counterparts in communication. In-service training in communication for UNICEF staff and counterparts. Innovative approaches (e.g. Third Channel). Enlist support of skilled communicators.*

(continued on page 19)

- *Facts for Life* is intended to strengthen efforts by governments, NGOs, health professionals, mass media, individuals and institutions, to help parents and communities put knowledge to practical use.
- *Facts for Life* is intended to inform and involve non-health institutions, organizations and individuals.

It also set targets. At national level these were:

- To integrate *Facts for Life* into the activities and programme cooperation of the UNICEF country office.
- To involve interpersonal and mass media channels, in ways that are socially and culturally appropriate.
- To create national or subnational versions, where necessary.
- To establish targets to reach parents in priority areas.

Audiences for Facts for Life

The ultimate audience is parents and other family members with particular attention to:

- mothers and fathers of children under five years old;
- grandparents, aunts and uncles;
- older siblings and other caregivers.
- future parents, particularly, men and women aged 16 to 20; young couples without children; schoolchildren.

UNICEF and partner agencies cannot reach these audiences directly and must use intermediate communicators, including:

- schoolteachers, health professionals and volunteers, government extension and field workers, religious and community leaders, artists and entertainers, youth and women's group leaders, employers and businesses, trade unions and social workers;
- the mass media, (television, radio, newspapers and magazines) as well as journalists, broadcasters, writers, photographers, film makers and other media professionals;
- political decision makers, opinion leaders in ministries, teacher training colleges, universities, schools of medicine and nursing, teaching hospitals, trade unions, professional associations, political parties, women's organizations, youth movements, cooperatives and farmers' organizations;
- all NGOs with strong roots in the community, especially those concerned with health and development.

Transforming messages

Messages need to be transformed or interpreted using stories, songs, talks, drama, role-play, posters, flip charts, billboards, videos, plans or television spots, adult literacy texts or newspaper articles. The strategy document said:

"The words, images or symbols used may vary greatly: what matters is that the content is communicated in ways that are understandable, attractive, feasible and culturally appropriate for particular target audiences. The transformation of these 'Facts for Life' — not merely their transmission from sender to receiver, is therefore the guiding principle in their communication."

Country-level strategy

The document referred to above set out a basic strategy at global, regional and country levels. At country level, this emphasized that *Facts for Life* would be central to partner agency cooperation, and would include:

- Looking for opportunities through social mobilization analysis, including selecting the most appropriate potential allies and partners.
- Integrating *Facts for Life* activities into national and subnational plans of action in a way that develops a feeling of national ownership.
- Building operational links with relevant and effective partners.
  "The aim of FFL is not episodic, high-intensity campaigns, but the commitment of key decision makers to a sustained educational effort."
- Audience analysis, training and monitoring, including training of UNICEF staff and key partner personnel.

Some of these steps will be covered in more detail in later chapters. At this stage it should be noted that:

- Developing a wide range of allies and partners in preparing national or regional versions ensures that *Facts for Life* is integrated into other agendas so that enthusiasm does not evaporate after the launch.
- Having good information on the current status of the target problem, and on target audiences and goals makes it possible later to assess and evaluate how well you have been doing. Although assessment is often seen as the last step, it is imperative to know before the first step what it will be possible to measure to judge how successful your efforts have been.
- Having clear goals and evaluating the outcome of programme communication is essential to convince managers and decision makers to give this work more resources. A survey[2] of decision makers funded by UNICEF and WHO in 1994 identified a lack of clarity about the aims and

(continued from page 18)

Achieving management objectives

Strategy 3: Broaden UNICEF exposure to other development communication experiences.

Action Points: *Put South-South cooperation into practice. Learn from experiences of others. Analyse experiences and lessons inside and outside UNICEF. Document UNICEF experiences effectively. Incorporate participatory communication experiences in FFL follow up publication.*

Objective: Broaden ownership and foster alliances.

Problems: *Not enough involvement from international partners — FFL seen as UNICEF-only publication. Professional resistance (eg education and health). Insufficient involvement of non-health communicators. Difficulty in getting health professionals to read FFL materials. Conflicting agendas of key partners. Lack of continuity. Lack of coordinating mechanism. Lack of services for which FFL creates demand.*

Strategy: Broaden ownership and foster alliances.

Action Points: *Take an intersectoral and inter-institutional approach to FFL at all levels. Identify relevant sectors/institutions/NGOs. Apply intersectoral approach to adapting national version and identifying priorities. Involve key political figures. Incorporate FFL into UNICEF basic education activities. Identify success stories of cooperation and use for advocacy. Incorporate FFL into curriculum of relevant institutions. Support capacity-building through workshops, training courses and equipment. Encourage application of FFL by child and youth organizations. Create newsletter to keep people up to date on activities and developments.*

Drawing the Lessons of Three Years' Experience, Report of Facts for Life/All for Health meeting in Amman (Jordan), June 1992

Tanzania: Putting a strategy into action

In Tanzania, a detailed plan was drawn up to adapt, launch and use Facts for Life. The main components were:

- *Knowledge, attitude and practice (KAP) studies were carried out in 1990 to collect baseline data.*
- *The President launched the Swahili version in 1991.*
- *Almost 90% of ward extension workers were trained in FFL content, and assigned villages to work with.*
- *Additional material was prepared to support FFL and was distributed to wards and villages.*
- *A national feedback mechanism was set up to review progress and constraints.*
- *A follow up KAP study in 1992 revealed that the number of mothers weaning their children at the age of four to six months rose from 42% to 71%. Knowledge on immunisation rose from 45% to 74%.*
- *In January 1994, a half-hour weekly radio programme using Facts for Life material was launched.*
- *Currently (1995), a Village Health Workers' communication kit has been designed, tested and evaluated to promote discussion on local health problems. When funding allows it will be widely launched.*

achievements of communication as the chief obstacle to releasing more funds for communication efforts.

Practical steps to devise or update a strategy

Following the strategic issues identified in the boxes on pages 18 and 19, there are a number of actions that should be taken when *Facts for Life* is introduced or when efforts are being renewed. This list is also useful when evaluating how *Facts for Life* has been used so far.

- **Hold an in-house UNICEF discussion about integrating *Facts for Life* with existing work.**
  How do you prevent this being a task only for communication officers? How does it work its way into programmes? Is the budget for communication adequate?
- **Compile a list of potential partners; government and NGOs.**
  Partners should help to adapt *Facts for Life* for national use. Academics and specialists in communication, such as journalists, should be included. A wider range of partners should be identified before implementing the strategy.
- **Devise a coordinating body to bring these people together.**
  An action team is needed to bring together government and NGOs, ideally not dominated by a single government department.
- **List formal and informal communicators.**
  Has the mass media been drawn in? Are there contacts with informal communicators (e.g. entertainers) who have influence in the community?
- **Draw up a strategy for the media and informal communicators that includes identifying and meeting their training needs.**
- **Outline a strategy for reaching influential policy makers.**
  What policy changes are required? Are they feasible? What is the best way to ask for them?
- **Plan a training programme for people who help community or group members to work with *Facts for Life*.**
- **Develop a strategy for transforming *Facts for Life* materials.**
  Including production of posters and visuals, and training so that artists, film makers, etc, are familiar with *Facts for Life* content and approach.

1. ***A Strategy for Implementation*** — *UNICEF Executive Director memo to country offices 1989.*
2. ***How Decision Makers see 'Communication for Development'*** *by Colin Fraser, September 1994. Commissioned by the Development Communication Round Table (See also opening of Chapter 13).*

3. Adapting Facts for Life for National Use

◆ See Appendix 1 for a full listing of national adaptations

ACTION POINTS

- **Creating a national version of *Facts for Life* helps to create a sense of national ownership.**
- **National versions should be culturally relevant and address local priorities.**
- **Government support gives access to ministries, removes potential blockages and raises awareness of *Facts for Life*.**
- **NGO support in preparing national versions prepares the ground for joint work with *Facts for Life*.**
- **Translations should keep the 'plain language' approach of the original.**
- **Local chapters should be added or deleted to meet local needs, but extra chapters should address priority issues in simple language. *Facts for Life* is neither a comprehensive child-care book, nor a technical manual.**
- **Selectivity, simplicity and consistency are the three principles to consider before adding material.**

Background

The international version of *Facts for Life* was published in five languages — Arabic, English, French, Portuguese and Spanish. It has been translated into a further 213 languages, through production of national versions. This has led to some countries publishing editions in several languages; 12 in China, 8 in India and the Philippines, 7 in Myanmar and 5 in Nigeria.

Egypt: The crucial role of NGOs

In Egypt, Facts for Life was seen as an ideal response to the presidential declaration in 1989 of a decade for the protection and development of Egyptian children.

Adapting a national version took a year. The process began with a UNICEF workshop to brainstorm ideas. A list of reviewers for each chapter was selected. Of 33 local experts, 10 were from the Ministry of Health, 10 from University departments, 2 from national research centres, and 6 from NGOs. An assistant coordinator was assigned to the project half time for six months under the Programme Communication Officer. The aim was to make Facts for Life:

- *more culturally relevant;*
- *address local priorities;*
- *address quality of life issues, so that FFL could be a 'child care' package.*

Forty-five partners in Egypt endorsed Facts for Life and played an important role in developing the strategy for a local version.

The original national publication partner was the National Council for Childhood and Motherhood. At a late stage the Council decided it wished to publish its own guide to child rearing. The Egyptian Paediatric Association (EPA) had been closely involved in reviewing the material and became the main partner for publication. The Association has high public visibility and authority in Egypt. The launch of Facts for Life at an International Paediatric Association meeting in Cairo, with Ministers of Health and Education and the Governor of Cairo present, attracted widespread publicity.

Nagwa Farag, Programme Communication Officer, says close links with NGOs are essential. "It is very good to have the support of ministries and ministers, but that is not the criteria for ultimate success. Attracting NGOs is crucial because they are the key to strengthening national capacity."

Producing a national version is essential in countries where none of the languages used in the five international versions is widely spoken. Even where an international version could be used, the process of producing a local version helps to foster a sense of national ownership, and extends the target audience to those who speak national, regional or minority languages. The use of local pictures makes *Facts for Life* relevant to teachers, health workers, educators and others who are going to use it. It is more important to ensure that photographs are ethnically and culturally relevant than to insist on the highest production standards of photography and reproduction. The process of discussing the text allows government and NGO allies to take ownership of the book and the messages. The process brings government departments and significant NGOs together, perhaps for the first time, and encourages different government departments to work together in a way they do not do every day.

Philippines: The challenge to let partners take ownership

The first country to adapt and implement *Facts for Life* was the Philippines. The process involved the creation of a social mobilization task force drawing together several government departments. Dr. Pratima Kale, at that time the UNICEF Representative in the Philippines, said: *"We had been hearing about WHO, UNESCO and UNICEF[1] working on something called Facts for Life. Many of the field people, including myself, felt that communication material for mothers really ought to be culture specific, and that you have to know the audience. To think of materials being prepared globally really seemed a little bit odd. Looking at those materials in my meetings in New York, however, I began to feel that perhaps there was a great value in the drafts that needed to be recognized.*

"Our next challenge was not to let our partners feel that international agencies had prepared something and that they had to accept it. We thought that we would give them the global version, let them test it and then accept it if they wanted, and once they accepted it, we thought it would be theirs.

"The social mobilization task force invited several partners from different agencies, the Departments of Health, Agriculture, Social Welfare, Education, the Philippine Information Agency and UNICEF. We requested them to review the material and gave them about a month to take these materials back to their respective agencies.

"Initially, the medical profession challenged the technical components; communication experts asked why people should use something that was global; arguing in favour of culture-specific material. All the arguments you could have heard at UNICEF headquarters were again to be heard here. When we finally heard that it had been accepted, that was about half the battle won. That was when it really became exciting because it was not a question any more of UNICEF trying to sell the idea. The

President Corazon Aquino (right) receiving Facts for Life *from Dr. Pratima Kale (left) in 1991.*

Philippine Information Agency agreed to publish it jointly with UNICEF. Several people, particularly the Department of Health, participated actively in adapting messages and truly Philippinizing it, and then the English version was published. Soon after that we began to get requests from the people who had participated in the task force. Having contributed to developing FFL, they were aware of the value of the information, and also felt a sense of ownership. The Department of Health requested 6,000 copies for every worker at the regional, provincial, municipal and barangay [neighbourhood] levels. The Department of Agriculture asked for another 6,000 copies.

"When President Aquino was at a ceremony, I presented a set of material that we had prepared and shared with her a copy of Facts for Life. *She seemed very interested and asked us as to how that was to be brought to every Filipino mother and father and asked about a Tagalog version. The Secretary of the Department of Agriculture was with us, and then it became really exciting because the Department of Agriculture agreed on the spot to translate* Facts for Life *into Tagalog and five other languages."*

Iraq

The Iraqi version was produced following the Persian Gulf conflict during the period of emergency with stringent international sanctions, and child health an everyday news item on television and radio. UNICEF Iraq persuaded the Ministry of Health to set up a committee, which brought together the National Childhood Welfare Council, the Iraqi Family Planning Association, and representatives of the Ministries of Education, Culture and Information, and Health. A UNICEF report says: "Writing the booklet was a social mobilization activity in itself as it motivated various people to integrate the messages into several channels."

Iran

In Iran, Facts for Life *materials were first translated into Farsi in 1990 and were widely used in health education. The Farsi edition was produced jointly by UNICEF and the Ministry of Education in 1993.*

In response to demands from the media and UNICEF counterparts, a second revised edition was released in 1994 in collaboration with the Ministry of Education and the Ministry of Health.

Facts for Life has been widely used by the media and health workers.

Simplified FFL booklets have been produced for the literacy movement.

Papua New Guinea

In Papua New Guinea, Facts for Life fostered the development of a multisectoral plan for production, distribution and training, involving the Ministries of Health, Village Services, Information and Education.

Obtaining political support

Many countries have obtained top-level backing to promote Facts for Life so that presidents, prime ministers and ministers become advocates for change. Political leaders can remove blockages, and focus media attention on Facts for Life to raise public awareness.

- *The* **Burundi** *Prime Minister asked the National Council for Children to give Facts for Life priority.*
- *In* **Guinea**, *Facts for Life was launched by the Minister of Information, ensuring instant access to the media.*
- *In* **Mali**, *Facts for Life was approved by the Council of Ministers and launched by the Minister of Information.*
- *The* **Mexican** *version contains introductory messages from the President and Health Minister.*
- *President Chissano launched the* **Mozambique** *edition at an international Children's Day rally.*
- *In* **Saudi Arabia**, *the Gulf Council of Health Ministers endorsed Facts for Life.*
- *In the* **Sudan**, *the Minister of Information directed the first television spot prepared from Facts for Life.*
- *In* **Swaziland**, *the Minister of Health launched the international version in the country.*
- *In* **Tanzania**, *the President launched the Swahili version in 1991, and the Prime Minister chaired a parliamentary seminar to enlist the support of MPs.*
- *The Deputy Prime Minister launched the* **Thai** *edition, calling it "a lasting gift of practical wisdom".*
- *In* **Viet Nam**, *The Vice-President launched Facts for Life "for the happiness of all mothers and children".*
- *In* **Zimbabwe**, *the Information Minister, Victoria Chitepo, challenged radio producers from 10 African countries to reach the younger generation with Facts for Life issues, especially AIDS.*

Using Facts for Life as a bridge to building alliances

ACTION POINTS

- **Before developing a national version, bring key government departments and influential NGOs on board.**
- **Develop an FFL task force/team. Include:**
  - **technical and academic experts to verify health information;**
  - **government/ministry/UN/international NGOs to develop awareness and support;**
  - **local NGOs, health workers and other nationals with a good understanding of community beliefs, needs and sensitivities;**
  - **journalists and artists to develop effective written and visual material.**
- **Partners should be chosen because they have credibility with target audiences, and the capacity and skills to carry out effective work. Training may be needed to boost capacity or skills.**
- **Partners must have the resources and skills to play their part in preparing a national version.**

  Be aware that academics, technical experts and government officials do not always understand what appeals to ordinary people.
- **Care should be taken to avoid *Facts for Life* being seen only as a health programme.**

Facts for Life can provide a framework around which partnerships and alliances can be built to identify problems and to work on solutions. This alliance can bring together a diverse range of people with many different skills, including

(continued on page 26)

Criteria for deciding whether a national version is necessary and appropriate

- **The purpose of producing a national version is to make material more relevant to local people.**
- **Chapters that are not appropriate to a country situation can be dropped and more appropriate chapters added.**
- **Local photographs give *Facts for Life* more immediacy.**
- **The text can be translated into one or more local languages, widening the range of people who can use it.**
- **The process of producing a national version builds collaboration between UNICEF, government departments and NGOs where there may have been little before.**
- **This process gives local people a sense of ownership.**
- ***Facts for Life* can become a jumping-off point for building national capacity.**

Factors that might make a national version superfluous:

- **One of the languages used in the international versions is widely used in the country.**
- **There is overwhelming competition in the market-place for this kind of material.**
- **The national capacity to produce a national version does not exist.**

NB: The balance of argument is almost always in favour of producing a national version, but it is less easy to decide in which languages it should be produced. Health workers and educators may expect good-quality material to be published in English or French, because that is the language used in school or official communication. It may be necessary to produce two national versions, one (or more) in a local language and one in the accepted international language.

Working without a national version

Although most countries found the process of creating national versions an invaluable step, it proved possible in the Caribbean to work extensively with Facts for Life material without a national version. Instead, Facts for Life messages were inserted into comic strips and video films, school books and posters. Where complete copies of Facts for Life were required, the (English) international version was used.

***Marjorie Newman-Williams, former Representative in the Caribbean,** said that Facts for Life was discussed with the media, education institutions and health workers, but that a national edition was not seen as the most important tool. Instead, the key messages were absorbed into forms that people used and understood.*

"Facts for Life for us isn't just a book that you distribute. The content is what is valuable, and what is important is how you translate what is between the covers into a living form. I think eventually that you will no longer be able to make the link between Facts for Life and the end product. I think that's good because it will have been absorbed and people will have made it theirs, and where it came from originally is no longer important."

The decision in the Caribbean was largely determined by the need to compete for attention in a culture where television viewing is virtually the highest in the world, and people and communities are bombarded with images from all sides. It was necessary to use the media that ordinary people used and understood.

The Caribbean is not the only region where it was decided not to produce a national version. Algeria, for example, relies on the French international version.

Ghana

When Facts for Life was being prepared in Ghana, the government and NGOs decided to ask the Ministry of Social Mobilization, rather than the Ministry of Health, to coordinate the effort, to underline that this was a communication challenge first and foremost.

Choosing partners

- *In China, a major partner is the All China Women's Association, an NGO with 50 million women members and branches at county and village levels.*
- *Egypt built up a team of 14 NGOs that agreed to pool resources to transform Facts for Life messages into materials acceptable to the audiences.*
- *In Belize, the Department of Women's Affairs became a main partner.*
- *In Botswana, the Medical and Dental Association was the first public body to adopt Facts for Life as a tool for enhancing communication in that country.*

Turkey

The preparation of a Turkish version took a year. The first translation was carried out by a committee dominated by staff from the Ministries of Education and Health. The experts who were sent drafts found the language too heavy. A second attempt was made using simpler language. This was pretested on target groups which included health staff, teachers, and adults with low levels of education. The results showed that overall 77% of those who saw it found Facts for Life reasonably easy to understand.

(continued from page 24)

educators, health personnel, policy makers, the media, artists and entertainers, religious leaders, women's and youth groups. Creating and launching a national version of *Facts for Life* will influence the future effectiveness of this coalition. It involves finding the key partners with the skills, commitment and resources to contribute to a local version, and with enough authority to attract other groups and individuals to work with *Facts for Life*. Major partners must have both *capacity* and *capability*. By capacity we mean they have resources in terms of personnel and equipment, and by capability we mean they have skills and motivation. In addition, they should have enough influence, credibility and authority to ensure that the national version creates widespread interest.

Clearly, it is essential for the task force to enlist the active support of one or more government departments. It is also essential to enlist at least one national NGO as a partner. This makes joint work easier to organize and, where people have low expectations of government, may lend credibility and prestige. An NGO with a record of achievement brings a wealth of practical knowledge and experience. Such NGOs generally have strong roots in communities, and can cut through the bureaucracy and delays that often afflict government departments.

Facts for Life contains key messages on timing births, safe motherhood, breastfeeding, child growth, diarrhoea, chest infections, immunization, malaria, and AIDS, and promoting these messages requires the active support of health workers. This does not automatically make the Department of Health the best partner in the process of preparing a national version. Some countries made efforts to avoid *Facts for Life* becoming solely a UNICEF/Department of Health enterprise, fearing that it would not then lead to a broad social mobilization, because of the risk that *Facts for Life* would be seen only as a health programme. The Ministry of Education is an essential partner if *Facts for Life* is to be used in schools or for teacher training. Such partners can be more easily attracted through a coordinating body that brings together relevant government departments, is open to NGOs, and has political support (e.g. is based in the Prime Minister's office).

NGOs chosen as partners should be able to contribute to the process of creating a national edition and have the prestige and authority that will lead to broader alliances. It will be easier to sustain *Facts for Life* activities if they are integrated into the day-to-day work of partner organizations. During the course of transforming *Facts for Life*, many other groups and organizations become partners, including business organizations, trade unions, religious leaders, traditional healers. *(Working with these partners is discussed in later chapters.)*

Translating Facts for Life into one or more local languages

Action Points

- **Editions in local languages make the contents more acceptable to local populations and more relevant to their problems.**
- **Achieving the simplicity and clarity of the original requires high levels of knowledge about local communities, and a high level of skill and awareness.**
- **Pretesting each local version is vital.**

In particular:

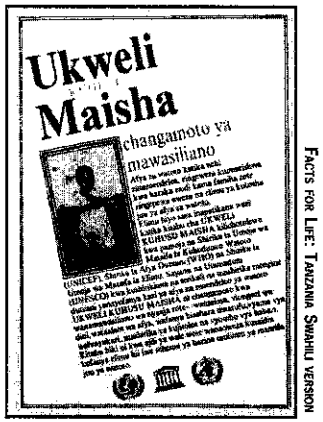
- **Research the need for and acceptability of local language editions.**
- **Do not assume that all people welcome 'their' local version over the national version, particularly if there is a quality gap in the standard of translation or production.**
- **Engage people to do translations who know the relevant community and can write for the target audience. Academics are not always good at knowing what will appeal to ordinary people.**

Most countries are made up of people who have different customs and speak different languages. Even where there is one official language, many people may feel more comfortable in their local tongue.

The advantage of translating *Facts for Life* seems clear in these circumstances, even where many people understand one of the international versions. However, it is dangerous to make assumptions. Research is needed to see which versions will be more effective. In some countries, key layers of people who use *Facts for Life* — teachers, health workers, local government officials — may expect authoritative material to be in the 'official' language. Some of these people may feel that they are being given an inferior copy if it is translated into their local language, especially if the national version is glossy and the local version is more modest.

Tanzania

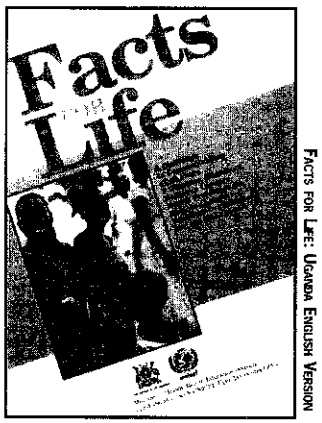
In Tanzania, Swahili and English are both taught in primary schools, and most people also speak a local language. UNICEF Representative in Tanzania, Agnes Akusua Aidoo, says that the Swahili version has the most potential. "The wonderful thing about Tanzania is that the community is literate in the national language, Swahili. People now have a reference source on nutrition, on education, child spacing, breastfeeding and so on, right at their fingertips. Everywhere you go, when people meet they have a reference document, and this is very important."



FACTS FOR LIFE: TANZANIA SWAHILI VERSION

Uganda

In Uganda, many teachers opted for the English version, although translations were available in several languages. However, pirated copies of the Lugandan version have been seen selling on local bookstalls — evidence that this translation found a market.



FACTS FOR LIFE: UGANDA ENGLISH VERSION

Lao Republic

In the Lao Republic, efforts were made to use very simple language and terms that village people understood. Chapters were field tested at village level to ensure that this had been achieved.

Nigeria

In Nigeria, 90 million people in 100,000 communities speak 200 different languages between them. Facts for Life was produced in Hausa, Yoruba, Igbo, Pidgin English and Tiv.

The task of translating, pretesting and finalizing each major language version was given to universities based in each area. However, many translations did not prove popular, and plans to produce 1 million copies of each were reduced to 50,000 when it was realized that people were opting for the English version.

Alfonso Gumucio-Dagron, former Programme Communication Officer in Nigeria, said: "Our experience is making us reflect on the appropriateness of printing Facts for Life in local languages. Although it looks good in UNICEF reports to see that new translations are being added every month, we should assess critically the real need and the impact of the translations.

"Field workers obviously speak either Yoruba, Igbo or Hausa. It is often their mother tongue. Nevertheless, they don't use it for writing or reading. Even if their communication with the communities is done in the local language, they still prefer to use the English version as the reference. They will translate as they read instead of reading directly from a translation."

Part of the explanation is that English is used in primary school education and is preferred for written material. Also, local translations are difficult to get right. The Pidgin translation was done by broadcasters, and UNICEF felt confident that it was safe in their hands. In fact, the broadcasters used a version of Pidgin unfamiliar to many of the people who read the book.

In the process of translation two separate quality targets have to be achieved. One is to ensure that the authority of the messages is maintained. This may mean enlisting the support of technical experts to ensure that local translations are medically correct. The other aim is to keep the clear and down-to-earth language of the original. Here it might be better to enlist the support of a journalist or a popular writer rather than an academic.

There is no short cut around pretesting each local version. There are many examples where academics or journalists, who were assumed to know a community well, produced versions that were not well received because the language was too complex. There are particular problems when preparing editions for some minority ethnic groups, the written form of whose languages may not be universally agreed or accepted, even among those who speak them every day.

Many countries have taken the precaution of testing translated versions before committing themselves to large print runs. Several countries, however, were forced to delay or scrap local editions of *Facts for Life* because translations were found to be inadequate, and sometimes this painful knowledge only became apparent after a long and expensive print run had been completed.

What standard of production should a local version have?

The quality of production of many local versions has been high — but this is not essential to achieve effective results. Production standards depend on the amount of money allocated to the national or regional version, the number of translations that have to be produced, the expectations of the target audience and the quality standards of local printers.

Some countries use the national version of *Facts for Life* as a showcase for images of mothers and children and local life. In Egypt, UNICEF staff are proud of the way that photographs commissioned for *Facts for Life* have been pirated and used in all kinds of other publications. The Iranian Farsi edition also includes photographs taken by one of the country's top photographers. Such photographs can be reused in other material produced alongside *Facts for Life*. High production standards may make *Facts for Life* easier to promote and may lend authority to the messages. However, effectiveness cannot be judged by glossiness. The standard of production should be appropriate to the audience, bearing in mind other material the audience is accustomed to seeing.

In countries with high quality production values, fuzzy photographs and poor-quality printing may be taken as a sign of low importance. On the other hand, there may be criticism if the publication looks too expensive. There is a case for

maintaining reasonable quality standards even in poor countries so that the community people who work with *Facts for Life* see the publication as a valuable resource, and try to reproduce reasonable standards in material derived from the book. Care at the design stage can achieve these standards at reasonable cost.

Adding or deleting chapters for a national version

ACTION POINTS

- **Only add chapters if you are selecting those topics that pose the greatest challenge to the health of children and families, where action is possible.**
- **Extra chapters, where necessary, should keep the direct style of the original and avoid complex medical descriptions.**
- **There is a trade-off between adding desirable chapters to extend the range of *Facts for Life*, and keeping a manageable list of priorities, as achieved by the original.**
- **National or regional data should be included to illustrate the risks to local communities.**
- **Special editions or formats have worked well where the aim is to reach particular target audiences — such as the armed forces.**

Messages in *Facts for Life* have been selected to address the main risks to child health. Some, such as immunization and hygiene, are universal. Others, such as malaria, apply in broad areas of the developing world, but not everywhere.

Part of the process of adapting national versions lies in selecting the problems that people can solve by taking action, around which it is possible to mobilize communities.

Chad

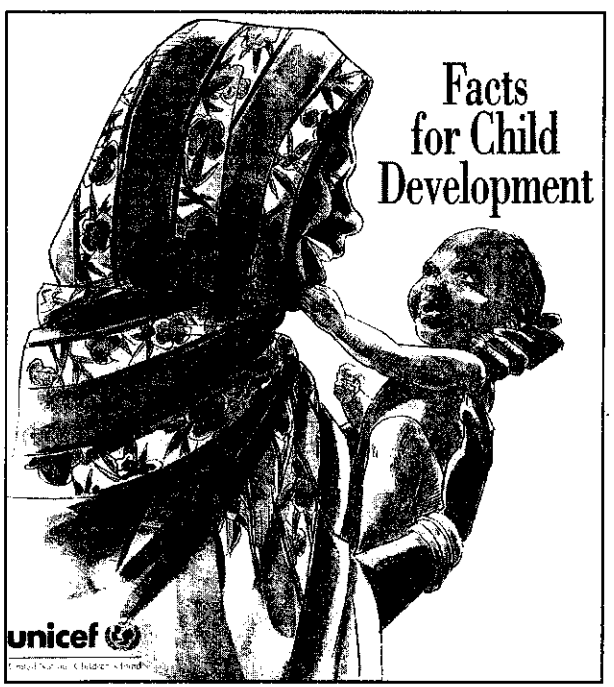
The Chad Arabic version is locally printed and modest in size, containing only a summary of the 'golden rules', but achieves a simple elegance through the use of high-quality local photographs.

Bolivia

Bolivian version of Facts for Life *specially produced for military personnel.*

Child-to-Child

The only other complete international version is Children for Health *published jointly by Child-to-Child and UNICEF, dealing with how messages can be given to children and be used by children. More on the philosophy and practice of Child-to-Child can be found in Chapter 6:* Children as Communicators.



A poster illustrating the seven child development prime messages was produced and distributed through child development networks. Copies are available from the Child Development Adviser, Education Cluster, UNICEF, New York.

Experiences of adding chapters, internationally, regionally and nationally

Many countries added chapters to address local or regional health risks. Others dropped international chapters from their national editions. This section looks at how some of these issues have been approached, and at the opportunities and dangers.

1. Second international edition

The second international edition, published at the end of 1993, contained one chapter not in the original, on Child Development. This emphasizes the value of love and play to children, and the role that parents play in promoting and observing development. It was a response to a widespread feeling that the psychological development of children should be addressed alongside their physical needs. This feeling was strongest in countries where the infant mortality rate had declined. As parents worry less about whether their children will survive, they naturally worry more about how they will develop and what kind of people they will become.

The extra chapter was drawn up by Peter Adamson, author of *Facts for Life*, and Cassie Landers, consultant to UNICEF on early childhood development. At first sight it appeared difficult to match the messages for this chapter to the style of *Facts for Life*, which was to give short factual and direct messages that could be acted on by parents, and that would make a real difference to their children. The tradition of UNICEF has been to deal in quantifiable targets so that it is easier to assess impact. On the other hand, some in the childhood development movement were concerned that the simple format might lead to complex messages being oversimplified.

In practice, Peter Adamson and Cassie Landers found that it was possible to give parents prime messages without oversimplifying the issues. The authors believed that all parents would want to know about these messages, and that by writing about parents and caregivers rather than simply about mothers, they could help in a small way to strengthen the role of fathers in providing the love and attention that foster good child care.

Cassie Landers said: *"The key facts that many parents and other carers do not know and many policy makers overlook, are that babies begin to learn from the moment they are born, and that the early years lay the foundation for the development of lifelong learning skills. Finding a way to present child development information in the context of mother and child health services is a gold-mine of an opportunity."*

2. Regional versions

A regional version has been produced in Latin America in four sections: health, nutrition, child development and child protection. Additional topics include skin illnesses, parasites, home accidents, women's mental health, oral health, cholera, contraceptives, community and food security, hygiene in food making and intake, child abuse, alcoholism, children and television, drugs, environmental care and adoption. The aim is a balance between health, nutrition and psychosocial development with an integrated, broad approach to child development. Felipe Risopatron, Project Officer in Chile, said:

"We hear a lot about the effect of health and good nutrition on the psychosocial development of the child, but there is also a reverse relationship. Psychological and social well-being have an impact on health and nutrition. This means considering the young child as a complete human being from birth, with needs for love and attention as much as needs for vaccines and food. The challenge is to empower families to foster the full development of the child's potential. Empowering parents with knowledge and skills is a key element for communication efforts within UNICEF supported programmes."

The section on psychosocial development promotes the need for contact between the child and parents, the importance of love and affection, the need for the child to interact with the world through play and language and the message that a warm and safe family environment helps the child's development.

The team developing this material recognizes the danger of expanding *Facts for Life* to the point where it becomes an encyclopaedia and loses its capacity to identify priority topics. Several meetings were held to reduce and simplify messages.

Recently, a Russian regional adaptation of *Facts for Life*, produced for the countries of Central and Eastern Europe, included an extra chapter on alcohol and tobacco. There are powerful arguments for including chapters on drinking and smoking in countries where these are serious threats to health and to the welfare of children and adolescents. However, as developed countries have found, it is easier to agree on the importance of the threat than to find an effective programme for action. Telling people that cigarettes and alcohol are harmful has been a spectacularly unsuccessful way of reducing their use. In some countries, action now includes extending smoke-free areas, punitive pricing policies and banning advertising — all examples of national and local policy-setting. Meanwhile, whole industries have grown up marketing products that allegedly help people to give up smoking. One of the principles we have already established for *Facts for Life* is that chapters should not merely highlight

Regional coverage by radio

Over a two-year period, Radio Nederland and UNICEF developed a series of Spanish-language radio programmes entitled Para la Vida (For Life). Producers developed a mixture of drama, conversations and news spots from Facts for Life themes to make up three 60-minute cassettes. Each cassette was accompanied by a user's manual suggesting ways of opening up a discussion, designed for use by groups listening to the broadcasts. It is estimated that about 120 radio stations in Central America and countless local groups have used the material.

Russian version

A Russian version, developed over a two-year period with the Russian Public Health Institute and Ministry of Public Health, added a chapter on alcohol and tobacco abuse.

Prime messages on accidents

Malaysian prime messages

1. Accidents are an increasing cause of death and disability in children.

2. Accidents can be prevented if people understand how they occur.

3. The common home accidents are falls, burns, scalds, poisoning, cuts, choking, electrocution and drowning. All these can lead to death and disability.

4. Home accidents can be prevented by close supervision of children and by making the home safe for children.

5. Parents must ensure that children are protected on the road and help them learn to use the roads safely.

6. It is the responsibility of parents, communities and the government to prevent accidents in children.

Mexican prime messages

1. The only way to prevent accidents is to act with caution.

2. Adults set an example for children, and can teach them either to protect and care for their health or to lose it.

3. The sense of safety and self-protection is acquired at home, and should be strengthened at school.

4. Pedestrians, drivers and passengers must take all precautions to prevent road accidents.

5. Many accidents also occur in the workplace, and affect the victims, their families and their employers.

6. Unsafe actions and conditions must be avoided in physical and recreational activities.

7. In the event of an accident, it is important to know both what to do and what not to do in giving first aid.

topics for concern, but also propose practical and possible action. Careful work is needed to ensure that 'action points' are capable of being acted on, not just exhortations to cut out bad habits. Issues such as smoking, drink and drugs relate to how people take risks and decisions about their lives. This has led some countries to look at the development of life skills packages to help people learn to make healthy choices. Life skills are discussed in Chapter 5: *Interpersonal Communication, Adult Learning and Training.*

3. National versions

The most popular additional chapter is on accidents, with at least 13 countries (and *Children for Health*) adding or planning a chapter on this topic. Paediatrician Dr. R. Krishnan, who wrote the accident chapter for the Malaysian version, reflects widespread concern when he says that accidents do not get the recognition that they deserve as a preventable cause of injury and death.

How Malaysia and Mexico added chapters on accidents

We can look at two examples of how this chapter has been tackled in Malaysia and in Mexico to see if there are common lessons (the Mexican version is translated from the Spanish). Both countries follow the accepted structure for Facts for Life chapters, with Notes for communicators, a limited number of prime messages and a larger amount of supporting information. The 'Note to communicators' helps to motivate those who will use the information:

Malaysian Note to communicators

"Accidents are an important cause of death and disability in children all over the world. They constitute one of the three leading causes of death in children in Malaysia. Accidents in children occur at home and on the road at school and during play. The incidence of accidents in children is on the rise in recent years.

"It is a common misunderstanding that accidents cannot be prevented. However, they can be prevented if everybody understands how they occur. Children are at special risk from accidents because they cannot recognize and handle dangerous objects or situations."

Mexican Note to communicators

"Accidents are the most common cause of death for people between the ages of 5 and 35. For children, it is estimated that for each fatal accident, there are over 500 non-fatal accidents, including 100 hospitalizations and an average of three permanent disabilities.

"Human error is a factor in 90% of all accidents, which means that 9 out of 10 are preventable. About half occur in the home.

"Adults have an obligation to provide children with safe surroundings and to teach them, from an early age, to understand their abilities and limitations, to identify risks and to avoid them as far as possible."

How Malaysia and Mexico added chapters on accidents

Both versions use national statistics to convince policy makers of the need for action. In both, the number of prime messages is small, and the style is popular and non-technical. The detail is in the supporting information, which acts as a practical guide to avoiding accidents. If we compare, for example, the sections on falls, we see that although each country concentrates on its own specific cultural risks, the advice is very similar in both.

The Malaysian version says

Don't leave children unattended on an upper storey, balcony or any other high place. Keep the door to the balcony closed at all times.

Don't place furniture near an open window. Children can climb on the furniture and fall out.

Ensure that sarung cradles are hung securely if children are placed in them.

Wipe spilt water off the floor immediately. Children may slip.

Ensure that the side railings of the cot are raised if a baby is placed in it.

The Mexico version says

Falls are the most common type of accident in the home; orderliness, cleanliness and good lighting help to prevent them.

Common causes include toys, fruit skins, liquids and, in general, any unexpected obstacle on the floor.

Falls are also caused by loose or broken railings on terraces, stairways and balconies, and by unprotected windows.

Do not allow small children to carry babies, and do not leave them alone in places from which they may fall.

Other chapters each added by more than one country cover bilharzia, cholera, dengue, the environment, guinea worm disease, iodine deficiency, leprosy, tuberculosis, teenage pregnancy, hygiene, water and sanitation, mental health and women's health.

Some editions of *Facts for Life* have been produced for particular audiences, rather than whole populations.

- In the Sudan, a water manual for pump maintenance was rewritten and subtitled *Facts for Life.*
- In Malawi, nine *Facts for Life* chapters were issued as leaflets, each of which could be separately distributed.
- In Bolivia, an edition for the armed forces included chapters on fatherhood and sexually transmitted diseases.

Mexico

In Mexico, 14 different Spanish editions were published, making a total of 1.2 million copies, of which 600,000 copies were distributed to primary school teachers. In addition, 3,000 copies were printed in Mixteco and Apoteco. A summary of the communications manual All for Health *is included at the beginning of each edition. Effort was made to ensure that the advice on immunization matched that given by national ministries. Facts for Life was the starting-point for training material on diarrhoeal diseases, acute respiratory infections and nutrition.*

Myanmar

Myanmar is introducing a chapter on Iodine Deficiency, a problem in many countries where natural iodine has disappeared from the soil and water. Lack of iodine can cause low intelligence. In pregnant women it can lead to the birth of children with mental or physical disabilities. One of the most recognizable signs of IDD is goitre. The Myanmar IDD chapter not only provides information about the effects of iodine deficiency and how to correct it, but even lists suppliers whose salt has added iodine.

Morocco

Morocco has included a chapter on smoking. This warns of the risk to adults, and to embryos and babies at the breast. It states that smoking is the first step towards drug-taking among adolescents.

Chile

The Chilean chapter on alcoholism states: "Children deserve to grow up in a family environment where the ingestion of alcohol is moderate." It warns that children under 15 could be harmed by alcohol and suggests ways to cut down on drinking.

How to develop a Facts for Life chapter

From the examples of chapters added at international, regional and local levels, it is possible to suggest some common guidelines to follow when adding a new chapter to a local version of *Facts for Life*.

Deciding whether to add a particular chapter

Extra chapters should be considered where there is serious and pressing local concern connected with maternal and child health and development, and where there is effective action that can be taken to eliminate or reduce the concern.

ACTION POINT

- **Be selective — add as few topics as possible. If we limit the number of priority messages there is a better chance they will be remembered.**

What is meant by "serious and pressing local concern"?

The list of extra chapters added by various countries (see Appendix 1) is a guide to the kind of issues that have been seen as serious and pressing. The most popular chapter, Accidents, is of universal significance, but the form that accidents take varies considerably according to the nature of the local environment: whether it is rural or urban, for example. Other popular extra chapters cover bilharzia and guinea worm disease and fully meet the criteria for adding chapters in the regions where they are significant health hazards.

Facts for Life is an attractive package, and many potential partners will have their own ideas on which topics should be added. However, there are already 11 chapters in the international version, and the consensus is that it would be a mistake to add significantly to this total. Any extra topic should have to force its way in by presenting an overwhelming case for inclusion. *Facts for Life* is not intended to be an encyclopaedia for all health problems. Extra chapters should cover pressing local health problems and concerns only.

What is meant by "effective action that can be taken"?

The point is to raise concern and a determination for action — not a sense of paralysing fear or guilt. There are serious issues where local communities may have little influence or ability to act; for example, the hole in the ozone layer is an important threat to the welfare of women and children, but it is hard to find local Action Points beyond lobbying politicians to take action.

Some issues demand services in place before a communication exercise begins. The inclusion of a chapter on alcohol, for example, could depend on whether there are services to support people who are trying to stop or reduce their drinking.

The test is: are there specific, feasible, do-able actions that can prevent or solve the problem?

Note to communicators

If you have decided to add a chapter, then the *Note to communicators* explains why this is an important problem that requires action. These will be the main arguments that convinced you that the chapter should be included. In *Facts for Life*, three or four paragraphs of strong argument summarize the case, raise concern and explain why it is necessary to act. *Note to communicators* often contains one or two compelling statistics. The international version uses global statistics. A national edition will be more persuasive if it uses national statistics. Try to include the total number of people affected in the country or region where the edition will be distributed.

Prime Messages

Prime messages are key points or actions that parents and communities need to know. They are simply put and give only the priority messages.

ACTION POINTS

- **Simplicity — make messages short and simple. Complex messages are less likely to be understood and remembered.**
- **Consistency — communicate messages in the same words where possible, so that they do not sound like different messages.**

Action Points suggested by Steve Umemoto, UNICEF Representative in Myanmar

- Prime messages should be clear, simple and replicable. "It is safe to immunize a sick child" is a good example.
- Parents or those looking after children should be able to act on each prime message.
- Prime messages should be feasible and specific, or they risk rejection.
- Prime messages must be technically correct, but not technically complex. They should contain as few technical or bureaucratic terms as possible.
- They should be limited to 10 or fewer for each chapter.

Selecting messages

What do parents need to know about the topic? "For information to break through the information clutter ... messages should be based on what is most important to the audience ... what they want to know, and not what is most important or most interesting to the originating agency."

Making Health Communication Programmes Work, Planners Guide, US Dept of Health and Human Services, Office of Cancer Communication, National Cancer Institution, April 1992

Questions and answers in Uganda

Uganda has introduced an innovation that could be applied in any country.

Each chapter of Facts for Life concludes with a series of questions and answers addressing concerns, objections and doubts that local people might have.

The first edition of Facts for Life in Uganda was issued in 1993. The first volume covered four topics, malaria, immunization, AIDS and diarrhoea, with questions and answers on each topic. Volume 2, with other topics, was issued in 1994.

The Malaria chapter answers questions on whether it is effective to burn leaves to drive mosquitoes away; how to dispose of rubbish to prevent mosquitoes from breeding; whether 'sweating it out' can cure malaria; whether drugs from local shops are effective.

The chapter on immunization answers 14 questions on topics ranging from traditional remedies to fears of side-effects. For example:

Q. Is it safe for a child to develop fever or rash or feel itching at the site of immunization?

A. Yes, it is safe and normal. The child may cry, develop a fever, a rash or a small sore. As with any illness, a child should be given plenty of food and liquids. Breastfeeding is especially helpful. If the problem seems serious or lasts more than three days, the child should be taken to a health centre.

(continued on page 37)

A prime message may be difficult to achieve, as in the case of some prime messages in the international versions, (*"A child under three years of age needs food five or six times a day"*), but not impossible for parents to contemplate. The action described should give parents a clear idea of the target they are trying to achieve. *"Illnesses can be prevented by keeping food clean,"* is one of the prime messages in the international chapter on Hygiene. The parent is given a clear course of action, although not at this stage detailed advice on how to achieve it. If the message had been *"Illnesses can be prevented by parents being careful with hygiene"*, this would have been too vague to give a satisfactory pointer to the kinds of actions parents should take.

Supporting Information:

Supporting information is designed to enable communicators to argue their case and to overcome common objections. It should be accurate, persuasive and carry the right amount of detail. Too little detail and communicators will be left unarmed. Too much and they will become bogged down in secondary points.

"What do people need to know to prevent or solve this problem," is a good test for deciding what should be included as supporting information. Since *Facts for Life* is not a comprehensive health manual it is not necessary to include full details. Only essential points should be included as supporting information. Some extra information can be given and common misconceptions cleared up through a question and answer section at the end of each chapter *(see side panels, pages 36 and 37).*

If you are considering adding a chapter on accidents, supporting information would be a good place to list the most frequent causes of death or serious injury in your country or region (available from a local or a major hospital). This is also the place to add detailed action on how to avoid accidents.

Action points in the supporting information in the Malaysian chapter on accidents include:

"Ensure that sarong cradles are hung securely if children are placed in them."

And the Mexican chapter on the same subject warns:

"Do not allow small children to carry babies, and do not leave them alone in places from which they may fall."

Both show understanding of local practices and are specific enough to alert parents or caregivers to a particular danger, but they do not go into detail, for example, on exactly how a sarong cradle should be hung.

There are many risks to small children, and in a chapter on accidents it may be tempting to give many messages. However, the underlying philosophy behind *Facts for Life* is that messages are prioritized, and those drafting chapters should consider the trade-off between keeping messages simple and clear, and making them comprehensive.

Authors also need to consider how easy it is for parents to act on messages.

If it has been decided to include a chapter on smoking, then there must be points that can be acted on, as well as alarming statistics. Is there any advice on how to make giving up easier? Are there recommendations for making some areas of the community smoke-free? One national version says about smoking: *"The main aids are will-power, conviction, involvement in sport and avoidance of stress."* This would be easier to act on if supporting information included tips on how to avoid stress or information on creating smoke-free environments.

The example *(pages 36 and 37)* from Uganda represents a successful addition to *Facts for Life*. This approach of adding questions and answers at the end of chapters should be seriously considered in future national or regional editions. It should be noted that the questions are derived from research on the beliefs and knowledge of local communities.

Removing chapters

Chapters may be removed because the problem (for example, malaria) is very uncommon in the country where the material is being produced.

The chapter on AIDS and some of the messages on birth spacing have been removed from some national versions of *Facts for Life* because they are thought likely to offend either influential people or the general population. This was particularly the case with the countries that produced national versions early. Working within cultural sensitivities is of course important. However, saying 'what is' is also important, and *Facts for Life* sells itself as a collection of the key information that people need to know to protect the lives of mothers and children. Presenting this information in a culturally acceptable way is half the battle. An approach must be found to present the key information on contraception, birth spacing and HIV/AIDS, and if this cannot be done in the national version of *Facts for Life*, then some other method must be found.

(This issue is examined in more detail in Chapter 12: Sexual Health and Cultural Sensitivity.)

Uganda

(continued from page 36)

Answers at the end of the AIDS chapter give readers details on how condoms should be used, and deal with common myths and misconceptions.

Q. Is it possible to tell who has HIV or AIDS by their hairstyle or clothes? For example, are women with "perm on their hair" or men with jeans more likely than other people to have HIV?

A. No, many people have HIV in Uganda and they wear different types of clothing. Anybody, irrespective of what they wear or how they look, can have HIV. One infected partner is enough to transmit HIV.

The question-and-answer format allows Facts for Life to give complex information. One question is:

"Is it possible to treat a child with diarrhoea using traditional herbs?"

The answer warns that some herbs can be harmful and may be prepared using unsafe water. However, it also acknowledges that qualified health workers may recommend some herbs. It concludes:

"Most Ugandan communities have traditional beliefs about diarrhoea. Some are harmless, some useful, some harmful. No matter what its cause, diarrhoea is dangerous because it results in the loss of too much water from the body. The proper treatment is always extra fluids."

Questions were based on research about the beliefs and knowledge of the audience. Health workers found the question-and-answer sections useful in overcoming the fears of people in the community.

Overcoming cultural problems

In Egypt, it was culturally impossible to include female genital mutilation ('female circumcision') in the national Facts for Life without becoming overwhelmed by controversy. A local NGO developed material on female genital mutilation in the Facts for Life format. UNICEF was not involved but supports NGOs with training on interpersonal communication skills and workshops on Facts for Life topics. In this way, work goes ahead without Facts for Life being put at risk.

Monitoring and evaluation

For purposes of monitoring and evaluation, the following key points from this chapter can be checked against current practice.

Why adapt?

To encourage national awareness, acceptance and ownership of the information.

Factors to take into account

The need to convince local partners (government departments and NGOs) that *Facts for Life* has something substantial to offer.

The need for local experts to have an opportunity to review and discuss the information in the international version.

Who will help to adapt?

Which are the key government departments?

Which NGO(s) has the capacity, capability and prestige?

Create a powerful coordinating body?

Factors to take into account

Ensure that the plain style of *Facts for Life* is maintained.

Ensure the right level of expert opinion.

Ensure the process does not become bureaucratic.

(continued on page 39)

Launching Facts for Life regionally or locally

The national, regional or local launch of *Facts for Life* gives an opportunity that may not recur to promote issues, problems and solutions. This is particularly the case if the preparation of a local version has the support of influential government and non-governmental figures. The launch should make full use of such support and will normally be a high profile media event. A leading charismatic figure should make a keynote address that will help to mobilize the media to pay attention to problems and solutions you wish to target. *(Examples of obtaining political support are given on page 24.)*

Influential media figures should be targeted beforehand to ensure that they are familiar with the issues, and to convince them that they will find interesting stories from the launch and supporting information. (*See Chapter 4 for more detail on working with the mass media.*)

Those NGOs that have been partners in preparing national editions should also be important partners in launching them, trying to ensure that other NGOs that may not have been so involved in the preparation do become interested in working with the material. A special meeting to launch *Facts for Life* to NGOs should be considered.

The method of distributing *Facts for Life* should be decided well before the launch, so that it is available where it is needed as soon as it is launched. It will also be necessary to train people in the information base and in a participatory method. Such training should already be in place by the launch date, so that some people have already become advocates for working with *Facts for Life* locally.

Monitoring and evaluation (2)

Why translate?

Because the international languages in which *Facts for Life* is published are not commonly used, and local communities want and expect to receive written material in their own language.

Translating: Factors to take into account

How many languages should be considered?

What percentage of people are truly literate in these languages (men and women)?

Which language would community-level workers (e.g. health workers, village representatives) prefer? *(What is the language of education?)*

Who will undertake translation? Will their language be understood by ordinary people, or will it contain academic or bureaucratic terms?

Who will verify that the translation is accurate and acceptable to its audience? *(NB: Pretest before committing to a large print run.)*

Production considerations

Use pictures of local children and families.

Quality pictures can be used for several purposes and make people value the material.

Illustrations need to be pretested too. *(See Chapter 11.)*

Monitoring and evaluation (3)

How to develop an additional chapter

Why add a chapter?

Because the international/national version lacks information on a priority problem, about which it is possible to take effective action.

Factors to take into account

Is there an urgent additional health problem not already covered?

Is there information to convince communicators?

Is it possible to develop a small number of effective prime messages?

Is it possible to provide supporting information which will lead to feasible and effective actions?

Launching* Facts for Life *in the country or a new region

Factors to take into account

What is the key audience to win over at the launch?

How will you enlist its support?

Can you win high-level political support?

If so, how will you use this?

What role will NGOs play?

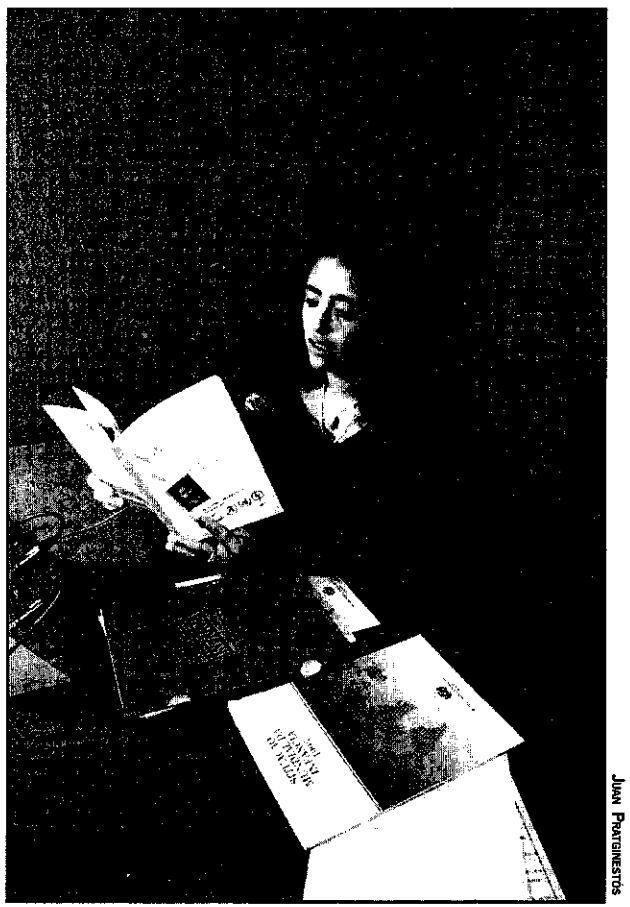
Have the media been primed and lobbied?

Is the distribution system organized?

Has training been organized to coincide with the launch?

1. UNFPA joined as a co-publisher in 1993, after the Philippine adaptation was developed.

4. Successful Communication Using Mass Media



JUAN PONTIGNESTOS

A broadcaster in Brazil uses Facts for Life *as her source material.*

ACTION POINTS

- **Mass media and interpersonal communication are both invaluable tools in reaching communities.**
- **Mass media are best at reaching large audiences with simple messages.**
- **Mass media have potential for education, but the power is difficult to harness, and needs a consistent approach.**
- **This approach can be broken down into eight steps:**
  1. **Define the problem**
  2. **Identify the audience**
  3. **Assess existing knowledge, attitude and practice**
  4. **Select communication channels**
  5. **Prepare messages and materials**
  6. **Pretest messages and materials**
  7. **Deliver messages**
  8. **Evaluate impact and adjust accordingly**
- **Journalists may need training to understand development issues, encouragement to find things out for themselves or financial support to travel to see for themselves.**
- **Mass media do not reach all parts of the population. The people who most need it may be the last to be reached.**
- **The timing and placing of messages on radio and television is as important as their duration and frequency.**

What the mass media do well

There comes a point following a national adaptation of *Facts for Life* where UNICEF and partners will take a lead in initiating a series of messages. These may be designed to highlight a health issue, to promote a new service, or to encourage people to change a practice that is harming health or the environment. No communication exercise takes place in a vacuum, and the launching of a campaign should be timed to fit in with plans for service delivery and training of people who will be having a more personal dialogue with communities.

One vital way to raise the profile of an issue, or to communicate simple messages, is to make use of the mass media, and to encourage journalists to cover issues on radio and television and in the print media in a way which promotes your organization's viewpoint. This is a an area of work that can bring many rewards, but can be difficult and frustrating.

The mass media have enormous influence on those sections of a population within their reach, and in particular upon policy makers and urban populations. Harnessing the power and potential of the media is not straightforward, and requires careful and consistent work with media policy makers and journalists. It is relatively easy to gain coverage of an issue, but not so easy to retain influence over the nature and direction of that coverage.

This chapter suggests eight steps on the road to successful communication, ranging from preparation to delivery and assessment of a campaign's effectiveness. The eight steps suggest a process that can be worked through, stage by stage. Some clearly defined campaigns can follow this guide precisely. Where communication has already begun, the steps can be used as a guide to improve on it, and the general principles can be applied although it may not be possible to follow each step exactly. In broader terms, we can view the whole of our work with *Facts for Life* as a communication exercise, to which the eight steps can be applied over a number of years.

The eight steps are a guide rather than a formula, but steps should not be omitted without good cause. Checking priorities and perceptions, and reviewing the effectiveness of broadcasts, for example, are time consuming but essential components of a communication effort.

Mass media and interpersonal media

Mass media and interpersonal communication are suited to different circumstances. Mass media are useful for reaching large audiences quickly with simple messages that raise awareness. Complex behaviour change requires interpersonal communication and a supportive environment.

Mass media does not change behaviour

"Mass media informs and creates awareness ... but it does not change behaviour. Precise behaviour can be modelled through the media and reinforced through interpersonal communication."

Guy Scandlen, Regional Communication Adviser, UNICEF Abidjan

The mass media are useful, for example, for raising awareness of AIDS. They can tell people that it is a big problem in this area; that it is a fatal disease caused by a virus that can be acquired through unprotected sex or through dirty needles. It can bring this message to the attention of many people quickly, and give a consistent message to each person in its audience. However, the media alone are unlikely to persuade people to change their behaviour, or to answer their fears and misconceptions. These require personal contact with the audience, to address personal beliefs, fears and behaviours.

Which type of communication is best suited for which task?

Mass media are suited for	Interpersonal communication is suited for
◆ Informing a large audience	◆ Giving information to small groups and individuals
◆ Raising awareness	◆ Responding to questions and discussing ideas
◆ Conveying simple information about events, dates, etc.	◆ Tailoring information to the audience
◆ Telling people the same thing at the same time (consistency)	◆ Sensing non-verbal reactions
◆ Influencing public opinion	◆ Adapting messages according to circumstances
◆ Floating policy proposals to test public opinion	◆ Building trust and a sense of safety among participants
◆ Stimulating discussion and debate	◆ Fostering a problem-solving approach, leading to action
◆ Spotlighting people's situations and problems	◆ Creating a commitment to act
◆ Giving people a platform	

Interpersonal communication is considered in Chapter 5.

At its best, the mass media can hold a mirror up to society, reflecting its concerns. They can also provide opportunities to present positive role models. It is possible for mass media to reflect interpersonal communication. Television can show intimate discussions to a wider audience, so that viewers 'participate', albeit passively. Television and radio drama can illuminate an issue by showing characters working through a realistic life situation.

Baseline study a starting point for effective campaigns

IN 1992, the Centre for Social and Development Studies at Natal University carried out a survey of South African mothers in a rural village, a squatter camp and an urban township. This baseline study will provide valuable information for many health education campaigns to come. Information included the following:

- *The majority of women knew about safe motherhood, but did not put their knowledge into practice because of lack of finance, inability to find work close to the family home and lack of infrastructure and support networks.*
- *Mothers knew that 'breast was best' but did not know why. Half would stop if they had the money for powdered milk. Half thought they should stop breastfeeding if the child becomes ill.*
- *Over 80% thought it was unsafe to immunize a sick child.*
- *40% of households in the peri-urban area had a child ill with diarrhoea in the preceding month. Most believed that food and liquid intake should be reduced when the child had diarrhoea.*
- *People were aware of the need for hygiene, but few had the opportunity to practise what they knew. In rural areas, 92% used the river as the main source of water supply.*
- *There was little sex education in the homes, indicating a need for it at school. 90% of parents had not warned their children about AIDS and were unlikely to do so.*

This study not only is informing health education campaigns but will also act as a baseline study when health education workers evaluate their efforts.

The Eight Steps

The eight steps to successful communication fall naturally into three stages, preparation, implementation and review.

Stage 1: Preparation

1. Define the problem you are trying to tackle

If you identify the problem, rather than the new behaviour (which is one proposed solution), it allows a wider range of solutions to be considered. A communicator is looking for messages that are relevant, timely, accurate and persuasive, that show cultural sensitivity and suggest actions the audience can actually carry out. To achieve this, a good communicator is first of all a watcher and a listener. What does the audience already know about this issue? Does it want to tackle the issue? Have previous attempts been made and what was the result? Data can be gathered through surveys, interviews or focus group discussions.

2. Identify your audience

The mass media reach a broad audience; two genders, different ages and many beliefs. Are you trying to reach mothers with your message? Do you want all parents to act? Is this a message that should be aimed at older children? Are you targeting religious leaders or traditional healers? Only when you identify the appropriate audience will you be able to plan the style and content of messages and the media you will use. If there is more than one audience you may need more than one style of message.

3. Assess the audience's knowledge, attitude and practice

This builds on the data that was collected in steps one and two, and reminds us that if the problem and the audience were given in advance you still need to do basic research. You need to know the present state of knowledge of the audience, and its attitude to the problem you are addressing. Is it their priority as well as yours? If their priorities are different from yours, are you targeting the right problem? How resistant are they likely to be to the message? What are the barriers to behaviour change? What sources of communication do they see or hear? What are the real levels of literacy? *(See also 'Seven steps on the road from resistance to action' on page 11.)*

4. Select your communication channels

Decide on the best means of reaching your audience, based on the information you have collected about literacy levels, and the communication channels they already use. It is often desirable to use more than one channel in a co-ordinated way; for example, using mass media to raise awareness, using

☞ All for Health, *a companion volume published alongside the first edition of* Facts for Life, *described 12 steps in health communication. There is no contradiction between those 12 and the 8 steps described here. The eight steps seem to break into more natural groupings.*

A knowledge gap or a service gap?

A survey in three regions of Uganda showed that one in six mothers applied soot and cow-dung to the umbilical cord stump. This dangerous practice was tackled during a safe childbirth campaign. The survey also showed that many children did not complete immunization because the health worker was absent or did not say when and where to take the child. This information was used to improve service delivery.

☞ *One might ask which comes first: defining the problem or identifying the audience? Often the original proposal identifies both; e.g. "Prepare a campaign to promote breastfeeding among urban mothers." The communicator still needs to decide which audience segment to target.*

A knowledge gap or a service gap?

Health data can suggest which campaigns should be a priority. A survey in 300 poorer counties of China showed that 8 out of 10 infant deaths occurred at home or on the way to a health centre. Half the children had received no treatment in the 24 hours before death. This suggested a priority campaign to warn parents of the early signs of illness.

posters at health clinics to target a message at mothers bringing babies there, and preparing visual and written material for interpersonal communication at literacy or child-care classes.

There is a fuller discussion on the preparation of materials in Chapter 11: Transforming Facts for Life Through Visual Arts and Drama.

5. Decide on and prepare messages

You can plan messages with confidence, because you have identified the problem and the target audience. What you have learned allows you to predict the response, but not to take it for granted. Preparation may involve setting up training and information for journalists, preparing visual material and the text of your messages, paying attention to language, simplicity and accuracy. For each communication exercise you should be trying to achieve a consistency of style and production standards. A unified campaign may need a logo. Will the materials be presented under a *Facts for Life* banner, or will the campaign have its own heading and style?

Preparation includes training

Training can be as important as preparing attractive materials and effective distribution. One country working with religious leaders accepted an offer by the Ministry of Religious Affairs to distribute 200,000 messages on child care for use by imams during their Friday sermons. A review a year later suggested that most imams who received the material had not known what to do with it and had thrown it away. This country is now working with NGOs to train imams to use the material.

Stage 2: Implementation

6. Test your messages

Testing gives you the confidence of knowing that you are not wasting your time, effort and money, by ensuring that your messages are understood. There are many examples where experienced communicators needed to adapt their text, drawings or mass media messages after testing. Testing needs to be more than a token effort. If using focus groups, for example, it is important to be sure that they really are representative of the target audience. Sometimes pretesting is done formally without achieving the real aim, which is to be sure, as far as possible, that the material really will be understood and well received. In the case of broadcast material, testing may only be possible through pilot transmissions, and it may prove impossible get television stations to agree even to pilots. In this case elements of the programme will need to be tested as best you can.

Pretesting is not a delay in implementing your programme — it is the first stage of implementation!

7. Deliver your messages

Now you can proceed with confidence, but you must still consider the timing. If you are promoting use of a service, are the service delivery workers prepared to meet the response? Will the vaccine be in the right place at the right time? Are conflicting or competing messages being put out at the same time? Is your audience on holiday, or working long hours bringing in a harvest? Is your carefully prepared television spot scheduled to run after midnight? Will the

people who said they would distribute materials deliver on their promises, or are your posters are turning yellow in a remote warehouse? Do the health workers know what to do with the material when it arrives? Are the training sessions up and running?

Stage 3: Review

8. Evaluate the impact and adjust messages accordingly

Evaluation is notoriously difficult, particularly where there are complex messages. Some of the anxiety that people feel about assessing and evaluating the impact of communication results from difficulty in deciding what to measure. You may hope that communication results in new behaviour, but even if you measure a change, you will be unsure how far your effort was responsible. Some changes take years, even decades, to become apparent. Sometimes, you can only measure raised awareness or increased knowledge.

If data has been gathered in the preparation phase, and if communicators are in regular touch with audiences, the problems of assessment are reduced. At least there is a baseline of knowledge, attitude and practice against which to measure change. Evaluation may be the last on a list of actions, but has to be integrated into every other stage of communication. Results from evaluation should be fed back to the community. They have a right to know this data, which they have provided, and it will either reinforce their efforts and actions, or suggest to them that the problem should be tackled in another way.

Distribution — a sticking point

Distribution can be a major problem, even with advance planning. In one country, the Post Office offered to deliver 100,000 copies of Facts for Life to decision makers, health workers, teachers, trainers, researchers, social workers, lawyers, religious groups, the media and NGOs. Only after work started did the Post Office tell UNICEF they could only manage 2,000 copies a day. It took two months to complete a mailing which had been considered urgent.

Practical issues in working with the mass media

The mass media have become so powerful and all-embracing that they shape the knowledge and opinions of more than half the world. They not only inform and mobilize, but set the agenda of issues judged to be important, and how they are viewed. With mass audiences and unrivalled access to opinion formers, the media have huge potential power. This power can educate and help understanding, and it can mislead and obfuscate. Often, the outcome of a media campaign is a mixture of education and confusion. Like the elements, the power of the media can be used, but rarely controlled. The aim is to harness the benefits and minimize the confusion.

Mass media are excellent for providing a boost of adrenaline through a high-profile launch, or through fund-raising telethons, but find it difficult to convey the complexity of change. The mass media can be used to spotlight issues and problems, but the spotlight is an uncomfortable place to live for long. The

Television in Egypt: Engaging media professionals

On launching Facts for Life, *UNICEF Egypt carried out a knowledge, attitude and practice survey of 230 journalists, scriptwriters, producers and directors.*

This showed that mass media professionals were more knowledgable about health issues than religious leaders or politicians, but less knowledgeable than health workers, educators or people working for NGOs. Media professionals put economic and population problems above those of education and health.

UNICEF sent out six mailings a year on child-related issues. There are now 6-10 health related programmes a week on television, about 38 hours a month. A soap opera sponsored by Johns Hopkins University uses Facts for Life *as the basis for health-related messages.*

Among health programmes were two containing Facts for Life *messages, one on childhood and motherhood and the other for newly-weds. To encourage programme makers to be more pro-active, UNICEF provides living expenses for the crew when film for this programme is shot outside Cairo.*

Dr. Mohamed Wafai, the consultant who carried out the survey, said television presentation of mother and child issues had improved since Facts for Life *was launched. "We are seeing the media setting the agenda for the public to think about issues. We have seen some impact on the Egyptian media, in relation to children, safe motherhood and home accidents. We do not care how it got on the agenda. However, I believe that UNICEF working with these organizations could have been a catalyst."*

Nagwa Farag, UNICEF Programme Communication Officer in Egypt, says that Facts for Life *was quickly accepted as the basis for television work but it took two years to get media professionals to accept training on development issues. "Media professionals are sometimes reluctant to look at the quality of what they do," she said.*

(continued on next page)

bigger the media and the more mass its appeal, the more difficult it is to put across complex messages with subtlety and precision. This is task which must be tackled positively, pro-actively and patiently, on the basis that you may be able to help the media do their work better, and they may be able to set an agenda that enables you to do yours more effectively. Being pro-active allows you to build a relationship with the media and gives you a chance of influencing the agenda. If you ignore the media you will inevitably end up by reacting to its agenda, which you will not have been able to influence.

In developed countries, the mass media have succeeded in bringing the plight of people in circumstances of war, famine or drought to public attention, and in doing so helped raise money for relief efforts. The cost has been that developing countries are often presented as helpless nations whose passive populations wait under trees for the next relief convoy. While this criticism may not apply equally to mass media within developing countries, here, too, they cover cataclysmic events readily, but rarely continue to follow the story once the immediate crisis is over, and rarely show people overcoming difficulties and solving problems.

The power of the media is to bring issues centre stage and to galvanize public interest. Our aim in developing a relationship with the media should be to maximise this potential, by encouraging programmes and articles that convey a deeper understanding. This requires a close working relationship and a degree of trust between UNICEF, media policy makers and journalists.

Training for journalists

Facts for Life lends itself to work with the media. It is a health communication package with a content of widespread interest. It has a clear purpose and it uses simple language. It puts the most important points first and it confines itself to the main issues. It has all the virtues of a well crafted news story.

Facts for Life can be a starting-point for offering support to journalists by way of training or visits. UNICEF can set up training courses for journalists and provide accurate and attractive source material. UNICEF can arrange field trips for policy makers and for journalists, and give the media access to people, places and stories they would not otherwise see. The aim of such training is to excite the curiosity of journalists about the issues UNICEF is working on, to suggest positive ways in which these issues can be presented, and to improve the journalists' information base.

It should be noted that the object is to highlight issues and to promote programmes and methods of working; rather than to promote UNICEF. The line may seem thin, but it is a clear one. The best and most independent-

minded journalists will resist offers of training if they think the real purpose is to persuade them to accept a UNICEF agenda, even if they are in sympathy with the general direction and thrust of that agenda. Just as UNICEF builds partnerships with allies, but maintains its own approach and line of thought, so, too, will journalists want to maintain the right to make up their own minds. The right approach is to use UNICEF material, especially *Facts for Life*, as the content of training initiatives, but to ensure that the training encourages journalists to develop skills and to ask questions. The training is not designed to make the journalists dependent on UNICEF, but to promote inquiring journalists who look for underlying causes while objectively reporting the immediate situation.

Some practical steps to setting up training for journalists

- Try to find a partner, such as a college of journalism, a journalists' trade union, or a major media organization, to co-sponsor training. If there is an existing training scheme for journalists, try to gain an input.
- Identify the journalists and media policy makers who may encourage training. Less experienced journalists may need training, while more experienced journalists and policy makers may simply need formal or informal briefings. Awareness sessions can be arranged for policy makers, editors and producers, followed by longer (two days or more) training for reporters. Try to ensure that the journalists who attend the training courses are those who will be sent on relevant assignments.
- Encourage journalists to review their experiences so that you come to understand their objectives, constraints and problems.
- Try to follow the training by suggesting some stories that could be pursued.
- Keep up a relationship with journalists who are making use of your material, contacts and experience.
- Hold regular briefings for interested journalists, offering both on-the-record interviews and background briefings. Update journalists' knowledge base through mailings or personal contact.
- It may be appropriate for the UNICEF Representative to chair sessions aimed at senior journalists or policy makers, to show that UNICEF takes their presence seriously.
- Do not call press conferences unless you have real news to announce. If journalists don't find something to write about, they soon stop coming.

Egypt: Media *(from previous page)*

Youssef Osman, Deputy Head of Egyptian National Television, supports the need for training. "The problem we face is how to upgrade the skills of those who prepare the children's programmes and how to assess the quality of scripts. We have to prepare people for TV work, especially in a country like Egypt where the impact of television is very high."

Nagwa Farag says that television was very effective in promoting oral rehydration and immunization but issues such as female circumcision could not be addressed. "Because TV reaches 90% of the population, there is a tendency to rely on it too much. But some things cannot be handled on TV.

"Despite the achievements of the past decade, there is a need for more in-depth work and also for an examination of the effectiveness of efforts to date."

A training course for television producers was developed by the Middle East and North African Regional Office of UNICEF (MENARO). In Egypt this course was attended by 70 producers during 1994.

Panama: working together

At the end of 1993, several journalists were invited by UNICEF Panama to discuss how childhood themes could be better tackled in the mass media. There was a unanimous and positive reaction — but the journalists wanted practical support.

UNICEF arranged monthly visits to projects and communities in rural areas that the journalists found hard to reach. A vehicle and per diem payments were made available.

The result has been a number of articles and broadcasts on the needs of children, and on ways to improve their lives. The articles have shown insight and have included high-quality analysis. They have been supported by good-quality photographs in the case of the print media, and interviews and film in the case of radio and television. The project has been running for two years.

Brazil: Training radio journalists

Radio is the only vehicle that covers the whole of Brazil. The importance of the 3,000 radio stations is underlined by the fact that 30 million Brazilians are illiterate.

UNICEF produces training programmes for broadcasters, with the Brazilian Association of Radio and Television Stations (ABERT). In 1993, 873 broadcasters received training, and in 1994 this rose to 1,400. (ABERT also printed and distributed 10,000 copies of Facts for Life to broadcasters.)

The training has three levels. The first is aimed at those who make decisions at radio stations. Owners and programme heads attend six hours of workshops and are encouraged to discuss the social role of the media, the rights of children and relevant legislation.

The second level is aimed at announcers. They attend classes followed by workshops where they discuss how to put knowledge related to children to use.

The third level is aimed at lay people (NGOs and professionals) interested in producing programmes. This includes 32 hours on broadcasting techniques, sessions on UNICEF, the rights of children and adolescents, and basic social and health issues.

UNICEF has created a Reference and Information Centre to keep professionals up to date.

Agop Kayayan, UNICEF Representative in Brazil, says: "It is necessary for the communications media to create a new kind of journalism against poverty ...to keep the population and particularly the poorest and most vulnerable informed about victories won and unmet needs, about new technologies and bodies of knowledge that may help them to survive and to take better care of their children."

Some of the latest and most exciting use of television is through animated film. For examples and discussion of this powerful method of communication through entertainment see Chapter 11 - Transforming Facts for Life Through Visual Arts and Drama.

Activities for journalists during or after training

You may suggest activities for journalists after a training or briefing session – especially if UNICEF is able to facilitate travel to areas the media do not otherwise reach. Journalists can:

- visit communities involved in programmes and talk to people about what they are doing and how;
- compare communities that have been included in a programme with similar communities outside the programme;
- carry out and broadcast spot surveys about levels of knowledge amongst policy makers;
- interview young people about what they think about health messages that are aimed at them;
- talk to people who have been on training courses about what they have learned and how they will apply that knowledge.

If this approach is adopted, then the relationship between UNICEF and the journalists will be based on mutual respect, and journalists' ability to question will be improved. Of course, it is rewarding if a journalist reports that UNICEF sponsored programmes are well thought out, well planned and well executed, but journalists who ask difficult questions are a valuable resource, because they can foster debate over issues, and communicate a real desire to do things better.

Journalists in countries with a high level of state media control tend to receive information and present it uncritically, rather than questioning or investigating, and rarely communicate a sense of excitement. As countries liberalize their media, UNICEF can help interested journalists to focus on the issues that concern women and children, which may have been missing from the media up until now.

The three arms of the media

The mass media can be divided into three distinct groups each with their distinctive strengths and weaknesses.

Television

Television is the most powerful of all media and can completely penetrate the lives of the communities it reaches. If it has not yet overtaken radio as the medium with the largest global audiences, it will soon do so. It is the most convincing medium, since it presents words and pictures together, and appears

to be the most credible. It reaches people regardless of literacy levels. It can also be the most difficult medium to influence. Television stations are often state controlled or run by large multinational organizations. Access to air time is precious and sought after. It is difficult to gain access to television, let alone to dictate terms. The most common forms of access to television are through fund-raising telethons, or information spots given by the television station or by the State as a public service policy.

Telethons can be very effective in raising money. Every year since 1986 the largest television station in Brazil, Rede Globo, has produced and promoted a week-long telethon called Criança Esperança to advocate the needs of children, promote educational campaigns and raise money to support UNICEF programmes. In 1991, the telethon celebrated 25 years of Os Trapalhoes, the most popular comedy group in the country, and raised $1.2 million. In all more than $7 million have been raised to support child health, education and programmes for street children. However, telethons are not designed to educate or inform people in any depth over the issues. This is perhaps changing with the growth of 'enter-education' or 'edu-tainment', where large events backed by star names are broadcast with a social theme. Here, more emphasis is on the information and education content of the programming, although the primary purpose may still be to raise money for a cause.

Television spots are also a popular means of raising awareness. Because spots are often given free, an enormous amount of time, effort and resources can be devoted to them without considering their effectiveness. Who wants to reject a gift? Yet it is important that the audience profile and the impact on the audience are tested, since otherwise people and resources are diverted from potentially more rewarding work with the media. Free television spots may be broadcast late at night, or follow long, dull broadcasts, or be put out on channels that few people watch.

Early television required large teams of technicians, which made outside or location broadcasting expensive and difficult. The advent of smaller electronic cameras has changed this, but it is still common in many countries to see hour after hour of studio-based 'talking heads' programmes broken by library film, rather than by film on location. Encourage journalists to go and visit sites and projects, and if necessary take them there through field visits. It will open their eyes. Many countries invested heavily in television equipment in the 1970s and early 1980s without adequate maintenance and replacement budgets. Some national television stations are today becoming more limited in their outside broadcast capacity, rather than becoming more innovative.

One way or another, state control of television is breaking down, if only through

Training journalists and producers

*The **Ghana Institute of Journalism** ran a six-week course for journalists on child survival and development, using Facts for Life as a basic text.*

*After UNICEF **Nigeria** ran Facts For Life workshops for producers, 1,487 radio and 658 television spots were broadcast in a year. UNICEF provides training and materials; the stations provide air time.*

*In **Sao Tome,** a four-week training course was held for radio producers. Rural communities are now being reached through radio drama in local languages.*

*In **Zimbabwe,** UNICEF ran workshops for radio producers from 10 countries, co-sponsored by the Netherlands National Committee for UNICEF. Information Minister Victoria Chiepo called on producers to promote discussions on AIDS with young people.*

Television around the world

*In **Guyana,** the country's newest television station has been airing two programmes weekly covering breastfeeding, teenage pregnancy, nutrition and Facts for Life. TV **Maldives** has been approached to broadcast six videos on Facts for Life topics, made locally. In **Ethiopia,** a television documentary was made on the top ten messages in Facts for Life, based on a UNICEF field trip. In **Argentina,** agreement was reached with the Tele-Educational System, SITEA, to show eight spots, based on Facts for Life, on 30 channels. These were expected to reach 18 million viewers. In **Chad,** a Facts for Life and Rights of the Child team visits villages to help communities script, develop, direct, act in and film videos that are shown in neighbouring villages and on national Teletchad. Typical videos 'expose' unsanitary conditions or relate stories of a person's conversion to good hygiene. **Turkish** radio and television broadcast programmes aimed at improving health information and stimulating use of health services. A popular actress made a programme about her pregnancy, and a series about caring for her child.*

Myanmar: Video backs immunization

There is only one television station in Myanmar, broadcasting for a few hours a day. However video cassette players have found their way into virtually every village. Video parlours screen imported and domestic videos at modest prices, powered by portable generators where electricity is lacking. UNICEF supported the Myanmar Film Organization in the production of a series of short dramas based on Facts for Life messages, using top artists. These dramas have been broadcast on state run television and radio. However, the messages are actually reaching a much larger audience through the network of private video parlours.

Creative quiz in Papua New Guinea

"Which immunization protects against diarrhoea?" *Callers jam the lines to respond to quiz questions like these on nationwide morning radio from Port Moresby, Papua New Guinea. Other questions invite written answers to win prizes of radios, T-shirts or copies of FFL, and these attract 250-300 entries a time. Broadcasts designed for schools are described by programme makers as "the most creative educational programme" they have ever done. Presenters are becoming FFL experts to stay head of the quiz competitors.*

Radio around the world

Bhutan Broadcasting Services *transmit Facts for Life material to local listener groups.*

The Bolivian Broadcasting Association *put out six messages based on Facts for Life.*

Radio Ethiopia *broadcast Facts for Life messages through a weekly programme, 'The Family', which ran for six months. Analysis suggested that radio had been the most effective tool for Facts for Life.*

Guinea *radio stations allocated 10-15 hours a week to child survival and development programmes, in four national languages and French. More than 1 million Guineans heard Facts for Life messages broadcast.*

the arrival of satellite stations that beam programmes across national borders. The cost is being reduced, and there are enough people with access to erode the effect of censorship. Video recorders and video parlours also reduce dependence on single state monopoly channels. Television has greatest penetration with urban populations or those who live close to towns. National channels reach the largest numbers of people, and these tend to reflect prevailing national customs, religions and beliefs. The influence of television is less in rural areas because people cannot afford sets or there is limited electricity. Video parlours, where people gather to watch pre-recorded tapes, give new opportunities to reach people in areas where television ownership is low and not everybody has electricity. Short promotional material on videotape can be shown before a film or main event of the evening. This is an exciting and so far largely untapped resource.

Radio

Radio probably still has a larger global audience than television, although it is being rapidly overtaken. Radio is a medium with some advantages over television. Radio programmes are cheaper to make, and because the equipment is simpler, radio programmes can be more immediate. Radio reaches more poor people because batteries make it unnecessary for the audience to be on the electricity supply. Although the global audience is huge, an individual radio station may target a small local audience. Radio has often been combined with other methods of communication to bring communities together, and it is widely used as an effective means of education through 'schools of the air'. Even where television gains a hold, radio is still powerful, because it does not require the whole attention of its audience. Radio can be listened to by people at work, in factories or in the fields. It is a medium that people want to keep once they have it, and it is never replaced completely by television. Even in places like the Caribbean where television viewing is extremely high, radio programmes are still very popular. It is no wonder that more UNICEF and *Facts for Life* messages have been prepared for radio than for any other medium.

One of the strengths of using radio is that it lends itself to a combination of media and can to some extent be interactive. Radio listener groups can hold discussions after a broadcast is over, and programmes can be taped and played back when a group of people are able to meet.

Even radio, however, is not universal. In the Sudan, a huge country with just 25 million people, radio is considered a very useful medium, and workshops have been organized for broadcasters to improve their knowledge of health issues. However, although immunization levels reached 80% during the

campaign for universal immunization, UNICEF discovered that information through loudspeakers had reached five times as many people as information given over the radio. A survey in Bangladesh in 1991 showed that in rural areas and urban slums the number of households with access to a *working* radio was 14%-23%, considerably lower than had previously been thought. The cost of replacing batteries proved too much for many people.

Newspapers and magazines

Newspapers have the advantage of being more permanent than television and radio, so that articles can be kept and referred to. There is more variety of print media, and access is easier. They are traditionally strong in urban areas and weak in rural areas. Newspapers have most influence among opinion formers and usually offer more analysis than television or radio. The press can be the best means of fostering debate in a relatively small but influential sector of the population. Newspapers have less influence outside the major urban areas, and very little where literacy levels are low. They are usually read by men rather than by women, although there is often a flourishing market in women's magazines. In some countries, comics are popular and acceptable as means of communicating with adults as well as with children. The written word can be read over the air, or read aloud at meetings as is done with a 'talking' newspaper in southern Mali.

Facts for Life in soap opera

One way to use *Facts for Life* has been to work the content into soap operas. In Latin America, the Caribbean, the Philippines and elsewhere, soap operas reflect the popular rhythms of everyday life. A message can be worked into a story line, so that the audience absorbs information without feeling it is being lectured. In Chile, this is referred to as "the democratization of knowledge".

Those whom the media does not reach

Finally, we should remember that millions of people do not have access to any form of mass media, and they are often the people communicators would most like to reach. Ed Lannert, at the time when he was UNICEF Middle East Regional Director, pointed out that as infant and child mortality levels fall, what is left are pockets of poverty where infant mortality and maternal mortality are high. He said: "The challenge is to see what can be done in these hard-core, high-resistance areas." It is precisely these areas and these people who are least likely to have access to the mass media.

Rural radio

The Philippines *makes extensive use of all media. One approach has been the use of rural radio to reach scattered islands and isolated areas. UNICEF works with an NGO, Al Hidayah, on rural programmes. In Cotaboto City, broadcaster Hadji Pikit puts out a two-hour programme each evening, which reaches 95% of the people who have a radio. It acts as a 'school of the air' and includes* Facts for Life *messages.*

The Philippine Foundation for Rural Broadcasters (PFRB) developed a handbook of radio scripts for members in island provinces. Up to 250 broadcasters read extracts during their programmes from the scripts or from a newsletter, Santinig. *Felimon Barral, PFRB president, says: "Santinig becomes part of your daily broadcast and a bible of your broadcasting profession."*

In ***Senegal,*** *a weekly programme called* Facts for Life *deals with health problems through interviews with health professionals. It is used with four regional stations as part of a rural radio project.*

Nigeria

One of the leading national dailies, Vanguard, *publishes a weekly column under the title* Facts for Life: the Child Health Column. *It is prepared by journalists on the paper based on their* Facts for Life *training. Another national daily,* The Guardian, *published a weekly comic strip in Pidgin English, where* Facts for Life *messages were translated into humorous situations. Radio and TV programmes have spanned five years in Nigeria with over 6,000 radio and 4,500 TV programmes. Broadcasting has been the single most successful use of* Facts for Life, *and opportunities will expand as more private stations open. A soap opera that will include child survival messages is being backed by UNICEF and UNFPA.*

India

In ***India,*** *the Hindi edition of* Facts for Life *was sent to 53 newspapers in Uttar Pradesh.* Hindustan Features *carries a weekly* Facts for Life *article.*

Monitoring and evaluation

The eight steps outlined in this chapter are, taken together, an exercise in monitoring and evaluating actions as they are taking place. Each step — defining the problem, identifying an audience, assessing its knowledge, selecting the right media, etc. — involves making assessments and checking perceptions. The final step evaluates the impact of the messages. These eight steps are useful not only with the mass media, but also for more local campaigns, involving leaflets and posters, and training people to introduce new ideas into schools and colleges, and to rural groups, etc.

Dr. John Hubley in his book, *Communicating Health*, portrays these steps as an interaction between the sender and receiver of a message, where a successful message reaches the senses, gains attention, is understood, is accepted, changes behaviour and finally improves health. His examples of failures at each stage of this process offer an insight into how communication should be monitored and improved. It was developed by John Hubley out of a participatory learning exercise.

	Immunization poster	Water and sanitation	Nutrition on radio	How to ensure success
Reaches senses	Poster at health centre only seen by mothers who already immunize their children.	Only men, not women, were at the public meeting. The women did not hear about water programme.	When the radio programme was broadcast, the women were working in the fields.	Research the listening, viewing and reading habits of the target audience.
Gains attention	The poster does not stand out compared with commercial advertisements.	The sanitation exhibition was boring, and people did not stop work to look at it.	The nutrition programme was boring, and the women switched to another station.	Discover the interests of the target group. Make the programmes interesting and test them first.
Is understood	Poster showing a doctor holding a hypodermic was seen as a devil with a knife.	The field worker talked about faecal-borne disease, and no one understood.	The radio talked about vitamins and proteins. The women did not understand.	Use simple language. Pretest words and pictures with a sample audience.
Is accepted	People who believe that measles is caused by witchcraft do not believe the poster.	People laughed when they were told that diseases were caused by faeces and bacteria.	The announcer was young, and the women did not believe she would know anything about children.	Base messages on what people already believe. Use credible sources. Pretest messages.
Changes behaviour	The mother wants to take the child for immunization, but the grandmother told her not to.	People wanted to build pit latrines, but did not have cement for slabs.	The women wanted to introduce new feeding patterns, but did not have money for food.	Target influential people. Make sure enabling factors are available.
Improves health	The vaccine was not kept cool, and the child became sick with measles.	Children were scared to use the new latrines, and levels of diarrhoea stayed high.	Women bought protein-rich foods, but stopped breastfeeding. Children developed malnutrition.	Direct messages at most important behaviours. Make sure support services are functioning.

'How communication fails' is adapted from Communicating Health *by John Hubley, published by Macmillan, 1993. Reproduced by permission of John Hubley.*

Placing information spots on television or influencing a story line of a radio soap opera require such time, effort and commitment that they can almost become ends in themselves. When they have been broadcast it seems churlish to question how effective they have been. However, it is important that work with the mass media be evaluated since it uses up a great deal of time and money.

It is worth drawing up an audit of which communication channels have been used, how much time was put into the work and what the benefits have been. Benefits may include raising the profile of a campaign among policy makers or raising awareness among the public, and in either of these cases it should be possible to take some measurements before and afterwards. Radio and television stations should be able to supply listener/viewer figures, but it is also important to know *who* was listening or viewing, and how far this group overlaps with your target audience.

The best that can probably be expected is that awareness of the issue or campaign has been raised. It may be possible to show that people have retained information they were given via the mass media, but if this has been part of a coordinated communication exercise, it is difficult to isolate particular causes and effects in terms of what people have come to know.

When media training is introduced and regular briefings and press conferences are held, it is possible to see the direct results in terms of column inches and air time, but also to measure a qualitative change in terms of how perceptive the articles have been and in increased accuracy. The knowledge and awareness of journalists, editors and producers can also be measured.

As part of an evaluation effort health workers and teachers can be enlisted to ask people where they learned about topics and issues, and this will establish whether media messages reached their intended audience. Where groups are set up to listen to radio programmes, they should be asked to provide feedback on the effectiveness of the programmes.

5. Interpersonal Communication, Adult Learning and Training

UNICEF: JOHN ISAAC

Literacy class for Afghan women during a break from carpet-weaving in Bagramt village.

PETER MCINTYRE

Barangay (neighbourhood) health workers in Metro Manila, Philippines, with local versions of Facts for Life.

ACTION POINTS

- **Interpersonal communication is best for reaching small groups of people to discuss complex problems, and for fostering a problem-solving approach.**
- **Effective interpersonal communication uses adult learning, with its cycle of learning, action and reflection. This is the form most likely to lead to behaviour change.**
- **When people are trusted to work on their own problems and to find solutions, their life experiences are at least as useful as formal research.**
- **People are expert in their own culture and community. The facilitator's task is to help them to use their experience.**
- **The focus is on learning rather than lecturing.**
- **Adults learn best when they are respected, valued and feel safe in the group and the learning process.**
- **They learn best when information or skills are relevant and immediately useful.**
- **People reach solutions more easily when they select and take responsibility for the problems that they are tackling.**
- **When training trainers in *Facts for Life* material, organizers should practise what they preach. Trainees should experience adult learning methods.**
- **In particular, role-play is an effective participatory method of learning and gives people the chance to experiment in front of their peers.**

"At school children are taught the things which we adults decide they should be taught. But adults are not like children who sit in classrooms and are then taught history, or grammar or a foreign language. As adults, we can try to learn these things if we wish; we do not have to do so. Instead, we can learn about growing a particular crop, about the Government, about house-building — about whatever interests us. We do not even have to start by learning to read and write. For literacy is just a tool; it is a means by which we can learn more, more easily."

Julius Nyerere, Freedom and Development (OUP 1973)

What is interpersonal communication best at?

In Chapter 4 we saw that interpersonal communication is best for reaching small numbers of people to discuss complex messages, or problems where solutions require community or group action. It is the most suitable form of communication for reacting to problems and questions, and for fostering a problem-solving approach. It is the form of communication most likely to result in behaviour change.

There are many kinds of interpersonal communication, including counselling, teaching and preaching. Many different communicators, such as teachers, health professionals, field workers, religious and community leaders, use interpersonal techniques, formally or informally. This chapter looks at a participatory, problem-solving approach, which is useful especially with groups who gather for specific purposes. These may be community organizations, women's groups, farmers' groups, religious groups, cooperatives or others.

This chapter also looks at how the trainer can act as a facilitator and apply some of the lessons of adult learning, using a problem-solving approach. The focus will be on training communicators who may be health workers, community volunteers, literacy workers or a wide range of others who work in communities. These are the people, whether they are grass-roots professionals or urban and village volunteers (health committee, water committee, literacy committee or community leadership), who have the greatest opportunity to introduce *Facts for Life* into the community.

The aim is to train people in a participatory approach. In that process, it is essential that UNICEF and partners practise what they preach. If community workers on training courses sit in rows listening to speakers with flip charts, they will naturally suppose that this is the way to tell people about *Facts for Life*, and adopt this least-effective way of giving people information.

Resource books

This chapter is modelled on work by Karen Tompkins Berney, who has developed a facilitators' manual as part of a UNICEF Workshop on Strengthening Participatory Attitudes in Communication and Development. A fuller account of the learning approach will be found in this manual (published 1995) or in Communicating About Health — A Guide for Facilitators' Training, also written by Karen Tompkins Berney and published in 1993 by USAID and the US Department of Health and Human Services (part of the Africa Child Survival Initiative).

Another useful account of this approach, also full of practical examples, is Training for Transformation — A Handbook for Community Workers, written by Anne Hope and Sally Timmel, published by Mambo Press in 1992.

See also Learning to Listen to Mothers by Jane Vella and Valerie Uccellani, published by USAID, which uses Facts for Life as its training material. (See extracts in this chapter.)

All these books should be available through UNICEF country offices.

Channelling energy into action

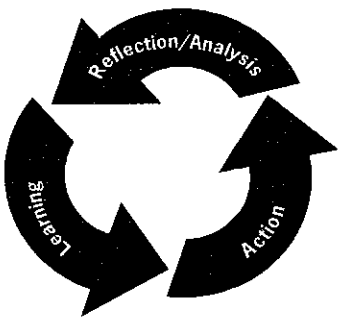
Often the first plan of action will solve some aspects of the problem, but not deal deeply enough with the root causes of the problem. By setting a regular cycle of reflection and action in which a group is constantly celebrating their successes, and analysing critically the causes of mistakes and failures, they can become more and more capable of effectively transforming their daily life.

Many discussions filled with feeling do not lead to action. They waste away in fruitless grumbling or wind round in circles, unless the energy is gathered, channelled and directed.

Training for Transformation,
by Anne Hope and Sally Timmel

Using interpersonal communication to help groups address problems

This approach is based on the principles of adult learning. The objective is to develop a process of analysis, learning and action so that people can tackle health (or other) problems and promote well-being. The process is designed as a cycle so that each circuit produces a better level of understanding and more effective action. There are other versions of this cycle. Paulo Freire originally described it as focusing on a problem, reflecting and acting. It has been described as looking, thinking and doing. Some refer to 'triple-A' (assessment, analysis, action). Whatever the terms, the process is the same.



Adults need a different approach from children. Adults are self-directed and self-determining. They are participating because they choose to and they want to. Communicators being trained in *Facts for Life* material have usually volunteered for this work and are highly motivated.

When working with adults, the focus is on learning rather than teaching. The teacher must become a facilitator (or helper) who encourages the learning process, rather than being someone who force-feeds information. The process by which the group develops is as important as the content of what people are learning.

When do adults learn best?

Adults learn best when:

- they feel *respected* as responsible and self-directed learners;
- they feel their own knowledge and experience are *valued*;
- they feel able to *trust* the group and feel *safe* in the learning process;
- they see how the information or skill is *relevant* to their lives or their work;
- they see that the information or skill is *immediately useful* in performing tasks or dealing with problems they are confronting.

Group work should be based as much as possible on everyday experience, and activities should be interactive and participatory. Trainees should spend as little time as possible listening to long lectures by the teacher. There will be a need to give information, but this should be in short bursts at appropriate points, and not all information will come from the trainer.

These five points, and statements on the next page about what people remember, are adapted from the writings of Malcolm Knowles.

We know this is the most effective way of learning because:
People remember:

- 20% of what they *hear*;
- 40% of what they *hear and see*;
- 80% of what they *discover for themselves*.

Promoting breastfeeding in Quezon City

People remember 20% of what they hear, 40% of what they hear and see and 80% of what they discover for themselves

In Quezon City in the Philippines, Marvelyn Palomique lives with her husband Larry and two children in a wooden house with no door. A metal grill laid across the doorway protects Ja-Ja, four, and Larry Junior, two, from running into the road.

The floor is mud because the home is one of tens of thousands in a kind of squatters' town. However, the room is neat. An elderly fridge rumbles away at the back of the room. A TV set shows cartoons. The children are well fed, and the family home is kept with pride.

Marvelyn is volunteer health worker for the neighbourhood and president of the organization of health care workers, Samahang Bantay Kalusugan sa Martin. She works with the Bunso NGO group, which trains women to promote breastfeeding.

One neighbour is taking a test, so that she can become a barangay (neighbourhood) health worker too. The practice test is difficult. She has to know, for example, that tuberculosis is caused by bacteria, not a virus, and she closes her eyes and repeats the words to memorize them.

Marvelyn's support for breastfeeding on the other hand comes from experience. She bottle-fed Ja-Ja, because she thought this was a step towards sophistication. But Ja-Ja was often sick and had to go to hospital. Marvelyn is now convinced that bottle-feeding does not protect against disease like the breast. Little Larry is two and still being breast-fed, and Marvelyn does not have to recite anything or concentrate to remember why.

Marvelyn visits other mothers. Winning them over is not easy. The women want to be free of breast-feeding so they can go to work. She shows them how to use a breast pump or advises them to find a wet-nurse. Some women are pressured by husbands who are frightened that their wives will lose their figures.

Marvelyn's husband Larry drives a jeepie, (somewhere between a taxi and a bus) and he was against breastfeeding when Ja-Ja was born, but he now stresses the benefits. "One can of milk powder will last about four days and the cost goes up every day." He says that Marvelyn was up almost every hour to make up bottle-feeds for Ja-Ja, but that did not prevent the child from becoming ill.

The barangay has many other problems: no jobs, no day centre, no hospital. The women are planning a stall to sell herbal medicines. However, breastfeeding will continue as their main campaign, because they are convinced that this is the single most important step to protect the health of their children.

They are up against persuasive opposition. An advertisement comes on Channel 9. A plump, well-fed child is blowing out a candle on a birthday cake. The child is well dressed, and the home has every material comfort that the squatter homes lack. A warm confident voice says: "Now your child is one, they need nutrition and protection against childhood disease. Turn to Lactum, world leader in nutrition." (A bottle feed is made in close-up.)

In tens of thousands of homes, the advertisement is seen and heard by mothers and mothers-to-be. They may not know from their own experience about the benefits of breastfeeding. They would dearly like their children to have what the child in the advertisement has.

They cannot afford the house, the furniture or the clothes. Perhaps if they scrape their pesos together, they might afford the can of milk powder.... After all, the other benefits will soon follow, won't they?

The role of the facilitator in the adult learning approach

What is the difference between a facilitator and a teacher? There may be none, depending how well a teacher works with adults to draw out experiences and helping them to learn. There is a big difference between a facilitator and an old-style lecturer, who usually sets the agenda, lays out the facts and draws the conclusions. A facilitator's role is to ask stimulating questions and to encourage trainees to reflect on their own experience and knowledge, and to help them understand how to apply that in their work. The facilitator uses the process of the group dynamic to encourage learning, rather than delivering facts.

But trainees need facts!

Yes, trainees need facts (that is why *Facts for Life* is such a valuable resource) but when they are learning how to communicate in their own culture, they are already experts, because they have cultural understanding, and a knowledge of the traditions, beliefs and practices of their audience. The trainer probably does not have this knowledge, but may know how to help them to apply it, and how to introduce the new information in *Facts for Life*. The facilitator is a resource for the group but does not necessarily have all the answers — and is able to say "I don't know". Part of the learning process is finding out where and how to find information.

The facilitator also acts as a guardian of the safety of the group. People will not say what they think unless they feel safe; they will not bring out a new idea if they fear it will be 'wrong' or make them look foolish. That is why the facilitator never 'dumps' on a response. If someone says something wrong or foolish, the facilitator uses further questions to elicit accurate information, but always protects the dignity of each participant.

Another key role of the facilitator is to ensure that the group feels 'ownership' of the lessons, so that in turn group members will help others to take ownership of health or development problems, rather than accepting someone else's agenda for problem solving.

Karen Tompkins Berney in *Communicating About Health* says: *"In working with people to promote health, it is important to pay attention to the amount of ownership they feel for the issue or problem you are helping them to manage. When people feel ownership regarding health problems, they are interested in solving those problems. The result of thinking `the patient needs to' is that the problem and solution are identified and owned by health workers, rather than by the people who have a problem to solve."*

An approach to training communicators

Part 1: Let the trainees experience the adult learning approach

When training communicators, you are both *telling* them about an adult learning experience, and also (more important) letting them *experience* it. Your aim is that when they return to their communities they will put a participatory approach into action, adopting a model for interpersonal communication that develops the facilitator role. This is one model they could use.

Eight steps in interpersonal communication

1. Begin by asking questions and listening to the group to find out about their health problems or about other issues important to group members and their communities
2. Begin a dialogue with the group around a problem they identify as a priority.
3. Facilitate discussion, so that group members pool experiences and knowledge, to attain a comprehensive understanding of the problem.
4. Share any relevant information you have (*Facts for Life* or other information that helps explain why the problem exists).
5. Encourage the group to identify appropriate solution(s), based on what has been learned in the discussion, as well as on social and cultural factors, personal preferences, etc.
6. Support the group's action to solve the problem.
7. Help group members to assess the results of their actions, and to consider modified or further action.
8. Start discussing another priority problem (*return to step 2*).

☞ *These eight steps can be seen as equivalent to the eight steps in communication in the previous chapter, which were more suited to situations where some use will be made of mass media. In small groups, if people are trusted to use their own experience, then the need for 'research' is diminished, because their experience is the research data. If trainees feel safe in the group and are in control of their own experiences, they are likely to present them in as objective a way as possible.*

In her book, Learning to Listen to Mothers, *Jane Vella suggests a similar set of steps for health workers to communicate with individual mothers. Her list, which takes us up to step 6 of this model, is:*

1. *Evaluate the child's situation with the mother.*
2. *Talk with the mother to establish priorities.*
3. *Share practical information with the mother.*
4. *Assist the mother to make a plan of action.*
5. *Listen to the mother's plan and offer encouragement.*

If trainees are to gain confidence to use this approach and become convinced of its value, they need to experience the method. Therefore, when working with the group the facilitator should:

- lead a discussion and make a list of the major health problems that are significant in the communities where the trainees will be working;
- agree with the trainees on a particular health problem as the focus for discussion;

Closed and open questions

Closed questions force someone to answer in particular ways (often yes or no). Open questions have no right answers, but generate broad, deep responses. A closed question would be "Has Anna been well since the last visit? (Probable answer: yes or no). An open question would be 'How have you and Anna been since your last visit?"

Jane Vella, (from whom these examples are taken), has defined what she regards as the four key open questions that should be asked in evaluating an experience.

- ***Description***
  What do you see happening here?
- ***Analysis***
  Why do you think it is happening?
- ***Application***
  When it happens in your situation what problems does it cause?
- ***Implementation***
  What can we do about it?

Language can be expensive!

There are many role-play ideas in the books mentioned in this chapter. One which is very successful when training health experts is described by Karen Tompkins Berney in Communicating About Health. *Words are given a monetary value according to how simple they are. For example, cough is a 10-cent word, while 'pneumonia' is a $2 word and 'streptococcal respiratory infection' can be worth $10.*

Health workers are asked to explain symptoms as 'cheaply' as possible. The manual says: "Fortunately, most medical terms can be defined in simple words understood by the general population. Health workers who want to communicate with non-medical people can find other words to say what they want to say, but they must learn to do so." The role-play generally impresses on doctors, nurses and health workers how 'expensive' their language can become, and how one has to work hard to keep it simple.

- ask open questions to draw out trainees' knowledge and experience of the problem;
- share appropriate information (e.g. from *Facts for Life*) to broaden the pool of knowledge;
- encourage trainees to identify the best solution(s) and the action(s) they will take for implementation;
- ask them to identify what evidence will tell them that their action has made a difference, and work with them to decide how they can collect such evidence.

Remember that role-play is a highly effective method of drawing out trainees' experience, and in encouraging them to participate fully in a learning process.

Part 2: Encourage the trainees to reflect on their learning experience

The facilitator can do this by asking questions:

- What happened? What steps did we go through?
- How did you feel while taking part in the discussion? (*safety, trust, relevance*)
- How do you think I valued your knowledge and skills? (*respect, value*)
- Was the discussion useful to you? (*relevance*)
- Will you actually take the action decided in your discussion? (*immediate usefulness*)
- What did you like about this way of learning?
- What would you have done differently?

Part 3: Ask the trainees to practise the learning model they have experienced

- Working in groups, the trainees can practise developing a learning experience, using another problem addressed in *Facts for Life*.
- Ask trainees to outline steps they would take in working with a group.
- Challenge them to develop a role-play to demonstrate their approach.
- Invite each group to present their role-play.
- Invite all the trainees to discuss the role-play. What were the strengths of each? Were any key elements missing?
- Encourage groups to consider additional ideas to improve their approach.

At the end of training sessions, give trainees time to describe how they are going to put what they have learned into action when they return home. This public commitment is strengthening for the individual and for the group.

Learning to *Listen to Mothers*

One of the guides to adult learning listed on page 55 has particular relevance for those developing *Facts for Life* courses. *Learning to Listen to Mothers* is a trainers' manual designed to strengthen communication skills for nutrition and growth promotion, written by Jane Vella and Valerie Uccellani and published by USAID. It uses *Facts for Life* as the source of information about nutrition for babies and young children.

Learning to Listen to Mothers outlines workshops, role-plays and discussions, and stresses the need for health workers and supervisors to learn how to talk to mothers. It says:

"Counselling mothers of small children in effective growth monitoring and promotion is both an art and a science. The science is in weighing the child, charting growth, comparing growth to international standards and knowing basic nutrition information. The art is in effective two-way communication with the mother: listening attentively to the mother's perspective and sharing new information about infant feeding practices in a sensitive, systematic, and sure manner.... The adults you are training do not need to be given a lot of new information to learn what they need to know. Rather they need an opportunity to exchange ideas and experiences. This will build their communication skills and basic understanding of nutrition and growth.

"Remember: Participants will do with mothers what you do with them. During each session, do what you teach: Listen! Encourage! Affirm! Question! Explain! Finally, remember that as an experienced trainer, you know best what will work with your group. Experiment! Try new things!"

Learning to Listen to Mothers reminds us that training workshops are about two-way communication, and not about correct ways to measure, record or interpret a child's growth. It encourages health workers not to introduce *Facts for Life* messages all at once.

"Facts for Life *is a handy resource for basic nutrition and growth messages for health promoters. However, health promoters cannot and should not tell a mother all of the messages about any topic, such as breastfeeding. Rather they should try to know the messages well, and then share one or two pieces of information that are the most important for this mother at this time."*

One of the practice skills outlined in *Learning to Listen to Mothers* is deciding which *Facts for Life* messages should be introduced in any given situation.

The teacher as communicator: Literacy training in Alexandria

PETER McINTYRE

Gamilla Hana, who attends a literacy class in Alexandria, with her three-year-old granddaughter Hadir Said.

In Egypt, UNICEF and the charity CARITAS produced flip charts and reading books from the Hygiene chapter of Facts for Life. Literacy campaigns are backed by the Ecumenical Committee for Health Education. In a bakery close to the centre of Alexandria, production has finished for the day. Flour sacks are stacked and whitened tables scrubbed. Seventeen women of all ages sit around a table as teacher Maha Rajab holds up a flip chart of pictures. Each student has her own booklet with the same pictures in smaller format. Maha Rajab talks about the picture: "The human body needs to be clean. Every part needs to be clean." She moves to the particular. "What is the importance of the eye?" "To see better," one of the pupils replies. Key words are copied as the women discuss why people need glasses, and whether television is bad for the eyes.

The teaching looks traditional, because the teacher is at the front and the 'pupils' are sitting at benches. Yet the atmosphere is light hearted. The teaching method draws the women out. The teacher has an infectious smile and listens and encourages. The women laugh as they learn. They talk about the problems of sharing bathrooms with other families. The teacher sums up the discussion. "We should encourage our neighbours and the people living with us to clean where they live." They look next at a picture of a child asleep, his face covered with a piece of net. In the next picture the child waves away flies. They discuss how he can be protected. The women have attended classes for a year. They can now sign their names, read what their children are doing at school, and read street names and magazines. One attended eight days after giving birth. What they clearly enjoy most is that their own experiences as wives, mothers and women are relevant and contribute to the learning process.

Literacy material derived from Facts for Life.

Other classes are jointly organized by Caritas and the Red Crescent at a medical centre that once specialized in treating polio. Women discuss pollution, looking at a picture of the Nile where people are swimming, while others wash clothes and one man washes his cow. The teacher, Aida Jebril, starts a discussion: "In the beginning it was clean. Who polluted it?" As well as learning to read, the women are learning how to take action in their own communities. Hoda Awad says: "We had a canal in front of the house. We used to wash ourselves there, and kids swam in it. We told our neighbours that we should complain and get a tap on the site. They said they had been doing it like this all their lives, but we complained and got a tap. We use it for drinking water and washing the dishes."

Aida Jebril, who has a B.Sc. in agricultural economics, said: "Working with these women is very fulfilling. As mothers, they are interested in their children's problems, and they have a thirst for information. I get to know their problems and help them on a personal basis. If someone is getting married or has had a success in exams, we go and celebrate with the family. If someone is sick at home and needs medical care we do a collection and give it as a group of women." Fardos Hamed, a schoolteacher who switched to teaching adults, said: "They have respect towards each other as a group. I don't feel it is like teacher and pupils, but that I am someone they can trust. Sometimes they tell me what they cannot tell their own families."

Life skills

The approach described in this chapter is based on the assumption that people acquire skills and knowledge through experience, and that they are able to make use of new information to transform problems. This assumes a degree of stability within communities, which allows knowledge, beliefs and skills to be passed on both among adults, and to new generations of young people. Customs and beliefs may be deeply ingrained in such societies and articulated by community leaders, religious leaders or teachers, or they may be passed on informally through storytelling or traditional healers. There are many communities where such stability has been shattered or eroded. This can happen through cataclysmic change, such as war or famine, where whole communities become refugees. It may happen through a process of migration from rural areas to the edge of cities, where new communities are being formed in conditions of extreme poverty with few fixed points or relevant traditions. It may happen through exposure to sudden cultural change, as satellite television and the symbols of consumer society arrive more or less overnight in a traditional community.

Any of these scenarios can produce a situation where many people — particularly young people — feel alienated from their traditional way of life, no longer look to parents and elders for guidance and make many decisions with few guideposts. The ability to take decisions with confidence can also be eroded in extreme authoritarian societies, where all important decisions are taken for the people, and it can be dangerous to have an original thought or to hold an unorthodox opinion. One UNICEF official described trying to conduct training courses in a country where there had been 20 years of military rule. *"There is a lack of creativity. People tend just to do what they are told."*

In such cases, training of trainers is complicated because life experiences may all appear negative, and the ability to learn from experience may have been distorted. People who have been dislocated may become apathetic or seek oblivion in alcohol and drugs.

Developed countries, which have their own marginalized people, are also rethinking how they can effectively address issues such as drug abuse, smoking, alcohol and the risks of AIDS, with young people who are not affected by distant prospects of ill health. In the newly independent states of Central and Eastern Europe, the search is on for a way to help people acquire the skills they need to make decisions and to make choices. A movement has developed that is seeking to develop a methodology for teaching life skills to people who find it difficult to take a long-term view because their own short-term future is so uncertain.

Life skills in the Caribbean

In the Caribbean, many issues affecting the well-being of infants are related to problems of youth and have psychosocial factors as an underlying cause.

- *Infants born to teenage mothers are more likely to be premature and have low birth weight.*
- *Teenage mothers often abandon education, lose the support of their families and cannot find work to enable them to provide for their children.*
- *The incidence of child abuse or neglect is higher among very young parents who lack parenting skills.*
- *The rising number of infants with AIDS is associated with early sexual activity in young people.*

Schools have been underused in supporting the health status of adolescents. A decision was taken to develop life skills within Health and Family Life Education (HFLE) classes. The core skills include decision-making, critical thinking, self-awareness, coping with stress, and communication, and these can be expanded to include assertiveness, negotiation skills and values.

Agencies have joined together to work on HFLE, endorsed by 18 Ministers of Education in the CARICOM region. The agencies include UNDP, PAHO, UNFPA, WHO, UNICEF and the University of West Indies, and they have been able to dovetail their projects.

Support material for the classroom is of high quality, and includes cartoon animation and comic strips (see Chapter 11: Transforming Facts for Life Through Visual Arts and Drama).

The challenges ahead include:

- *going to scale across the Caribbean;*
- *encouraging the parenting role of fathers;*
- *sharing the development of life skills among parent-teacher associations;*
- *reaching young people who are not in school;*
- *modifying legislation to reflect the Convention on the Rights of the Child.*

WHO develops life skills package

The World Health Organization has prepared a life skills package on the prevention of alcohol abuse, drug abuse, teenage pregnancies and other problems. This package has been developed in collaboration with a number of organizations and experts, and is designed to be widely applicable in a variety of settings and countries.

WHO shares information on life skills in its Skills for Life newsletter. To be included on the mailing list write to Dr. J. Orley, Senior Medical Officer, Division of Mental Health, WHO, CH-1211 Geneva 27, Switzerland.

Although the nature of life skills may differ across cultures, there are core abilities that can be universally offered.

Some of these fundamental skills are:

- decision-making and problem-solving;
- creative thinking and critical thinking;
- communication skills and interpersonal skills;
- coping with emotions and coping with stress;
- self-awareness and empathy.

WHO puts forward a conceptual framework as a way of understanding the role that life skills play in promoting positive health behaviour and adopting prevention strategies, where psychosocial competence, is defined as a person's ability to deal effectively with the demands and challenges of everyday life.

knowledge attitudes & values + **life skills** ⇨ **psycho-social competence** ⇨ **positive health behaviour** ⇨ **prevention**

KISS A VIP!

Another way of listing these skills is by remembering the phrase KISS A VIP as follows:

Knowledge,	*Attitudes,*
Information,	*Values,*
Social skills,	*Influences,*
Self esteem	*Personal skills and competence*

TACADE

This approach is in harmony with the adult learning approach. In particular it recognizes that situations exist where young people and adults may need extra help to develop personal skills and competencies.

Jeffrey Lee, Chief Executive of the British TACADE organization (one of those advising WHO), said: *"Too often in the past — and still in the present — we have promoted the view that the way to overcome any problematic issue is by providing information, as if by giving knowledge alone we will be able to affect behaviour, including drug use behaviour. It is increasingly recognized within the education field that in dealing with drug education it is necessary to address not only information, but also other factors such as people's attitudes and values, the range of influences upon them, their self-esteem, and their personal and social skills."*

The work by WHO shows the distance that has been travelled from 'providing information' to developing the skills needed to consider options and to make choices so that people can, in fact, make use of that information. Training packages prepared as part of a *Facts for Life* initiative need to take account of life skills. These are not only needed when addressing issues such as drug education with young people. Addressing the capacity of people to use information and to make informed choices is as important as having accurate and relevant information available.

Monitoring and evaluation

The approach outlined in this chapter contains within it many of the techniques for monitoring and evaluating the effectiveness of interpersonal communication. Evaluation should be built into training courses as a matter of routine. Some of the questions that should be asked are outlined on page 60. It is, however, easier to ask these questions than to get completely honest answers. Trainees who feel grateful for their opportunity and who feel goodwill towards the trainer are liable to over-praise and reluctant to criticize. For this reason, written evaluation forms are not always the best method of gaining feedback. The trainer can draw out issues through discussion and make it clear to trainees that criticism is welcomed because it allows the trainer to improve courses for future students. If trainees are experienced in this form of learning and accustomed to evaluation they may be happy to give reactions in writing. The aim is not so much to find out what people liked and did not like, but what has been learned from the action they have taken. To reflect on the learning process two good questions are: "What has been useful?" and "What would you do differently another time?"

One obvious form of monitoring is to keep an eye on how popular courses are over a period and how many people drop out before the end. Word of mouth is a powerful way of recruiting people to courses, and a low take-up rate or a high drop-out rate indicates that the course is either at the wrong time in the wrong place or is too technical or has some other problem that needs to be corrected.

It should also be possible to monitor the results of training. If interpersonal communication skills have been taught to community-level workers, then how far are those skills being used in their subsequent work? Following up trainees six months after a course helps to evaluate the effectiveness of the training, and can also secure the trainees in their new practices. Here, the important question may be: "How are you using the information from the training in your work?"

6. Children as Communicators

UNICEF: JEREMY HARTLEY

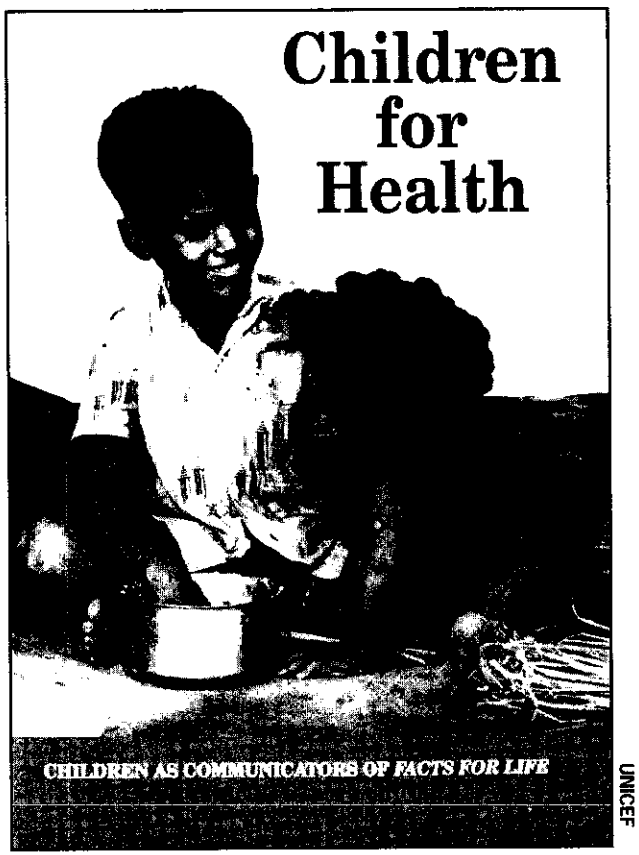
A Romanian child in a Bucharest crèche where UNICEF backs a project encouraging creative play in preschool education.

ACTION POINTS

- **Children have a right to health knowledge and to the skills to put that knowledge into practice.**
- **Children can be powerful communicators — to each other, to their families and to their communities.**
- **Lessons can be learned from the Child-to-Child movement, which values children as agents of change, promotes their ability to think and act critically and promotes their role in education and health.**
- **Child-to-Child activity is effective in school, in clubs and in the community.**
- **Adapting *Facts for Life* for work in schools and youth clubs means transforming the messages so that they interest and entertain children.**
- ***Children for Health* has adapted *Facts for Life* so that messages and activities are suitable for children and for teacher-to-child communication, inside and outside school.**
- **Child-to-Child and Teacher-with-Child activities can only be introduced into school when teachers are trained in their use.**

Action Points

- Child-to-Child and Teacher-with-Child activities can best be introduced on a widespread scale when the knowledge base and activities are integrated into the curriculum.
- Curriculum changes take several years and require the support of the Ministry of Education.
- If *Facts for Life* is integrated into the school curriculum, its information will become part of the learning of every student.
- Integration into the school curriculum does not guarantee that young people will be taught to think and act critically. An examination approach to health education can lead to rote learning without understanding.
- Orientation and use of *Facts for Life* at teacher training colleges is a vital step in helping to ensure that *Facts for Life* will be taught in schools in a correct way.
- The Child-to-Child approach should be adapted to meet the needs of young people who drop out of school.
- Child-to-Child methods do not mean using children as free or cheap labour to do jobs that nobody else will do.



The Children for Health *publication is available in Arabic, English, French and Spanish.*

Child-to-Child

Child-to-Child was launched in 1978, shortly after the 'Health for All' Alma Ata conference, and in the run-up to the International Year of the Child. It asked what special contribution children could make to improve the health of other children, families and communities.

Child-to-Child is:

- *a philosophy: valuing, trusting and respecting the child as an agent of change;*
- *an approach that promotes and involves children as movers in education and health in school and the community.*

This approach promotes active, community-involved learning and uses methods that are natural to children.

It links children and families in positive action to reduce conflict in society and it prepares future parents to understand basic health priorities, and to pass these messages on.

Child-to-Child promotes active learning, through methods that stimulate thinking and understanding. Knowledge is retained more effectively as children teach it to others.

The original intention was to focus on information being given by children to children. It is now used in a wider sense of children becoming communicators, and in children being a special target audience for messages.

Stories in Mozambique

Three children's books were produced for the June 1994 national mother and child campaign. They are Vem af o bebe (A Baby's on the Way), O nosso bebe (Our Baby) and Ev e a Rita (Rita and Me). The last is about two girls sharing hints about growing up. Illustrations and text were done by a UNICEF consultant who specializes in children's education.

Children have the most to gain

Children have the same rights as adults to health education information. As young people, they have the most to gain from improvements in the health status of communities, and young people have qualities that enable them to communicate in ways that older people cannot. They have the capacity to teach their peers in a language and style that is most effective. They are looked up to by younger children as role models and as sources of information. They can also be a source of knowledge and inspiration to their families and communities, introducing knowledge and new practices that can protect their health and protect the environment.

Children have always played an important support role in extended families, helping to care for brothers and sisters. The dividing line between helping the family and community and being exploited is a narrow one, and depends in part on cultures, customs and economic status. Many families wish to ensure that their children receive a better education than they were able to. However, pressures of poverty force many children, particularly girls, to drop out of school to take an adult load. Promoting Child-to-Child activities affirms that young people have a right to a childhood and to an education, and that this will equip them to help families and communities better in the long run.

The basis of the Child-to-Child movement is that children should be accepted as partners to promote the health and well-being of families and communities. This enhances their worth in their own eyes and in those of adults.

Children for Health

The Child-to-Child Trust, in association with UNICEF, published a special edition of *Facts for Life* in 1993 to promote messages to and through children. *Children for Health* contains all the key messages of *Facts for Life*, together with suggestions for making them easier for children to learn. The chapters on safe motherhood and birth timing have been combined, and chapters have been added on accidents and food for the family.

Children for Health is a response to the appeal in the Declaration signed by Heads of State at the World Summit for Children:

"Among the partnerships we seek, we turn especially to children themselves. We appeal to them to participate."

Children for Health is designed for those who work with children, not for children themselves. The introduction outlines the range of people who can use it.

"We who work with children must help them to do so. We are all those who plan programmes, write materials, train teachers and health workers and who work with

children and their families in schools and communities. This is a book for all of us. It is not a text for children; not a lesson-by-lesson guide for teachers. It is a resource book of ideas. We can use them in many different ways."

Children for Health is therefore aimed at policy makers, curriculum planners, health education planners, teacher trainers, schools, clubs and youth groups and organizers of out-of-school groups. Although the school is one of the main arenas where this work can take place, none of the activities needs to be classroom based, and they are all suitable for out-of-school clubs or other non-school organizations. Editors Hugh Hawes and Christine Scotchmer emphasize that children communicate in quite different ways from adults:

"When children become partners in promoting health they contribute something special to the partnership. Children have special advantages and special roles in spreading health to others.

"Younger children often spend more time with older children than with adults. They admire them, copy them and do what they say. Groups of children, particularly influential and popular groups, can influence their peers in a way which adults can never do. Children, through their innocence, can often remind adults that their actions are unwise or unsafe. They can act as the conscience for the community."

Children for Health suggests a wide range of activities for children to carry out:

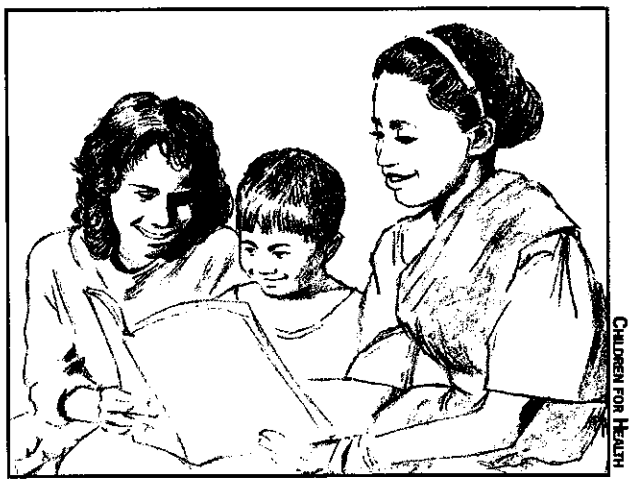
- community surveys,
- role-plays,
- production of posters,
- composing and singing songs.
- discussions,
- campaigns at fairs/open days,
- dramas,

Children can also:

- demonstrate health skills;
- observe and record health practices and health status;
- describe and measure the outcome of their activities.

However *Children for Health* emphasizes:

"Activity on its own does not achieve learning. What is needed are methods which promote active and critical thinking, leading to well-planned and effective action."



Children as partners, from Children for Health.

School health programmes

Schools can develop school health programmes. These go further than simply including health issues in the curriculum. They promote the health of children and the environment in daily life. Children play leading roles in school health committees, and they help to set priorities and to plan and monitor health events in the school and the wider community.

Teachers' guide in Papua New Guinea

The Curriculum Division of the Ministry of Education has produced a Teachers Guide Book for FFL, which is basically a synopsis of Children for Health with the emphasis on participatory classroom activities.

Respect children — don't exploit them

Hugh Hawes, former Director of the Child-to-Child Trust and co-editor of Children for Health, says that activities need to be appropriate and interesting for children.

"Child-to-Child must not be used as an excuse to exploit children to do all the environmental chores, or merely to use children as megaphones to pass on adult messages: copying posters, delivering slogans devised by adults. We need to remember the essence of using children as communicators and agents to improve health is to tap their own particular gifts, their imagination, their enthusiasm, their innocence....

"By passing on messages and undertaking health action, the older child learns, remembers and understands through teaching and doing. At the same time, skills in communication and interpersonal relations are developed.

"By their interaction with older children, younger children feel a sense of security and bonding ....

"The use of Child-to-Child approaches, effectively planned and carried out, helps to give children a sense of worth and autonomy, often present in traditional societies but sadly absent in the mass production approaches of some modern education systems.

"Once we accept that children have a special role to play in teaching each other and learning from each other, we open a complicated and very productive menu of learning patterns.

"Conventionally, the concept of 'respect' was always conceived as flowing in one direction, from younger to older. Now we are suggesting a two-way traffic."

Children do better when involved

Children for Health says that when a school is involved in a successful Child-to-Child (or Child-to-Community) programme, children are more likely to attend school regularly and do better in class. Schools also benefit from closer links with the community, health workers and health services.

Children for Health focuses on 12 areas where action can save and improve life. These cover:

- breastfeeding
- child development
- diarrhoea
- coughs and colds
- AIDS
- accidents
- child growth
- hygiene
- immunization
- malaria
- safe motherhood
- food for the family

Each section contains *Facts for Life* prime messages together with supporting information and a selection of ideas for action that can be developed in work with children.

Examples of Children for Health activities

- The chapter on breastfeeding suggests that children carry out a class survey in which children ask their mothers how long they were breastfed, and when they were introduced to solid food.
- The chapter on diarrhoea suggests pouring water into a gourd with two holes in the bottom, to show that liquid lost when a child has diarrhoea must be replaced.
- The hygiene chapter describes an experiment with a sand-filled container, water and dye, to show that polluted water can spread underground and pollute a well.
- Children role-play situations in which they learn to say 'no' to unhealthy actions.
- Older children are encouraged to note how a younger brother or sister develops skills, and to recall what made them frightened or happy when they were little.

Evaluating actions in Children for Health

Each chapter of *Children for Health* ends with simple evaluation questions, designed to test what children have learned, and what activities they are now carrying out in the community. For teachers, it lists questions to help them consider whether children understand the issues. There are also questions to focus health workers on drawing children into their activities.

By the beginning of 1995, there were 90,000 copies of *Children for Health* in circulation in English and French (*Les Enfants Pour la Santé*). Regional versions

are being developed by UNICEF in Arabic (by Amman) and Spanish (Bogota). Brazil is developing a Portuguese version to train teachers. In India, a Gajarati version is being prepared by the Centre for Health Education and Nutrition Awareness in Ahmadabad and a Telequ version by the Andhra Pradesh School Health Education Project in Hyderabad. Sri Lanka is using the material in local languages in a school health club programme, an Amharic version has been developed in Ethiopia for primary schools and a Hassanya version is planned for Mauritania.

Steps to consider in introducing a Child-to-Child approach to the school curriculum

If Child-to-Child activities are to be introduced on a large scale, then we need to consider *where* they will be introduced, *who* will introduce them to the children, *how* to train those who will interact with the children, and *how* to evaluate what the children have done.

The school curriculum is a natural home for *Facts for Life* material and activities, but not the only one. The advantage of using the school curriculum is that once achieved it will then be on the agenda of every child attending school. It is necessary to consider how in-service training will be offered to existing teachers. The new material must also be introduced into teacher training colleges simultaneously, so that new teachers are familiar with it and how it should be used.

There is already widespread experience in UNICEF national offices of bringing material into the curriculum.

Those countries that have made the most progress have formed partnerships with Ministries of Education and, where they exist, curriculum bodies. Many countries have also drawn in the Department of Health to ensure that they are happy with the content of the material. Usually *Facts for Life* has been readily accepted as the basic course knowledge, because it has already been officially recognized in the process of producing a national version.

The most successful approaches are those that accept that it will take a number of years to change curricula, and that recognize that teachers are already trying to cover a wide range of topics with inadequate resources. Many schools are desperately short of materials, and one of the most valuable resources that teachers have is material produced by UNICEF, especially if this has been done in conjunction with the Ministries of Education and Health. UNICEF materials are often the highest-quality visual material available to the classroom teacher.

Zambia: 'Freedom fighters for health'

In Zambia, Child-to-Child programmes emerged between 1984 and 1986. President Kenneth Kuanda called on every school to adopt Child-to-Child and for all children to look on themselves as freedom fighters for health. Child-to-Child is now a government programme in the Ministry of Education, supported by the Ministry of Health and UNICEF.

The first programme was difficult to monitor. In 1989, resources were concentrated on named teacher education colleges with their attached schools. A list of skills in health education for school-leavers was drawn up and teacher training was improved, with donor support.

Health is not introduced as a separate subject, but is taught across the curriculum. Child-to-Child is also seen as a activity club, preparing materials and demonstrations that can be taken to schools.

The overloaded nature of timetables has made it difficult to make progress everywhere, but primary schools associated with teacher training colleges have shown the best results, promoting health messages to communities in the form of songs, plays and poetry. Child-to-Child members prepare presentations for schools assemblies, open days or mothers attending mother and child clinics.

Child-to-Child practices are being spread from one school to another through a system of twinning.

Dominican Republic

Facts for Life is being used as source material for the health section of the school curriculum in the Dominican Republic. Two NGOs have drawn up a training package from Facts for Life and piloted it with teachers and students. It contains five modules: Who are We?, Life and Health, Environment and Quality of Life, Do We Eat or Feed Ourselves?, Love and Tenderness.

Bombay children teach their neighbours

In Malvani, a suburb of Bombay, a Child-to-Child programme was set up in 1986, to train children as health educators. It recruited 175 children and each child was asked to 'adopt' five families and pass on knowledge and skills.

A survey identified the main local health problems. Project staff drew up a list of topics and devised a series of activities to help children understand and apply knowledge. Children carried out health checks on each other, conducted community health surveys and encouraged neighbours to attend health centres.

The credibility of the children grew, and adults began referring to them as 'mini-doctors'. An evaluation showed:

- *Children retained knowledge, particularly when a disease was prevalent in the community.*
- *Parents could remember few details, but became well versed in treatment and prevention.*
- *Adopted neighbours remembered little, but were more likely to use health centres.*
- *Children were more alert, curious, expressive and communicative, as well as cleaner and more concerned about personal hygiene.*

There were drawbacks. Children were worried about missing 'real' lessons, and parents were reluctant to allow children to stay after school. Classes are now part of the curriculum and taught by teachers, rather than health workers. The programme is being introduced into Bombay's municipal schools.

Turkey: Working in and out of school

In Turkey, Facts for Life messages were integrated into the curriculum, and a programme was designed to help children protect their environment. A children's colouring book has been developed with FFL messages. A Child-to-Child project was started for children of agricultural migrant workers, who work with their parents nine months of the year.

Course materials should emphasize activity as well as knowledge and involve role-play and games to make the learning process more fun (and therefore more effective). It is sometimes hard to achieve this, because education is taken seriously and learning by rote is the customary way of acquiring information. This makes it all the more necessary to work closely with teacher training colleges to ensure that teachers understand the materials and are committed to working with them. A pilot project in a few schools is often a good way of testing the quality of the materials, the effectiveness of the training and the value of the approach.

In making an assessment of the effectiveness of school based activity it is necessary to be realistic about the numbers of children attending school, and about levels of literacy. Sometimes official literacy levels overestimate the ability of children and adults to take in written information because they are based on asking people whether they can read, rather than through an objective test.

If possible, evaluation should go beyond a totally fact-based examination, because children are being shown skills and ways of working as well as facts. Children need to learn but they must also understand, and the facts should be relevant to their everyday lives.

Reaching children who miss out on school

The school may be the most efficient way of reaching large numbers of young people with knowledge, skills and training, but in most countries there is a high drop-out rate, and many children do not attend in the first place. Children who miss out on school need targeting but are rarely reached with special programmes because they are isolated or working. Official statistics may suggest that this is a small problem, but they often underestimate the number of children not attending school, particularly the number of girls not attending. In order to prevent young women from dropping out of school, teaching young people about the risks of becoming pregnant and about contraception is essential. There is also a strong case for special programmes for young women who become pregnant at school age, since by definition they are in need of knowledge or skills. They are already parents who will be passing on their skills and knowledge to their own children. Instead, in many countries girls who become pregnant at school age are punished and expelled. Young fathers are rarely punished in this way.

Adolescents are not a homogeneous group, and a clear picture of this diversity of young people is needed to target interventions more effectively. UNFPA considers that there at least four major subgroups for adolescents:

- adolescents in school;
- couples in a stable union;
- married or engaged couples;
- other sexually active young people.

The fourth group itself includes diverse groups of young people including street children, those in organized groups, or children who grow up without the parental guidance and support of a father or a mother.

The existence of people in these different situations means that the risks of pregnancy may need special attention, and this work should begin in schools. WHO studies say there is no evidence that sex education in schools leads to earlier or to increased sexual activity.

Dr. Merson, former Director of the WHO Global Programme on AIDS, said in November 1993:

"In many societies, sex education for children and young adults is one of the most hotly debated and emotive issues facing educationalists today. But it is time to stop arguing. If we care for our children and young people we must give them the knowledge and the skills they need to make responsible and healthy positive choices when it comes to sex and protecting themselves from the risk of HIV infection."

It is important to extend Child-to-Child activities to youth clubs outside school and to programmes set up for children in difficult circumstances, because they are refugees, street children, orphans, in trouble with the law, or for some other reason not integrated into the school system. Some programmes could also be aimed at older children who missed out on education.

Efforts to reach children who are not in school need to involve grass-roots organizations that have the trust and respect of children. Working with an NGO that is already working with street children or young pregnant mothers is a good way of extending the reach of Child-to-Child activity. Some of the country examples in this chapter show innovative approaches to working with young people. These techniques are also widely used in teaching about life skills, covered in Chapter 5: *Interpersonal Communication, Adult Learning and Training*. In particular, see the country example of the wide-ranging approach to life skills using the school system being adopted in the Caribbean (page 63). Chapter 11 contains further examples of how *Facts for Life* material has been adapted for use by children through animation, visual arts and drama.

When Child-to-Child activities are being used outside the school setting, it can be useful to set up an award or certification scheme so that young people who take part in the work or who complete a course receive recognition for doing so. This can be especially beneficial in restoring the self-esteem of young people who have dropped out of school.

Mexico: Young people and sex education

The Mexican Family Planning Association (MEXFAM) runs the Gente Joven programme to provide sex education and family planning services for young people in low-income urban areas. Gente Joven covers 19 cities with five major components.

- *More than 1,500 volunteer promoters aged 16-20 provide information and condoms to young people in their own communities and refer people to family planning clinics.*
- *Sex education courses in schools and factories.*
- *Music, theatre and group discussion for teenagers in street gangs.*
- *More than 100 radio programmes for young people, combining music with information on sexuality, reproduction, family planning and human relationships.*
- *A series of films and videos to trigger discussion about sexuality.*

Male Involvement in Reproductive Health, UNFPA, 1995

Why girls drop out of school

Pressures from home make it very difficult for some girls to complete their schooling. "She had been told that if she wanted to attend school, then she should make a contribution to the family gardening from which her fees would be paid. She worked hard every morning and invariably turned up late for school. She was regularly punished for lateness. After a long school day, she would arrive home 'late' and again be punished for not doing her share of evening chores."

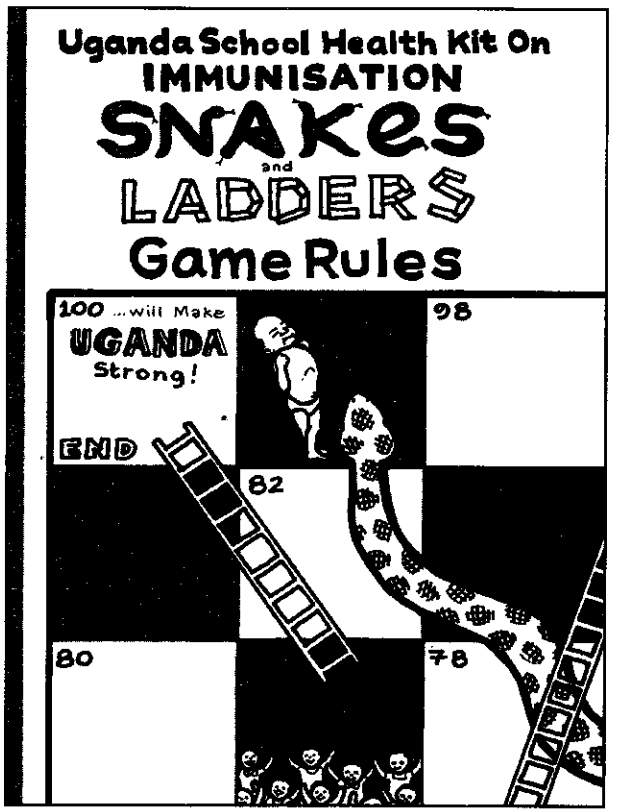
UNICEF Report on Focal Project, Uganda 1992

Mali: Traditional songs and games

In Mali, a programme started in 1990 to reach village children who were not attending school. Material based on traditional games and songs was used, and report cards were adapted to give the young people prestige. The self-esteem of children increased as they took responsibility for teaching other children, and started to play leading roles in village health activities.

PETER McINTYRE

Health messages on a school toilet in Uganda.



Snakes and ladders from the Ugandan school health kit.

Further examples of working with children

Introducing health education into the curriculum in Uganda

Uganda has one of the highest birth rates in the world, a young population and a national drive to improve education. During the 1980s, school enrolment and the number of teachers doubled and the number of community primary schools grew by 85%. Parents meet 90% of the cost.

The government's aim is for 90% of children to enrol and 50% to complete primary schooling, and it is backing schemes to help girls to stay in school. In 1990, enrolment was 69%, primary education was completed by one in three of those who enrolled, and girls were twice as likely as boys to drop out.

The School Health Education Project (SHEP) was set up in 1987, within the Ministry of Education, bringing together government departments and funding bodies. Health was introduced to schools through the National Development Curriculum Centre. Mrs. Mary Owor, coordinator of SHEP, says the health sector was very weak following the Amin years. *"We were desperate. We needed a way of getting the vital information about health to the community and so teaching health through the curriculum came up."*

Health education was integrated into the basic science course. SHEP brought together UNICEF and the Ministries of Education and Health to improve the quality of materials, in order to make lessons more interesting and effective. UNICEF now supplies high-quality teaching packs, containing health-related materials. These include a game of snakes and ladders promoting immunization and breastfeeding. Ladders show health gains, while the fattest and longest snakes show *'Women who do not get TT immunization risk tetanus in newborn babies,'* and *"teachers who fail to have their own children immunized are a bad example to us all!"*

The health pack also contains a comic and notes about role-play. It emphasizes how children can help each other to learn and how they can tell parents and grandparents about the issues. Each school gets at least two sets, and 8,000 primary school teachers have been trained in how to use the packs. An assessment has begun to see what changes have resulted from this initiative.

Supporting immunization in the Sudan

In the Sudan, teachers and pupils were mobilized to support the immunization programme and to promote health messages. In Kordofan, where there was low immunization coverage, a teachers' training kit was prepared, including an immunization manual and the Sudanese version of *Facts for Life*. Teachers were trained in interactive teaching methods, including discussions, exploration

and role-play. Friends of Health societies were formed, and school health days were introduced. Teachers designed innovative games, such as a health treasure hunt. In mathematics, children measured the amount of salt and sugar needed in oral rehydration. Games encouraged children to eradicate mosquitoes, and to understand immunization. A report says:

"For the first time, large numbers of female and male teachers were mobilized in a serious endeavour to raise the awareness on health issues amongst the population. The outcome of the Kordofan project was the training of large numbers of teachers, students, religious leaders and village chiefs, to become the nucleus of a future Facts for Life *team of trainers."*

Afghanistan — Picking up the pieces

In Afghanistan, much of the school system collapsed following the end of the Russian occupation in 1989, as opposing factions continued hostilities. Schools were closed or destroyed, teachers fled and attendance dropped.

However, in the last couple of years there has been growing demand for education and schools have started to open their doors, relying on teachers who give their time for little or nothing.

In this context, UNICEF Afghanistan started an Edukit and *Facts for Life* project in 1994 to support primary school teachers and students.

- The *classroom kit* is set of materials to help teachers prepare simple visual aids, such as literacy and numeracy charts. A copy of *Facts for Life* adapted and translated into Dari and Pashto is part of the kit.
- The *student kit* provides students with 10 notebooks, 8 of which are printed with prime messages from *Facts for Life*. The ninth notebook contains messages on mine awareness (land-mines are a major risk), while the tenth is blank for the student's own health messages. The kit contains a school bag bearing quotes from the Hadith, which supports education for men and women.
- There is also a *school kit* which contains a first-aid kit, a wall clock with batteries and a thermometer.

By June 1995, materials had been distributed to 80% of primary school children and UNICEF had introduced *Facts for Life* into hundreds of schools. This was achieved at a time when the security situation prevented UNICEF from making use of a centralized school system or a Ministry of Education structure for training, validation and distribution. Instead, four-day training workshops for teachers were held in five areas, and work is in hand to incorporate *Facts for*

Romania: Young people broadcast to the nation

In Bucharest, young people have become health messengers promoting discussion among older people and street children on the best way to protect health. An NGO encourages teenagers to join an action group on a particular subject, on AIDS, drugs, street children, the problems of elderly people or how to protect Romanian forests.
Each group then produces health material. They have also produced and taken part in their own radio programmes or health broadcast over national radio.

Myanmar: Parents encouraged to join in

In Myanmar, Facts for Life *is being integrated into the primary school curriculum, with a teacher-child-parent approach. This involved setting up a* Facts for Life *task force in the Department of Basic Education. Parents are encouraged to read the material before signing to say that the child has done the homework. Topics include hygiene, coughs and colds, food needs and, in rural areas, malaria.*

Jordan: 10,000 teachers trained

In Jordan, UNICEF, UNESCO and WHO combined to develop and test health materials for teachers, offering 10 days training over 6 months. The project was launched after a survey of 10 schools found that teachers were not providing the health information students wanted. More than 10,000 teachers have now received this training.

Egypt: Values for Life

In Egypt, UNICEF and the National Centre for Children's Culture drew up Values for Life, as part of a peace education programme. Summer schools, scouts and youth groups promote interdependence, tolerance, conflict resolution and participation through 'do-able' activities, concentrating first on the environment and water issues.

Facts for Life is also being integrated into basic education. A round-table expert discussion, including the National Curriculum Centre, was presided over by the Minister of Education. The Al-Ahram newspaper published a three edition discussion of the issue.

Syria: Quizzes and games

In Syria, a children's version of Facts for Life has been produced in English and Arabic, with quizzes and games at the end of every chapter. The aim is to provide preparatory and secondary school children with basic health information.

Bangladesh: Putting mistakes right

In Bangladesh, a quarterly children's topic book has proved popular with 10-12 year olds. It contains stories about a child who always makes mistakes over health and another child who always puts him right.

Viet Nam: A children's newspaper

In Viet Nam, a children's newspaper, The Pioneers, was produced in cooperation with the Ministry of Health. It included quizzes for children up to the age of 15.

Life into the basic curriculum. The UNICEF Jalalabad office uses the materials to improve education for displaced people living in camps, providing training for some of the 1,200 teachers there.

Impact will be assessed through questionnaires to 150,000 primary schools students and 5,500 teachers. To keep up the momentum of the project a drawing contest for children has been organized, while teachers have been challenged to produce innovative, effective and attractive teaching aids.

Colombia: Putting health on the agenda at election time

The image of one child had a huge impact on the first popular election of local mayors in Colombia in 1988.

UNICEF formed a partnership with the National Federation of Coffee Growers and an organization that promotes local government to launch a television, radio and poster campaign. Pictures showed eight-year-old Juanita coming out of school and telling her friends that when she grows up she wants to be mayor, so that she can improve their lives. Then she tears out a page from her school notebook and writes the mayor a letter.

"I am Juanita, you do not know me, but I know you. I know you are a very important person. Who is going to be in charge here. Who is liked and respected. My mother says that you are going to do a lot for us, because now there is money to do things in this community, and that you will do them. For this, I must think about myself and other children like me. I would like you to know that we are lacking schools, clean water, food, health... Our problems are many but there are easy solutions, that don't need much money, only that you want to do them. I cannot vote because I am a child. I cannot give you my support yet, but you, yes, you can give me yours. Excuse me and thank you!!!"

A pamphlet with Juanita's photograph and the punch-line, *"I cannot give you my support yet, but you, yes, you can give me yours,"* was sent to each of the 3,500 candidates, with a brochure providing data on child mortality, malnutrition, lack of access to primary education, school drop-out rates, street children and so on. It was written so that every candidate could assimilate the facts for use in their campaign.

Hundreds of candidates wrote to pledge their support. In Bogota, the winning candidate began a basic social services project in the poor quarters of Bogota immediately after his election.

The following year, Juanita re-emerged. Posters were customized for every community, showing the number of children who had not been fully immunized. Juanita's punch-line appeared on the poster, together with an appeal: *"Mr.*

Mayor, let no child remain without immunization at the end of your term of office." Some mayors were angry because low figures in their communities were highlighted, but almost every mayor responded by trying to improve immunization coverage.

In this campaign, it was the image of the child that was powerful, rather than the involvement of children. With hindsight, lack of child participation was cited as a major fault, and it was concluded that the campaign would have been more effective if it had allowed for greater involvement of children.

Other examples

Among other examples of working with children:

- Angola produced *Facts for Life* as children's storybooks.
- The Caribbean published a colouring book warning young children to be wary of strangers. Children are encouraged to act out scenes in the book and colour them in.
- A Kenyan children's magazine, *Pied Crow*, was devoted to *Facts for Life* issues.
- In Pakistan, *Nanhey Doctor* (Little Doctor) is an illustrated version of *Facts for Life* issues for children.
- In Saudi Arabia, *Facts for Life* colouring books have been made available at health centres.
- *Facts for Life* is being integrated into school curricula in Burkino Faso, Cameroon and Yemen. In Djibouti, it has been built into teacher training courses.

Working with the Scout and Guide movement

One of the most significant areas of work has been with the Scout and Guide movement, which has hundreds of thousands of members around the world. In May 1994, the World Organization of the Scout Movement signed an agreement with UNICEF to help achieve 80% oral rehydration therapy use globally. The Scouts will spread the message of ORT to families. The agreement was signed in Geneva at a follow-up to the World Summit for Children, entitled the Contribution of Youth to Lasting Peace.

UNICEF Bangladesh has developed materials that can be adapted by other countries, consisting of three posters, a video and a manual entitled *Actions for Scout and Guides on Oral Rehydration Therapy.*

The Juanita poster in Colombia.

UNICEF: CAROLYN WATSON

Family planning education in a refugee camp for Mozambique women in Zambia in 1989. Addressing family planning issues is important to encourage young women to finish their schooling.

Scouts in the Middle East have already published 5,000 copies of *Facts for Life* in Arabic with the scouting emblem. UNICEF made 3,000 T-shirts with FFL logos and 1,000 badges used by Scouts. These have been sent to a number of Arabic countries and distributed through the scouting movement.

In Egypt, the Scouts joined forces with the Young Men's Moslem Association, the Red Crescent and the Young Men's Christian Association to distribute 200,000 copies of *Facts for Life*. There are more than 25,000 Scouts in Egypt, including 1,000 in schools and 7,000 in universities. During leadership training, each Scout troop takes it in turn to involve itself in the community, building latrines and installing handpumps. While engaged in this work they held discussions on health education in the home for women and mothers. Scouts reported that they liked the simplicity of the *Facts for Life* messages but wanted an even simpler version for young people. They also asked for training on communicating with young people, especially about drugs and AIDS.

Monitoring and evaluation

Working in schools and with young people would seem to be a very productive way of communicating health messages. Each chapter of *Children for Health* ends with evaluation suggestions to test what a child has learned and put into practice. On a wider front, it seems important to monitor and evaluate how well the quality of child initiatives can be maintained as they expand and go to scale. Some schemes have a tendency to grow beyond the capacity of available trained youth workers and teachers. The example from Bombay given on page 72 shows that these programmes need the support of committed teachers or youth workers who can carry some of the burden.

A summer school project for 7- to 12-year-olds in Egypt had to be cut back because the logistics of training supervisors could not keep up with the rate at which groups grew. The summer clubs ran for two to three months with games and sports, and including messages about health and hygiene, and skills-learning sessions. UNICEF provided materials, and the clubs grew rapidly from 73 in the first summer to 1,200 clubs covering 60,000 children in the fourth year. Dr. Malek Zaalouk, UNICEF Health Officer in Cairo, said this rate of growth was too fast. *"The idea was to communicate the message to the child and they would communicate it to their parents. The children were wonderful and wanted to join in and do something. The problem was inadequate training of teachers. Too many of the lessons were like school."*

7. Working with Non-Governmental Organizations (NGOs)

Action Points

- NGOs have close links with communities and are trusted by the people with whom they work.
- NGOs have flexibility and are able to respond to changing situations with a minimum of bureaucracy.
- Although individual NGOs may be small, the combined reach of active NGOs in a country is usually very large.
- NGOs can interact with communities in ways that communities accept, and in ways that encourage them to review priorities and actions.
- Not all NGOs are the same — they range from large international organizations to local self-help groups.
- Small NGOs often have few resources and should be supported through training and the development of high-quality communication material.
- NGOs need to maintain their independence when involved in collaborative work.

Girl health monitors interview a grandmother and granddaughter in Bogota, Colombia, under the Supervivir programme, which brings together health workers, UNICEF and a number of NGOs including student organizations, Scouts and the Red Cross. 350,000 high-school students do several weeks of community service as trained health monitors.

Bangladesh: Social allies

Bangladesh was one of the first countries to ratify the Convention on the Rights of the Child, but UNICEF still needed social allies. It found support from Ansar-VDP, a national organization with members in every village, and an NGO, BRAC, with workers at village level. The Bangladesh Red Crescent has adapted Facts for Life messages into emergency preparation packages for 20,000 volunteer workers.

Africa: Bringing NGOs centre stage

UNICEF ***Nigeria*** *wanted to help NGOs to network more effectively since they were working in isolation from one another. They published a directory of NGOs, with more than 200 entries. The directory proved an effective working tool for building alliances. UNICEF supports three NGO networking newsletters, on the environment, nutrition and food security and adolescent education and reproductive health. There is extensive collaboration between NGOs promoting primary health , girls' education and breastfeeding.*

In ***Ghana,*** *the revised strategy for advocacy and social mobilization places greater emphasis on involving NGOs. Both Muslim and Christian NGOs have been mobilized in support of Facts for Life.*

In the ***Sudan,*** *NGOs are considered a still untapped resource. The Red Crescent, a co-sponsor of the Sudanese version of Facts for Life, has a strong following. The scouts have 30,000-40,000 members.*

In ***South Africa,*** *before majority rule, work was done through NGOs that would not have agreed to collaborate with government agencies, such as health departments.*

They formed the Campaign for Children's Rights, which advocates a Bill of Rights with a section on children's rights. Even before majority rule, plans were laid with NGOs to publish Facts for Life in 10 languages. Priority audiences are victims of violence, returnees and street children. This shows the potential of NGOs where government organizations are not trusted.

NGOs have close links with communities

Effective intervention with *Facts for Life* depends on the quality of the interaction with trainers and the community. Non-governmental organizations (NGOs) play a unique role in this process. NGOs range from major multinational organizations working with budgets of many millions of dollars on projects in several countries, to small local bodies like self-help groups, where people organize themselves around a limited range of objectives, without a great deal of outside assistance. Typically, whatever their size, they have strong local roots, and this intimacy with the community enables them to work effectively in partnership. Larger NGOs, such as Oxfam, CARE, Red Cross and Red Crescent work with local groups. Local self-help groups are better rooted in communities than local government departments, less bureaucratic than government agencies and able to respond flexibly and sensitively.

The combined reach of NGOs is very large

In many countries, NGOs are an important way of going to scale, since between them they reach most communities, even though individual NGOs may be small and require support.

In Egypt, a seminar of NGOs convened by UNICEF estimated that more than 80,000 families were reachable through person-to-person contact via NGOs, using more than 3,000 educators, including teachers, youth leaders, health workers, social workers and rural development workers.

Nagwa Farag, Programme Communication Officer in Cairo, said: *"It is very good to have the support of ministries and ministers, but that is not the criterion for ultimate success. Attracting NGOs is crucial because they are involved in strengthening national capacity."* This is a two-way benefit. The NGOs benefit from an input from UNICEF, and they in turn increase the range and scope of interventions into communities. An evaluation of two years' training of NGOs in Egypt showed that knowledge and skills within these organizations had improved significantly.

NGOs need help with training and capacity-building

The entire NGO network within a country has a wide reach, but many individual NGOs are small organizations with limited capacity. Whereas international NGOs have their own programmes, approaches and training structures, indigenous NGOs will almost always put training and capacity-building at the top of their list of needs.

Ed Lannert, then UNICEF Middle East Regional Director, speaking at a *Facts for Life* assessment workshop in Jordan, said that answering this need could

be crucial to successful use of *Facts for Life*. For half a decade UNICEF had emphasized the accumulation and diffusion of knowledge about what works to improve conditions for children. Now, the task had become one of getting this information in the hands of families.

"There is a real desire by NGOs to participate more, and unless we can help them build up their capacity, we cannot build up the FFL movement."

The main way in which UNICEF can increase the capacity of NGOs is by training their workers and volunteers, and by training them to train others. To some extent, UNICEF may also be able to provide materials, which can be developed jointly with an NGO. UNICEF can also play a coordinating role, not only between NGOs and government organizations, but also by bringing NGOs that are working independently into joint work with each other.

In most countries, NGOs are already working on the key problems highlighted by *Facts for Life*. Here the introduction of a *Facts for Life* working group can be an opportunity for building bridges with NGOs. The joint commission, or task force, can become a focal point for joint work by several NGOs that may have been working autonomously, and can now direct their efforts more effectively by eliminating duplication and maximizing cooperation and understanding between organizations. In Viet Nam and Romania (see boxes, pp. 81 and 84) UNICEF has found *Facts for Life* to be an excellent tool for cementing relationships with large and effective NGOs.

NGOs value their independence and autonomy

While NGOs welcome the material support that UNICEF can offer, they value their independence and autonomy. Those working with NGOs must respect their integrity and the qualities that give them credibility with the community.

This is particularly true where NGOs have been alienated from government. In the Philippines, UNICEF helped to build on an upsurge of interest in joint work between NGOs and government agencies after the Marcos years, but was aware that caution from those years remained, and that suspicion of government must to some extent be reflected in suspicion of a UN organization that works with government. Ofelia Valdecanos, former UNICEF Social Mobilization Officer in Manila, pointed out that many Philippine NGOs were inspired by the Convention on the Rights of the Child.

"We had NGOs that organized in different areas asking us what we think of the Convention. There were regional consultations on the goals of the Convention, and there was a consultation meeting with local government officials who were consulting with their local organizations."

Romania: The umbrella role of Facts for Life

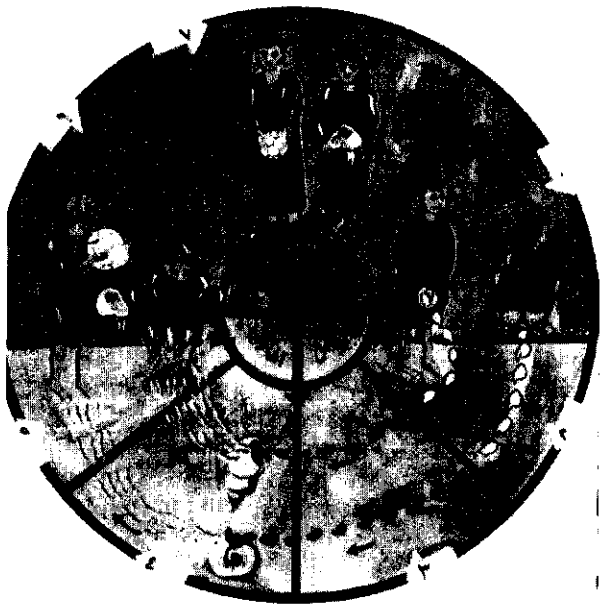
The Romanian edition of Facts for Life *was due to be published by the end of 1995, drawn up by a working group of specialists in woman and child health appointed by the Ministry of Health. Facts for Life will be used as an umbrella programme, particularly in forging relationships with the major NGOs working in the country. These include:*

***Health Messengers Association**, an indigenous Romanian NGO, which organized children into a mobilizing force, trained to run Child-To-Child activities. The young people hold meetings with government ministers and organize press conferences to highlight action areas including drugs, alcohol and smoking; AIDS; the environment (especially defending Romanian forests); children in hospital, or at risk from homelessness. They prepare weekly broadcasts for national radio and write two pages for a national health magazine.*

***World Vision International:** The Romanian Programme Office has focused on introducing primary health care, including a health education strategy and a wide variety of educational activities on breastfeeding, family planning, AIDS/HIV, etc. Primary health care courses have been added to the medical curriculum, and a teaching programme in PHC and Community Medicine has been introduced.*

***The Soros Foundation:** The Foundation launched a Health Education Programme in Romania in 1992, aimed at 10- to 16-year-olds, focusing on sexuality and family planning, AIDS, alcohol and drugs, nutrition, the environment and conflict resolution. The project emphasizes active learning methods including discussion groups, brainstorming and role-play. The programme includes TV shows, theatre, peer counselling and a teenage newspaper, Teenage Fever, which publishes 50,000 copies.*

***Youth for Youth:** Broadcasts a radio programme to young people on family planning and sexuality and the prevention of sexually transmitted diseases.*



Working with communities in Upper Egypt

NGOs can help communities to review priorities and actions

In Beni Suef in Upper Egypt, a large NGO, CARITAS, supports a small one, Coptic Organisation for Services and Training (COST), in working with small rural communities. UNICEF offered training to both organizations in the form of eight workshops on Facts for Life and interpersonal communication skills for front-line workers.

Health workers and other members of COST are trained to become close to communities, trying to work on community priorities rather than their own, and introducing new ideas when they have won people's confidence.

Dr. Magdi Latif, organizer of COST, said: "We discuss community priorities with the leaders during home visits and we inform them that we will be carrying out a basic survey. They may only mention the most important problems but the survey shows other kinds of problems. Our assessment changes all the time, and after two or three months, when our knowledge is deeper, we have to adjust our understanding.

"We have to negotiate priorities with the people. We can't just say that their priorities are sacrosanct. It is more complicated than that."

Health worker Olfat Isaac describes how in Saida village they began by asking parents about all the children below the age of six. Mothers were taught to use coloured strips of paper to measure their children's arms as a guide to their development.

"We started a regular check-up of children and when the kids were being examined we would sit and talk to the mothers. After this we started a nutrition campaign in two villages. We started to promote a mothers' group and a mothers' class in order to learn about people's nutrition. We talked about topics very similar to Facts for Life, hygiene, diarrhoea, breastfeeding, complementary feeding and immunization."

Posters and visual material were produced by a local artist Nabil Morcos, who used Facts for Life as a starting-point. Material was pretested, and CARITAS provided training for health workers in how to conduct classes.

(continued on page 83)

Pictured left are materials developed by COST for use in Upper Egypt, drawn by local artist Nabil Morcos. Above, the cycle of infection of bilharzia is shown. Below, a poster advocates birth spacing.

Working with communities in Upper Egypt

(continued from page 82)

Health workers knew, for example, that if they offered unfamiliar foods, communities would not be interested. Instead, they suggested complementary feeding, using locally grown food. Community leaders were invited to help with a survey so that they would know how to do it by themselves in future. Interested mothers were encouraged to take a test of their knowledge of nutrition. Everything was aimed at ensuring that communities could take over the project when COST left.

In a second, very poor, community, a health committee of 12 men and women was shown how to raise family awareness of health issues, and to promote proper use of canal water and latrines. Children were taught about hygiene.

In a third village, health workers had to negotiate priorities with a community that had piped water and a high level of literacy. A needs survey showed that the most popular demand was for a veterinary service for cattle. Although this was far from the original aim of the COST team, it met this need before arranging classes for children and women, based on Facts for Life.

Health workers practise role-play, where they confront widespread beliefs such as the myth that Nile water is safe. In one sceptical village, they brought photographs of sick children to convince leaders of the need for immunization.

Mobil Morcus, COST Director, says they build up skills in communities so that improvements continue when they have gone. "We train people in the community who have specific qualities, and they work very closely with us. We do not hide things from them. They see us coming up against problems and finding ways of modifying the situation. They put a lot of their own efforts into solving the problems. With time, we have less responsibility and they have more."

COST is pleased with the quality of the work with these small communities and is now seeking ways of working as successfully with a less intensive commitment of resources, so that more communities can be covered. The health workers regard Facts for Life as one of their basic texts, but feel they still need more training in transmitting messages and mobilizing communities.

Women feeding their children with supplementary foods suggested by COST during work with communities in Upper Egypt.

China: An NGO with 750,000 branches

In China, no NGO pursues a completely independent path, but many have strong roots in the community. UNICEF has links with three major NGOs in publishing and using Facts for Life. The Child Development Centre of China, and the Chinese Association of Science and Technology offer a specialist input. The All-China Women's Association has branches in each of the 750,000 administrative villages in China and a total of 50 million members. This network allows the NGO to reach down to families. However, the organization has little day-to-day contact with other NGOs. UNICEF is helping to train its members in a participatory approach.

Viet Nam: Credit and Facts for Life

In Viet Nam, the Women's Union (WU), a mass organization, worked with UNICEF and the Ministry of Health to train 25,000 Facts for Life communicators.

In January 1995, a report found that new credit and savings schemes for women and Facts for Life messages were regarded as complementary tools by women in Tuyen Quang and Yen Bai.

"The link with Facts for Life has served to improve the quality of life. The participating groups of women met every month when the repayments took place. They also read and discussed Facts for Life. The women were encouraged to go home and share Facts for Life with their husbands. Participants state that their and their children's health and nutrition have improved.

"The women who were considered as bad risks for credit by the society and of no consequence are now respected and listened to. The women discuss Facts for Life, production and the use of the credit monies with their husbands.

"The clear success of the combined scheme of credit and Facts for Life indicate a need for the replication and multiplication of such schemes."

Mission Report to Hanoi, by Rita Reddy (UNICEF/EAPRO)

UNICEF encouraged NGOs to form groups and federations so that many small bodies could be brought together to discuss policy and larger-scale questions. Amihan Abueva, Secretary-General of the Salinlahi Foundation (an alliance for children's concerns representing 33 NGOs in the Philippines), said that working with government was important but so was freedom of action. At a UNICEF discussion, she said that NGOs should retain a right to independence and freedom to criticize. *"It is necessary to maintain a certain independence of thinking. I view UNICEF as basically being on the side of the government. It says it wants to bring government and NGOs together, and it provides us with an opportunity to meet with the government, but it always veers towards what the government wants. As an international body connected with the United Nations, it is an organization of government policy. UNICEF always wants to work with ready-made structures."*

She linked this to what she saw as a reluctance on the part of government bodies to let local self-help groups take over the work. *"There is still a patronizing attitude that things should be changed for children, but the concept that the children should help to make this change themselves is not yet understood."*

Teresa de Silva runs the CHILDHOPE organization, which campaigns on behalf of street children in Manila. She sees the same dilemma for NGOs whichever country they are in. "Working *with UNICEF has been a very useful experience but I still have concerns. By virtue of being an intergovernmental organization, UNICEF always has to place leadership in the hands of government. In Metro Manila, 90% of the programmes are for NGOs, and we have to have recognition as equal partners and be prepared to abdicate the leadership role to the community. Do we want the community to become responsible and to fully take over the programme?"*

How can this problem be overcome? In the Philippines, UNICEF holds regular meetings with NGO representatives and devotes a large amount of time to training and support. Trust is built through joint work. UNICEF Manila accepts that it is better to have pro-active NGOs that are critical, rather than passive NGOs which become uncritical junior partners.

Special editions prepared by NGOs

Some NGOs have not simply been partners in publishing and using *Facts for Life*. They have gone further and translated or produced special editions.

- In Colombia, Profamilia reprinted a low-cost version of *Facts for Life* for teachers and for nurses in rural health centres.
- In Indonesia, a leading family planning NGO produced a local language version to use with its family planning network.
- In Vanuatu, Save the Children Fund (Australia) helped produce the Bislama version of *Facts for Life*.

The work with NGOs around the world is so extensive that no more than a sample can be given.

- The National Women's Association of Bhutan is training rural women leaders as health communicators using *Facts for Life*.
- Women's Union members in the Lao People's Democratic Republic act as community mobilizers and a channel for health education messages.
- Pakistani NGOs are considered vital in contributing to research on how *Facts for Life* can combat harmful practices and superstitions.

Monitoring and evaluation

It is worth considering the range of NGOs with which UNICEF is working, and whether this can be extended, and whether the ties can be strengthened. This evaluation can be done internally, but could be more usefully undertaken in a joint session with NGO representatives, at which both sides could review the progress in collaborative work and ways of improving it. These are some of the questions that need to be addressed.

How far do these NGOs extend the reach of programmes beyond other existing means?

How credible are these NGOs with the people in communities where they work?

What are the training needs of these NGOs?

Do the NGOs have particular needs to adapt existing written or visual material?

What feedback is coming from NGOs, and how is this being used to improve understanding and planning by joint planning groups and by UNICEF officers?

Are there any large and significant NGOs working on health and development that are not collaborating?

What steps can be taken to improve links with these NGOs? How can collaborative work with NGOs be sustained?

What training can be offered to NGOs to increase their reach and skills?

Working with trade unions

One specialized group of NGOs is the trade union movement. These have different status in different countries, in some being part of the establishment, in others almost part of the underground. Some unions have millions of members and can be a force for social change as well as a channel for communication.

In the ***Philippines,*** *two big unions joined a campaign against the exploitation of children at work. At first they were reluctant, because they did not have child members, but they saw how child labour forced down wages, and led to consumer boycotts in other countries. They also found that firms with child labour had the highest rates of accidents.*

In ***Syria,*** *the Peasant's Union for Women in Agriculture has been an important entry point for reaching the increasing number of women in the labour force.*

8. Working with Health Workers and Traditional Healers

UNICEF: CAROLYN WATSON

Health worker, mother and children in Indonesia.

ACTION POINTS

- **Health workers are an essential resource for health education and promotion.**
- **Health workers are experts in their own field, but may benefit from training in communication skills, aimed at improving dialogue with the public.**
- ***Facts for Life* should be integrated into the training of all formal health workers.**
- **Some health workers have little pay or prestige. Improving the image and self-image of health workers is important if they are to play a full role.**
- **Some doctors may resist training in communication skills. Professionalism can be an obstacle to seeing the whole person rather than the disease.**
- **The informal health sector is vital in bringing *Facts for Life* to the grass roots.**
- **Traditional healers and traditional birth attendants can be effective promoters of *Facts for Life*, but need training to ensure consistency and accuracy of messages.**

The role of health workers

The term 'health worker' can cover a wide range of professions and skills from the urban hospital consultant, with a high salary and many years of training and experience in the diagnosis and treatment of disease, to an unpaid village health worker, who may receive only prestige or, if lucky, some help with the farm in return for giving advice, administering drugs and knowing when to call in outside assistance. In between come the trained and semi-skilled nurses and assistants who are the backbone of health care systems where there is little money for high-tech equipment and drugs. This sector works alongside, and sometimes in semi-cooperation with, the informal health sector of herbalists, traditional healers and traditional birth attendants. Some people in the informal sector are skilled healers passing on the knowledge of centuries and eager to work together with the trained medical sector. Others are charlatans peddling superstition and quack cures. For millions of parents in both rural and urban areas, there is little or no free service. They pay their money and hope that the birth attendant or healer is a good one.

Health workers are, or should be, central allies in promoting *Facts for Life* and the health messages it contains. They have skills, knowledge and authority, and if they and UNICEF are not working together, then the initiative loses a great deal of its potential power. Most medical and nursing training is aimed at passing on knowledge and practical skills, so that students can recognize and treat disease. Nurses and doctors are taught to question patients in a particular way to elicit symptoms. Then the clinician makes a diagnosis and offers medication. The patient's role is passive, and the clinician asks little from the patient other than that he or she takes the medication as and when prescribed.

However, most of the issues raised by *Facts for Life* require changes in the way that people think and act so that they actively participate in solving problems. What professionals can do is to listen to how people describe their problems, help them uncover the underlying causes and help them understand how they can avoid health problems in the future through new practices. When a patient presents a symptom, this may mask an underlying concern that the patient will only reveal if he or she feels permission to do so has been given. The clinician therefore needs an ability to listen, and to have a dialogue with people so that they are willing to talk about underlying problems. Clinicians also need training in giving information, so that people can understand it and act on it. Information needs to be given in small doses, in language that people use every day, and repeated so that it sticks. It should, where possible, be backed up by a written reminder, or a leaflet or a poster, which will reinforce

Links with medical organizations

*In **Bhutan**, UNICEF arranged briefings on Facts for Life for all medical doctors and health staff. In **Botswana**, the Medical and Dental Association resolved at its annual conference to adopt Facts for Life as a means of improving communication about child health messages.*

Winning support from MoH

*In **Iran**, Facts for Life was prepared and launched by a joint committee of UNICEF and the Ministry of Health.*

*In **Mexico**, the Ministry of Health was the main partner for having 1 million copies of Facts for Life printed. The local version follows ministry recommendations on vaccination schedules and oral rehydration.*

*In **Sri Lanka**, the Health Education Bureau supplied every field health worker with a copy of Facts for Life.*

*In **Yemen**, the Ministry of Health issued four illustrated booklets on diarrhoea, breastfeeding, immunization and hygiene. They were all based on Facts for Life.*

Philippines: Training village health workers

In the Philippines, barangay health workers are trained in Facts for Life and communication techniques. (A barangay is a village or urban neighbourhood.) Volunteers who complete the courses become barangay nutrition scholars. In Metro Manila, barangays display blackboards showing the number of births and deaths over the past month, and levels of illness and immunization. Voluntary workers collect information based on indicators on which the community has agreed. UNICEF offers training, and each monitor collects from about 20 households. Results are used to target services and training.

the new information the health worker is giving. Health workers should be trained in interpersonal skills so that they can lead group discussions in communities where people have common problems. Professionals will be more effective and prevent disease as well as treat it, if they listen to people more and talk to them as equals, and take time to explain why a new practice is important. Achieving the role of a friend and a trusted adviser may depend on improving the status of health workers, because the health worker is often seen as a dispenser of medicine, rather than a source of knowledge and support.

Working with doctors

One of the main purposes of *Facts for Life* was to gain international agreement on the technical content of the messages. It has succeeded at international and national levels in settling the technical debate. Doctors know that the text has been approved by the World Health Organization and by many groups of paediatricians. They can have confidence in the technical content of what is being communicated. The support of doctors and other health workers has been central to the strategy for preparing and using *Facts for Life* in many countries.

Some doctors are gifted communicators, but this is by no means always true. In developed and developing countries, patients often feel they have not been told enough, that they have not been addressed as equals and that they have not been given an opportunity to ask questions.

Training doctors to communicate effectively with people is not easy. They have their own professional standards, and many do not regard listening to patients as an important skill. One way to overcome this is to try to get communication skills accepted as a source material in medical training courses. Doctors are more likely to accept these new skills if they think it will make them more effective, because people are more likely to follow their advice. *Facts for Life* can play a bridging role in this, because it can be used as the information content of a course, which challenges doctors on how they can best explain the issues it contains. Doctors are trained to accept the findings of clinical trials, which compare the progress of patients who have received a treatment to the progress of patients who did not. This approach can be used to convince doctors of the need for communication skills. A training module built around *Facts for Life* could include trials in which one group of people is given information in the old way, while another is given information after a discussion about their problems. It is then possible to evaluate the effectiveness of medical advice by testing how well people have understood and followed it.

In Egypt, the Egyptian Paediatric Association (EPA) became the main partner with UNICEF in publishing *Facts for Life*. Dr. Hani Ali Hussein Sami said that EPA saw *Facts for Life* as a major means of promoting child survival and development in Egypt, particularly in teaching about nutrition, diarrhoea, accidents, acute respiratory infections, hygiene and immunization. *Facts for Life* has been distributed to medical schools, and used in workshops to increase the knowledge and awareness of health workers on priority issues affecting women and children. EPA committed itself to researching the knowledge, attitude and practice of doctors, nurses, medical students and mothers, tightening up on the international code for marketing breastmilk substitutes, and improving collaboration between government organizations and NGOs in support of *Facts for Life*. It also gave the medical profession better information about the issues covered in *Facts for Life*.

Oral rehydration had been successfully promoted in Egypt, and this resulted in a decline in the number of children coming to hospital rehydration centres for treatment. Doctors routinely prescribe ORS for diarrhoea. However, 42% of doctors still prescribed antidiarrhoeal drugs and antibiotics, which are generally not effective for acute diarrhoea and can be harmful. *Facts for Life* helped convince these doctors of the importance of stressing the need for mothers to continue to breastfeed a child with diarrhoea.

Winning the support of medical practitioners is important also for ensuring cooperation with the Ministry of Health. There are many instances where the Ministry has itself played a leading role in promoting *Facts for Life*.

Working with nurses and community health workers

While doctors have influence, in most countries they are few and far between, and there are many more nurses, midwives and community health workers involved in delivering health services. Training needs to be concentrated on health workers and volunteer assistants because they have the most contact with parents. It is important that *Facts for Life* health messages and an appropriate method of working with them find their way into formal training courses for nurses and doctors, as happened in Ghana, where the Ministry of Health recommends *Facts for Life* as a basic book for public health nurses, and Turkey, where *Facts for Life* is used in the training of midwives, nurses and doctors. Most people who offer health advice are not fully trained professionals. They are poorly paid or volunteer health workers who have some training and experience, with limited access to drugs and simple medical tests. Immunization campaigns and hygiene programmes depend on these health workers who are often chosen because their have credibility in their own communities.

Uganda: Paid and voluntary sectors

In Uganda, village 'resistance committees' support health issues and training for traditional healers, to supplement a health service that is short of money.

Buikwe Medical Centre in Mukono district is a low concrete building roughly divided into examining room, treatment room, dentistry room and a laboratory. When they have supplies, technicians can test for malaria, tsetse fly and stomach worms. Faded UNICEF posters are the only decoration.

Medical assistant Olivia Kato, 25, is the junior of two medical assistants, who between them see 70-90 patients a day. She spent three years training for this job, which is somewhere between a nurse and a doctor. She is assisted by midwives, nurses, medical orderlies and lab staff. Charts on the wall show that in 1991 there were 12,000 malaria cases seen at this medical centre alone. Olivia offers health education as well as treatment when people come to an immunization, family planning or antenatal clinic, and talks to women about family planning.

A couple of miles away in Kakuku village, a meeting is under way beneath a tree. Community health worker Laurence Kimbowa with two other community health workers shows 50 village people a UNICEF poster on clean water, and talks about its importance in preventing ill health. A man asks how they can be expected to boild water when they can't find enough firewood for fuel. "You can't compare collecting firewood to saving life," a woman retorts.

In the Medical Centre, the emphasis is on providing a service. In the village meeting, the emphasis is on debate and learning how to reduce the risks to health in their own community.

Tanzania: Community health workers

In Tanzania, acute malnutrition is rare. However, in 1992, 178 children in every 1,000 died before their fifth birthday. The reason lies in the large number of children who are moderately malnourished and so have low resistance to malaria, measles, pneumonia and other infections. A successful nutrition programme originated in Iringa to help parents to recognize danger signs and improve the nutritional status of their children. The success of the programme is attributed to the dialogue taking place within the community, which has put health on the agenda of every parent. This relies both on the formal health sector and on elected village health workers.

Parents and communities organize three monthly village health days when all children under five are weighed. Teams from the nearest clinic immunize the children and examine them for signs of illness.

Traditional birth attendants prepare bowls of porridge with 'power flour' — sprouted grain with enriched nutritional content. Mothers are taught to add protein from ground nuts, eggs or sardines. The children clean every drop from their bowls.

Parents study weight cards almost as if they were school reports on their children.

Shaban Ali, a volunteer health worker in Mbete, Morogoro, says: "If there is a problem I go to the villagers and talk to them about the way to put it right, and ask them to change the children's diet."

Shaban and his colleague Fatuma Abdullah were elected by villagers for their reliability and steadiness. Shaban is paid by the village and is trained to use the first-aid box and to give drugs. Fatuma is training, walking six kilometres every morning to join other health workers in a class, and six kilometres back to the village. She will not be paid until she finishes her training, but is happy to do the work. "It helps me too, because I know how to look after my own two children better than I did before."

Training originally designed to improve the knowledge and skills of health workers can be adapted to ensure that it includes training in communication. Often, health workers are badly paid and have low prestige. A vicious circle can develop where people expect little from health workers, resent paying fees and do not treat them with respect. Health workers are discouraged because people do not follow their advice, and this makes them resentful and rude.

Introducing communication skills may make the process more expensive and longer, but it will dramatically improve the power of health workers to help people understand why illnesses occur and what they can do to prevent them. In China, UNICEF helped to ensure that training for a mother and child health programme for 'village doctors' and health workers included interpersonal skills. First, however, the trainers themselves had to be trained in those skills. Although it slowed down the programme and added to the cost, the trainers greatly appreciated the opportunity to improve their skills.

Working with traditional birth attendants and traditional healers

Traditional birth attendants and traditional healers carry the knowledge and customs of generations and pass their skills on from generation to generation. Some of their lore is of intense value, such as knowledge about the effects of herbs and plants. Other knowledge is based on beliefs that clash with modern scientific information. Most traditional healers are keen to learn and blend together the new knowledge with their traditional beliefs. At the same time, there are traditional healers who have relied on witchcraft as a source of income and see the new methods as a threat to their authority. Those who are introducing *Facts for Life* into this situation do best when they find the points of agreement with traditional healers on which they can build, while making opposition to the most dangerous practices clear. Where new ways of working do not conflict with belief systems and benefits are rapidly seen, then the traditional sector is likely to endorse and adopt the new practices.

Hadija Mohammed, a grandmother and one of five traditional birth attendants in her Tanzanian village, was elected onto the 14-strong village health committee and received 10 days' training — 5 on modern birth methods and 5 on nutrition. She said: "In the traditional way, a woman could give birth at any place. Now I make sure that the woman is in a clean and safe place. If I get a problem I rush them to hospital. I can examine the baby from the outside and see whether the child is in the proper position. Before I attended the course I would have pulled the baby out feet first. Now I push back the cord and take the mother to

a dispensary. It happened once to the wife of my son. The woman was so weak that she could not even blow the fire. My new training saved her life."

In the neighbouring village of Towero, the traditional birth attendant and the village health worker are a mother-and-daughter team. Health worker Zena Omari received six months' training, three months of it away in Morogoro town. Her mother, Mariam Mlanzi, has delivered 90 children herself but is proud of the skills of her daughter. "My daughter has learned about health, and she teaches me about child care and other things, like the preparation of food for the children, sanitation and personal hygiene. I was not educated but I made sure that my daughter went to school so I can now benefit by my daughter teaching me."

Traditional healers and traditional birth attendants are increasingly being accepted as an established and accepted part of the health delivery system and being offered training to make sure that their practices are not harmful. They provide a valuable communication channel because they have access to the mother and child, and they have a high level of credibility.

Training faith healers in Nepal

Nepal was one of the first places to offer health training to faith healers because it provided an answer to a practical problem. There were 600 doctors for 17 million people, but there were 400,000 faith healers who were erroneously telling mothers to reduce feeding when the children had diarrhoea. Many people in rural areas were completely reliant on the faith healers for advice and treatment. UNICEF enlisted the support of Gurkha soldiers who were returning to their villages. They were trained to teach faith healers in oral rehydration therapy. A million cards were produced, showing how to mix the solution, with a picture of the faith healers' god on the other side. Healers were harnessed as a force for educating families rather than misleading them.

Creating dialogue with traditional healers in Africa

In Swaziland, there are 45,000 registered and practising traditional healers, who are often the first health contact with parents. They have a high degree of credibility, but some traditional practices are now considered harmful to their health of children and families. The Ministry of Health has 15,000 health workers who are overstretched and do not carry as much credibility with many communities. When *Facts for Life* was being prepared, the president of the Traditional Healers' Organization was invited to help devise key messages. There was at first no agreement between his organization and ministry officials. UNICEF encouraged dialogue, setting up a one-week workshop for traditional healers and ministry programme managers. Participants were divided into

Cards prepared for religious leaders in Nepal explaining oral rehydration. One side has the instructions, the other a picture of a god.

Tanzania: A traditional healer fights against ignorance and superstition

In Tanzania, traditional healers joined UNICEF in a determined effort to overcome superstition. Musa Makweto, a healer known throughout East Africa, supports the UNICEF programme and the campaign for universal immunization, and is on his local village health committee. He became convinced of the need for immunization when one of his 49 children died of measles. "From that day I was advised by experts never to delay in getting my children immunized, and I tell this now to other parents. I advise parents how to feed their children properly and to feed them more than three times day."

He attended a one-week training course run by UNICEF and is interested in developing closer links between traditional and modern medicines.

"There have been exchanges of ideas with medical experts. If I have a patient and I don't know what kind of disease it is I send them to the hospital. Sometimes when they have diagnosed the illness, if they don't have any good medicines, they send the patient to me for treatment."

He said, however, that changes were needed on both sides. Traditional remedies would die out if traditional healers were not given credit for treatments they passed on through the Institute of Traditional Medicine. On the other hand, charlatans gave his craft a bad name. "Sometimes this profession is referred to as witchcraft. The criticisms are 75 per cent true. There are many traditional healers who are bogus."

groups. The traditional healers recommended withholding food from children with diarrhoea: while health workers recommended feeding as supported in *Facts for Life*. The health workers used an analogy of water boiling out of a cooking pot and ruining the food, to show that children needed nourishing when they had diarrhoea. By the end of the week, there was considerable agreement between the two sides in favour of feeding children who have diarrhoea, as well as on other issues. The dialogue opened up communication between the two organizations. The participants composed songs on immunization. The Traditional Healers' Organization has now endorsed the Swazi edition of *Facts for Life*, and its members have used the oral rehydration solutions in their own work.

In neighbouring South Africa, where work has also been done with traditional healers, one herbalist dismisses this 'white man's medicine' but another looks at *Facts for Life* and says: "This is what I have wanted all my life".

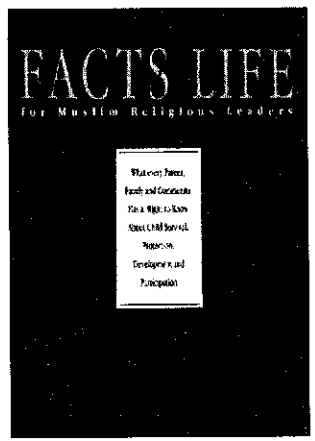
9. Working with Religious Leaders

Action Points

- **Religious leaders in many regions have a strong influence that goes beyond spiritual duties. A religious leader may be looked to for teaching on morality and a wide range of subjects.**
- **Religious leaders often carry more authority than government officials and in some cultures have a traditional link with healing that makes it natural for them to take a broader interest in health and the development of children.**
- ***Facts for Life* has been used in many countries as the basis for work with religious leaders.**
- **Religious leaders can reach large numbers of people with health education messages — people who are not reached by mass media or other means.**
- **Religious leaders need training in the information content of *Facts for Life* and in participatory methods for sharing it, so that they increase understanding by parents, rather than making them blindly obedient to certain courses of action.**
- **Male religious leaders have more direct contact and influence with men. Gender issues may make it difficult for them to communicate effectively with women.**
- **Ways should be sought of involving women religious teachers in talking with women in the community, as has been done in Muslim areas of the Philippines.**

"(Congress) recognizes that Muslim women are crucial to development in Islamic societies and that the improvement of their status and the extent to which they are informed and participate in making family decisions will be essential in determining the future quality of life and growth rates of the Islamic population ..."

Declaration from the International Congress on Islam and Population Policy in Jakarta and Aceh, February 1990



FACTS FOR LIFE FOR MUSLIM RELIGIOUS LEADERS IN MUSLIM MINDANAO, PHILIPPINES

"Children are the most valuable jewels for mankind."

— *from* **Child Care in Buddhism**

"Love your children and be merciful to them. If you promise them, fulfill your promise, for they expect you to cater for them."

— *from* **Child Care in Islam**

"Behold, children are a gift of the Lord; the fruit of the womb is a reward. Like an arrow in the hand of a warrior, so are the children of one's youth." (Psalms 127: 3-4.)

— *from* **Child Care in Christianity**

All published by UNICEF Myanmar

How Facts for Life for Muslim religious leaders came about

In the predominantly Catholic Philippines, four Muslim provinces have a wide degree of autonomy. The region of Muslim Mindanao, in the south of the country, is rural, with 2.1 million people in 83 towns and 2,000 villages. Since 1988, UNICEF has been supporting efforts to reduce child mortality through an Area-based Child Survival and Development Programme.

A handbook based on Facts for Life and the Qur'an is designed to help religious leaders and teachers, including ustadhs and ulamas, support this programme.

Researchers, sponsored by UNICEF, the University of South Mindanao and Mindanao State University, interviewed 200 imams. They found that imams would have liked to do more on health and development, but were waiting to be asked. They were keen to promote work for women, and to solve the problem of teenage pregnancies. The researchers felt that religious leaders and teachers needed training so that the messages were accurately conveyed. Researcher Zenaida Lim said: "The religious leaders must be trained in community development ... and on how to encourage community work and back religious teachings with practical aspects of life."

There are many women ustadhs and ulamas. Dr. Sapia Abdulrachman, from Mindanao State University, says: "Training should be offered that is relevant to the welfare of women and children. If you are working with women, it has to be women who talk to them."

Dr. Abas Candao, Executive Secretary to the Regional Governor, says that working through religious teachers helps make up for a shortage of trained health workers, and helps to overcome suspicions. He said: "People still have doubts because their houses were burned, and they feel they can't really trust government. We have to get people in whom they have full trust and confidence. These people are the religious leaders."

(continued on page 95)

Religious leaders play an increasing role in health issues

Religious leaders in many regions have an influence that goes beyond their strict spiritual duties. In all the major religions of the world, the religious leader is looked to for pastoral care and is often regarded as an authority on morality and a wide range of subjects.

Religious leaders often carry more authority than government officials, and in some cultures have a traditional link with healing that makes it natural for them to take a broader interest in health and the development of children. However, most religious leaders do not specifically receive training in health education or in child care.

Religious leaders are increasingly involved in helping to promote messages about child health and community development. In addition, this involvement is becoming more organized as religious teachings are scrutinized to find material that would be supportive to child health messages. The link between religion and health care and health teaching is not a new one. Many religious practices have their roots in promoting hygiene, good diet and what was considered to be safe and good behaviour.

All for Health (UNICEF 1990) noted that in Brazil the Catholic Church was a major provider of health care, with 14,000 nuns and priests working in hospitals, clinics and rural health programmes. There are 7,000 Catholic priests in Brazil alone, and the Church has 120 radio stations and thousands of newspapers and magazines. In 1987, the National Conference of Brazilian Bishops launched a national programme to promote the use of oral rehydration, and a Pastorate of the Child programme has trained more than 30,000 community workers in simple ways to protect child health.

Facts for Life for Muslim religious leaders

The link between Islam and child care is ancient and strong. Scholars at the University of Al Azhar in Egypt have identified texts from the Qur'an and hadiths that support child health messages. These have been distributed through mosques and Islamic schools, and this work has been used in other countries.

In the Muslim areas of the Philippines, a further step was taken with the publication in November 1993 of a special edition of *Facts for Life for Muslim Religious Leaders*. The book was jointly developed by UNICEF and the autonomous region in Muslim Mindanao through a consultative assembly that included a team of 11 writers, 9 researchers, 11 technical writers and many religious leaders and officials of all the main parts of the region. It contains 11 chapters, each headed by religious writings, followed by child-related messages

and recommended practices in the home and the community. The text was produced after extensive consultation and participation by hundreds of people at local level, which in itself raised consciousness of the issues. The introduction explains the motivation for producing the book and the role that religious leaders — men and women — are expected to play. It says:

"Given their key and unique position in Muslim communities in the Philippines, religious leaders have a crucial role in informing and motivating parents to apply child health messages, and in enabling them to demand and utilize community services....

"The practical, life-saving messages of Facts for Life, *coupled with the authoritative voice of religious leaders, will continue the positive change so far achieved for children and women in Muslim communities.... This handbook has enlarged the participation of Muslim religious leaders in safeguarding the rights and well-being of children in their communities."*

The introduction also suggests how the book can be used in communities.

"This handbook is best used in weekly khutba *presentations, lectures and other community development activities, in which religious leaders are increasingly involved. A survey of over 300 Muslim religious leaders has shown that they have in fact begun to go beyond ministering to the religious needs of the* umma *or community. The survey also says that, given the chance, most religious leaders would participate in community programmes in health, nutrition, education and livelihood generation.*

"The participation of Muslim religious leaders in promoting child survival, protection, and development is an opportunity to fulfil the amanat, *Allah's trust of leadership, by addressing the needs of tomorrow's leaders. It is, at the same time, a realization that social change and development of the* umma *should start with ensuring the well-being of the community's most vulnerable members, the children."*

The text includes religious practices as well as medical and health information. It tells parents what prayers should be said, and which religious practices to observe. It includes details of which immunizations should be given and when, and identifies the early warning signs of pneumonia in a child. It promotes breastfeeding, with supplementary foods from six months, and encourages parents to share responsibility for child care and to show affection to their children. It contains advice on keeping children away from smoke, and ensuring that they are protected from abuse and in times of conflict. The text promotes conservation of natural resources, speaking out against 'slash and burn' agriculture and the use of poisons. The handbook defines the Islamic concept of development as 'a multi-dimensional phenomenon', saying: "It involves physical, social, economic and above all, spiritual upliftment of the people".

Facts for Life for Muslim leaders

(continued from page 94)

Dr. Candao has personal experience of the influence of the imam, dating back to 1970 when he was qualifying as a doctor and went to help with a cholera epidemic in Buluan, Maguindanao. "For three days and nights I had no sleep. Patients were lying all over the floor. I helped here and there, and then I thought we should try to boil the water and to disinfect the wells. This was the first time that I had been to that place. Nobody would let me add anything to the water and nobody would let me give vaccinations. Nobody would listen to me.

"The next day was a Friday and at noon prayers I visited the imam and talked to him. I told him who my parents were and where I came from. He allowed me to talk before prayers; to tell them what I wanted to do. Then they came for vaccinations and allowed me to chlorinate the wells.

"We are very optimistic about this initiative, because the basis is the fundamental belief in the region: the Qur'an. We have been waiting for a long time to teach our people how they can take care of their health. It is not new knowledge. Everything is in the book (Qu'ran) that everyone believes in."

Religious NGOs reach millions of women

In ***Indonesia,*** *21 religious NGOs reach 15 million women with Facts for Life messages as part of the child survival and development partnership. The Indonesian Council of Muslim Scholars advises on the negative aspects of early marriage and the importance of clean water. Islamic counsellors advise brides-to-be on the importance of immunisation against tetanus toxoid. Islamic schools involve students in child-to-child work on* Facts for Life *issues.*

Bangladesh: Building the capacity of imams

In Bangladesh, the most urgent messages relate to clean water, sanitation and hygiene. Lack of sanitation is estimated to cause the deaths of 300,000 people a year.

Vigorous attempts are being made to get religious teachers to help, since 90% of the population is Muslim and most males attend the mosque every week. (There is only a very small number of women religious teachers.)

The potential of Islamic leaders to mobilize was brought home to UNICEF during a religious gathering of 2 million people. The religious leaders allowed a UNICEF communication officer to address the crowd and to distribute a million copies of a leaflet about sanitation.

Attempts were made to provide imams with information though the Ministry of Religious Affairs. Material was produced for all 200,000 imams, with the intention that they could use it in a 15-20 minute talk at the mosque every Friday. However, because the material came without training it did not at first have a major impact on the imams. UNICEF Bangladesh realized that it is important for largely autonomous imams to feel ownership of material if they are going to use it. Reworked material is now offered with training. UNICEF uses Facts for Life in training sessions.

Others were also working with imams. In 1992, the International Planned Parenthood Federation trained 2,000-3,000 imams in aspects of family planning. About 30% went on to discuss the subject before Friday prayers.

Health Minister Kamal Ibne Yusuf Chowdhury said: "Convincing the largely conservative clergy that without family planning the country's population of some 120 million would swell to untenable proportions was a major breakthrough in bringing down the size of the average Bangladeshi family from seven children to just over four children in a little over 20 years."[1]

A work of this sort reflects specific social, cultural and religious concepts along with the health messages. There are advantages and pitfalls to this. For example, the Muslim version acknowledges and values women as having the major responsibility for raising children and caring for them and for community development. However, this version also follows traditional religious and cultural customs, e.g. an obligation for a woman not to leave her house without the consent of her husband.

Lessons from work with religious leaders

There are some lessons emerging from the experience of allying child health messages and *Facts for Life* to religious leaders, and some questions that need to be addressed if the work is to be done effectively.

1. Religious leaders are interested in information that addresses the problems of their people. They will choose to promote the issues that seem to them to be the most important, and it is therefore important to know which issues religious leaders are most interested in. By the same token there are certain issues that religious leaders will feel reluctant to promote or feel that they are not the best advocates for these issues. It is not enough simply to hand religious leaders a pre-decided agenda for action and expect them to promote it. The level of discussion and negotiation seen in the Philippines is necessary.
2. FFL is designed to be an empowering tool, and if it is to fulfil that role, then parents must understand the information and want to use it. There is a qualitative difference between understanding a message and wanting to act on it, and acting on a message because it comes from authority, or because it is perceived as dogma.
3. It is also important to avoid the danger that messages are misused. This applies particularly to those societies where ill health is often connected with sin, and where there is a tendency to blame those who become ill or their parents or other relatives.
4. Care must be taken that information is accurate and that recommended actions are in line with agreed best practice. It is well-known that religious texts can be read or interpreted in more than one way, and because the texts carry authority with many people it is possible for some texts to be misused. A small minority of Christian denominations argue that the Bible justifies refusing to allow some medical interventions such as surgery, and some Muslims have understood the support that the Qur'an

gives for breastfeeding as meaning that children should not be weaned until they are two. (*Facts for Life from Muslim Religious Leaders* does not support this reading. It says that babies need supplementary food from the age of about six months.)

5. There is conflict between some religious teachings and some health education campaigns, notably on family planning. The Catholic Church has opposed use of condoms and the contraceptive pill, while health educators promote contraception as a way of achieving birth spacing or to prevent the spread of HIV and other infectious diseases. However, a report on international and interfaith consultation held in Belgium in 1994 concluded that most religions endorse contraception as a means of improving reproductive and public health, promoting responsible parenthood and contributing to population stabilization. It also concluded that where a religion opposes artificial contraception, this teaching is widely disregarded by many followers. "Coercive contraception is rightly condemned, but voluntary contraception may be seen as demonstrating a commitment to the physical, mental and spiritual health of human beings and the well-being of families."[2] While tact and diplomacy may be needed in discussing how this issue is to be presented, it cannot be in the best interests of health education or the long-term relationships between UNICEF and religious leaders simply to remove all mention of family planning or of AIDS from training material given to religious leaders, as has happened in some countries.

6. Most religions stress the need for children to be obedient to their parents, a message that has a positive side and a negative one. If communities are to develop, sometimes children must challenge the beliefs and practices of their parents.

7. There are also some teachings that confine women to a subordinate role in decision-taking, although how these teachings are interpreted can vary widely. Most religious leaders are male, and some are not permitted to marry or have children. This may make it difficult for them to understand the problems women face and how they feel about their lives. The development of women religious teachers would appear to be an important element of this work. Women are often more effective in communicating with women.

These problems are not unique to working with religious leaders. Religion is just one part, albeit a very strong part, of what goes to make up a cultural

Buddhist work with Facts for Life

*In **Myanmar**, 95% of the population is Buddhist, and religion plays a powerful social role. Booklets relate teachings of the Buddha to child care. The Young Men's Buddhist Association has an annual examination — the Mingala Sutta- which is tackled by 25,000-30,000 people. The Association has incorporated Facts for Life questions into the exam. UNICEF awards certificates and prizes.*

*In **Sri Lanka**, the support of Buddhist monks has been enlisted in the protection of the rights of children, educating parents and the community on maternal and child health and nutrition. However, the lack of a central organizing mechanism has proved to be a major difficulty.*

*In **Bhutan,** Facts for Life was used in workshops for monks and traditional healers.*

Community educators in Pakistan

A project in Pakistan's Northwest Frontier province demonstrates that contraceptive use can be successfully raised in a culturally conservative area, even where women's mobility and decision-making powers are severely restricted.

In Mardan, a city of 270,000 people, teams of community educators promote family planning through home visits, distribution of condoms and other contraceptives, and referrals to clinics. The project started in 1988 through the Urban Community Development Council, an all-male group of political, religious and community leaders.

Female educators were added to the teams after the men reacted positively to family planning and wanted women educators to speak to their wives. Today, the project has 40 teams of 200 community educators and five clinics and enjoys widespread community support.

Male Involvement in Reproductive Health, UNFPA 1995

The Sudan: Imams prepare sermons

In the ***Sudan****, training for imams was included in a strategy to introduce* Facts for Life *into Kordofan, an area the size of France with a population of fewer than 3.5 million people. Early attempts to distribute material to imams without training failed. Now, during training, imams are asked to prepare a sermon based on what they have learned, and to deliver it in front of the rest of the group. This project has been much more successful.*

Mozambique: National forum held

In Mozambique, UNICEF has used Facts for Life *with Protestant, Catholic and Muslim communities. Religious leaders are included in training and implementation activities. The Christian Council of Mozambique has used* Facts for Life *as a guidebook to promote health education. UNICEF held a national forum in 1993 to establish broad coordination among religious leaders from different groups.*

identity, and is not the only area of life where cultural values and health education may be in conflict. Parents themselves may find it difficult to talk to their children about sexual matters and may prefer that the issue is not raised in any material that is produced for their children. At least by producing material that discusses birth spacing or HIV in a religious context UNICEF and partners can create a dialogue and public forum where areas of agreement or apparent contradiction can be discussed. Chapter 12 includes advice on cultural sensitivity and some hints on how to minimize opposition.

1. Quoted by UNFPA — correspondence 1995.
2. *World Religions and the 1994 United Nations International Conference on Population and Development: A Report on International and Interfaith Consultation*, Belgium May 1994. Convened by Park Ridge Centre for the Study of Health, Faith and Ethics, Chicago, USA.

10. Working with Business and the Private Sector

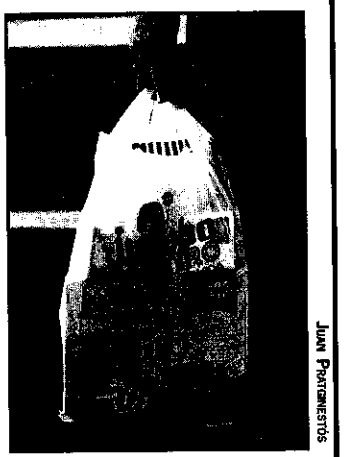
ACTION POINTS

- **The private sector can make significant contributions to UNICEF work in cash or in kind.**
- **Business may sponsor projects, support fund-raising efforts, or give services or materials at cost or reduced price.**
- **Caution should be exercised to ensure that the company's business practice is in accord with UNICEF aims.**
- **The private sector is profit based and will expect to see a benefit in becoming involved with UNICEF.**
- **This benefit could be an improvement in the company image or an increase in sales.**
- **Some private sector finance may be available through trusts or funds set up to support socially useful projects.**
- **Working with trade unions can be one way to gain support from a company's workforce.**

Brazil raises $12 million

Since 1986, Brazil has looked for extra funding to support UNICEF programmes and to mobilize human, technical and economic resources. The mass media and private sector have become important allies.

In 1991, Brazil raised $12 million in resources and services, mostly through collaboration with the media, which has given valuable air time and advertising space. The Rede Globo telethon advocates support for children and for education, and raises more than $1 million a year in cash for UNICEF.



JUAN PRATGINESTÓS

One of the biggest supermarket chains in Brazil includes Facts for Life messages on its carrier bags, distributing 120 million bags a year with messages on immunization, oral rehydration therapy and hygiene. Marketing is being expanded as UNICEF Brazil invites plastic spoon manufacturers to support oral rehydration, and paper companies to support poster campaigns, etc.

A toy manufacturers' association, ABRINQ, was formed to support the rights of the child. It organizes an annual meeting with UNICEF and invites individual businesses to respond to appeals for help.

The Brazilian Service in Support of Micro and Small Corporates (SEBRAE), with 3.5 million small businesses, and the Brazilian Association of the Printing Industry (ABIGRAF) agreed in 1993 to distribute 1 million copies of the Brazilian Facts for Life. The President of SEBRAE committed his organization to a survey of the status and needs of workers under the age of 18. These initiatives take place under the nationally agreed Pact for Children.

Mobilizing business support in Zambia

In Zambia, the Ministry of Labour and Social Security introduced a Population and Family Welfare Education Programme in 1979, with technical assistance from the International Labour Organisation and financial support from UNFPA.

In the second phase, 75 companies that had developed alongside railway lines were selected for family welfare education. The criteria for selecting the enterprises were that each should have more than 100 employees, that there should be a works council or recognized trade union, that each should have a company medical clinic and that the company agreed to take part.

The Ministry of Health supplied contraceptives for the programme, while NGOs like Family Life Movement of Zambia offered training. The Employers' Federation and the Zambia Congress of Trade Unions supported the work.

The major problem with the programme was dependence on donors for contraceptive supplies, and workplace-based supplies were later dropped, on the assumption that if the communication programme was successful, then contraceptives would be available through Ministry of Health outlets.

UNFPA Programme Advisory Note, 1995

Business cards in the Philippines

In the Philippines, UNICEF and the Magnolia Cheese and Butter company organized a promotion, giving away UNICEF Christmas cards with their products. A company executive said: "Our responsibility is to make a profit for the shareholders. However, we are trying to compromise because we feel the private sector has a responsibility to society." Since 1992, the company has given away 40,000 cards a year — increasing sales by 20%. Last year the company purchased $23,000 of UNICEF cards for the project.

The cost of producing and distributing national versions of *Facts for Life* is high — and commitment to communication means also commitment to a budget for communication. In a growing number of countries, UNICEF has made collaborative links with business organizations to win material or financial support for these efforts.

The private sector may support UNICEF in a number of ways and for a number of reasons. Business can contribute in cash or in kind — material support being most commonly offered. Businesses are profit-making organizations, and large-scale contributions to UNICEF's work are unlikely to rest on altruism alone. Many businesses, however, see a spin-off benefit for their companies in supporting UNICEF efforts.

The private sector may contribute:

- cash to sponsor particular projects;
- support in fund-raising, particularly through giving television or air time, or advertising space;
- at cost or reduced price services for printing copies of *Facts for Life*;
- tax-exempt contributions through regulations designed to encourage corporate giving;
- advertising space on company products;
- material goods free or at reduced price.

The motivation may be:

- because an arrangement promotes the company's goods or services simultaneously with UNICEF messages;
- because the company image benefits from its association with UNICEF;
- because a company has a policy to support local communities or has a trust fund to support socially useful projects.

The most common form of support is through fund-raising. Some businesses organize fund-raising events for a variety of causes and are willing to see part of the proceeds go to UNICEF. Others will fund-raise specifically for children's issues, particularly if their customers are parents. Television companies are willing to provide a mix of entertainment and serious fund-raising in telethons, which can raise millions of dollars. (Telethons are marathon TV programmes lasting 24 hours or more, where entertainment is combined with celebrity appeals for viewers to pledge money.)

Material support probably accounts for the greatest benefit to UNICEF. Printing companies offer free or 'at cost' printing. Specialist firms offer help with design or distribution. Much work with the media involves an extra benefit to UNICEF,

as television and radio stations agree to broadcast UNICEF spots during air time that they might have sold for advertising.

Some companies put aside a percentage of their profits for social aims and can be approached for support from this fund.

Finally, there have been deals involving some kind of sponsorship where a business has promoted a message in return for an association with UNICEF, thus improving the prestige of the company. This has sometimes meant that company and UNICEF logos have appeared side by side, although this should take place only after checking that there is no risk of possible embarrassment to UNICEF.

It is important to ensure that the company is reputable and that its activities are in harmony with UNICEF values. For this reason, association with the company should not appear to give any kind of blanket endorsement by UNICEF. The basis of the arrangement is that the business is supporting UNICEF, not the other way round. The decision on whether a particular project goes ahead can only be taken by the people on the spot who are in possession of the best information about the company and the project being proposed.

It is clear, however, from the support that UNICEF Brazil has been able to mobilize (*see box page 99*), that there is potential for far more financial and material fund-raising from the private sector. It is also clear from the experience in Zimbabwe and Zambia (*see boxes on this page and page 100*) that there is considerable potential for working with companies and trade unions to protect workforces and their families from disease. It is interesting that in Zimbabwe there was strong support for the workplace schemes from government, which was concerned that economic productivity would decline in the country if the spread of HIV and AIDS was not checked.

Clearly, health campaigns that catch a national mood are more likely to be supported by the private sector. The *Juanita* campaign for child health in Bogota (*see pages 76-77*) was supported by the National Federation of Coffee Growers, which allocated money to social programmes in coffee-growing communities, in the days of good coffee prices. The *Juanita* message was also supported by six private radio networks, which provided free peak air time.

Mobilizing business support

The Italian-based energy and chemical multinational corporation ENI has supported the printing of Facts for Life in ***Angola, Ecuador*** *and* ***India.***

In the ***Caribbean,*** *Disney trained artists in film animation, and the skills are used on UNICEF's behalf.*

In ***Myanmar,*** *10 of the country's top commercial artists adapted characters to appear in a series of entertainment cartoons on Facts for Life messages.*

In ***Turkey,*** *Rotary organized leaflet drops from aeroplanes about polio, while a milk company agreed to UNICEF messages being printed on 2 million milk cartons.*

In ***Malawi,*** *AIDS prevention messages were printed on beer containers as a result of a UNICEF agreement with a local beer manufacturer.*

In ***Zimbabwe,*** *many companies have taken part in a project jointly with trade unions where workplace representatives are trained in health promotion to prevent AIDS and are able to distribute condoms. These 'peer educators' have been successful in reducing the spread of infection on large tea plantations and in mines. At four mines owned by Rio Tinto Zimbabwe, the number of sexually transmitted diseases treated at company clinics fell by half to three quarters over three years.*

***Working Against AIDS,* part of the Strategies for Hope series from ACTIONAID**

Talking taxis in Liberia

The Transport Union in Liberia collaborated with UNICEF to put health promotion messages and the UNICEF logo in their cabs — instead of messages promoting cigarettes and alcohol. An initial 400 drivers registered to carry the messages, under what was dubbed the 'Talking Taxi Campaign'.

More than 750 cabs now carry the material. The logos are popular because drivers feel it gives them prestige, and some have gone as far as to advertise their cabs as 'a healthy taxi'. Several passengers have sought out UNICEF Facts for Life material.

11. Transforming Facts for Life through Visual Arts and Drama

One of the Images for Life produced in the Sudan, a powerful package of material that includes an artists' design manual, posters and flip chart materials. Words and pictures were also printed on 400,000 match-boxes, to promote immunization.

ACTION POINTS

- **We remember more of what we experience than of what we hear. Film, animation and drama bring issues to life.**
- **Visual material increases the impact of health messages and helps people to remember them longer.**
- **Pictures and drama should reflect the lives and experience of the audience.**
- **Visual material must be pretested. What works in one community will not necessarily be understood in another.**
- **Different cultures have different exposures to visual arts and drama. Image-rich countries require a different approach to communities with no television or advertising.**
- **Drama, songs and traditional arts have the potential to reach people untouched by mass media.**
- **Drama can win hearts as well as minds. Traditional drama can effectively reach traditional communities.**
- **Drama is never enough on its own. It needs support through other education.**
- **The quality of drama, cartoon films and visual material should be of a high standard.**
- **Visual arts and drama should be evaluated to ensure they are communicating the correct messages and to keep costs within acceptable limits.**

Introduction

As well as mass media, posters, leaflets, face-to-face teaching, meetings and schools, *Facts for Life* has been communicated through animated film, comics, plays, songs, poems, comedy routines and religious talks. Messages have appeared on carrier bags, match-books and even on corrugated metal walls of emergency housing. They have been broadcast on radio to farmers and through interactive broadcasts to schoolchildren. They have been translated into pictures for people who cannot read, and film clips to be shown before feature films. They have been broadcast to audiences of millions on television, and to audiences of two or three. They have even been used in a circus.

Using *Facts for Life* effectively means harnessing messages to the experiences of the audience, rather than turning up the volume. The book is a starting-point for effective communication, which also needs innovation, inspiration and ingenuity. There are many ways in which this material can be brought closer to the experiences of people, starting with the process of national adaptation and the inclusion of photographs of local people.

It is clear from work at national and local levels with *Facts for Life* that many outmoded concepts about 'communicators' are being laid to rest. All kinds of people have credibility with communities and are willing to help present the information in *Facts for Life* in innovative and effective ways that connect with the community's everyday experiences.

Initially, the use of drama, humour and visual material was low key and made use of what skills health communicators could find locally. Today, there are few barriers to what can be achieved, as television and high production values spread to more countries. There is today a large, well-organized 'enter-educate' movement that combines drama, film, animation, song and dance, all using the highest production values, and linking entertainment to health or social messages. This approach attracts mass audiences and excites attention, although it is difficult to assess how far it contributes real and lasting change.

George McBean, formerly Communication Officer in Nepal and now Area Communication Officer in the Caribbean, has seen a revolution in the use of artistic material as people found innovative ways of working. *"People who were creative but who didn't necessarily have medical backgrounds could use the messages in Facts for Life as the platform for creativity. Before Facts for Life came along, the life of an artist was miserable because you could never get two experts to agree on what was to be put into packages. After Facts for Life you could say 'I have something to refer to, and this is something which experts have said is correct'. The science is the same in every country — what is different is the way that you explain it.*

"In the 1970s, if you talked about cartoons and comic strips it was not serious enough for development people. If you were not putting food into babies' mouths what were you doing? But everyone likes to be entertained. That is the same in slum areas or cities.

"The old approach was communicators pouring information onto the mother. This does not work. You need to go to areas with high infant mortality rates and build your communication strategy. Are books read? Is TV watched? Do people pay attention to posters? There is no point in producing these things if your target audience does not see them.

"You will see examples where Facts for Life *has been interpreted by drama groups, puppet shows and animation. I believe that animation, for instance, will be played again and again for years to come, perhaps after* Facts for Life *as a book has disappeared. In our own programme we have taken the decision that we don't want to produce anything which is not 'pirated' by the public. We produce a comic and it's pirated and photocopied. We do a tape of music and someone will reproduce it, and that is a measure of success."*[1]

In this context, 'animation' is animated 'cartoon' film. In many countries, it is an accepted form of adult entertainment and therefore a useful form of education.

'Pirated' in a figurative sense — UNICEF material is usually copyright free.

Breaking the shackles of conventional communication has been very important. However, as with everything, the world has an uneven division of communication materials. Some societies are starved of materials and inexperienced in understanding their conventions. Others suffer information-overload, bombarded by images of all kinds from every side from a multibillion-dollar advertising industry. In such image-rich countries it is important to be selective, targeting material at specific groups rather than trying to reach everyone with everything.

This chapter looks at visual arts, drama, animation and the emerging enter-educate movement. Using *Facts for Life* creatively raises many of the same problems whatever the method of transformation.

Transforming Facts for Life through the visual arts

Few communicators would prepare written material without considering literacy levels among target audiences. However, pictures are routinely used without anyone considering how (or whether) they will be understood. The use of pictures in health messages is so widespread that the posters and illustrations may be taken for granted. They simply become the business of the artist, who is presumed to know what will work and what will not.

Millions of people, including most artists and health communicators, live surrounded by advertising and mass media, saturated with images from their

earliest years. From these images, we learn a complex visual code, specific to our time and culture, and we learn the code so early and so thoroughly that we come to think of the connections as being natural. In fact, visual conventions have to be learned, just as we learn to read maps. It is learned knowledge and not instinct that tells us that ticks and crosses reflect desirable and undesirable actions, arrows indicate direction and shaded lines behind a figure represent movement. Computer software designers today spend millions trying to persuade us that clicking on images with a pointer is 'intuitive'. In fact, as new users know only too well, nothing is intuitive, and all these lessons have to be learned.

In the developing world, there are still many communities that are *not* exposed to commercial images from their earliest years, and whose understanding of pictures may be very different from that of the artists who produce them. For these communities at least, the capacity for confusing or obscuring messages through misunderstood images is probably as great as with written material, perhaps greater. Written material may miss its mark altogether, and someone who is illiterate will know that he or she has not understood. Images almost always say something to their audience, even if the message is false or distorted. An audience may be totally unaware that it has misinterpreted a drawing.

This capacity to confuse may be subtle and unexpected. Ashote Chatterjee, from the Indian National Institute of Design, recalls[2] how a poster used in a campaign to eradicate guinea worm infection in Rajasthan showed an idealized village to demonstrate a clean environment. At the last moment, the printer added a seemingly trivial embellishment; silhouettes of children running and playing between the houses. When the poster was used in villages, the audience concentrated almost exclusively on the children. Were they fighting? Were they running away? What had scared them so much? The Sanitation Water and Community Health Project, which had commissioned the drawings, was dismayed, and in a later series of posters, fewer messages and strong simplicity emerged as the essential points.

In 1976, the National Development Service of Nepal and UNICEF carried out a survey to test whether 400 adult villagers in remote rural areas understood pictures. None of those surveyed had been to school and none could read. The survey demonstrated that understanding images is a learned skill, connected with cultural background and that there is no common shared intuition between those who have been trained at art school, and those who have scarcely seen a drawing in their lives. Although this survey is now 20 years old and its specific findings may be out of date, the overall message from the survey is timeless and true. Not only beauty is in the eye of the beholder, but meaning as well.

Crosses may be misunderstood

The use of crosses to indicate unsafe or unsatisfactory practices is controversial for a number of reasons. Even in visually aware societies there is concern over 'negative' messages.

The Middle East UNICEF Senior Child Health Adviser Dr. El-Fathih El-Samani recalls that many women misunderstood the meaning of a poster designed to promote breastfeeding, which showed a bottle of milk with a cross through it. There had recently been an election during which the X symbol was promoted as showing support for a candidate. The result was that a high percentage of mothers thought the poster was promoting bottle-feeding.

In the Indian guinea worm campaign, there was a debate over whether to use pictures of people defecating in the open with a cross through them. The design team expressed doubts, but the campaign workers felt it was the only way that undesirable practices could be illustrated. Evaluation showed that the cross was not well understood.

Figure 11.1

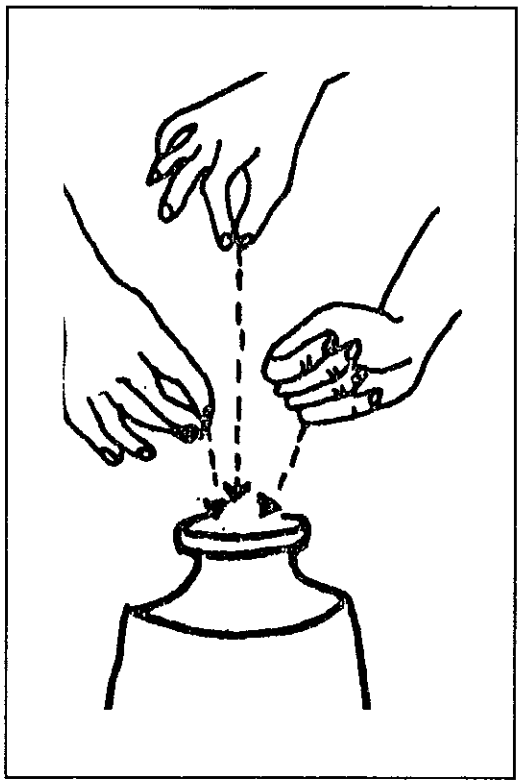


Figure 11.1 was part of a sequence of pictures on preparing oral rehydration mixture. Only 69 out of 410 villagers (16.8%) recognized it as hands putting something into a pot. Six out of 10 villagers failed to recognize hands at all.

Figure 11.2 was designed to show a link between polluting water and becoming ill. Only one out of 89 villagers understood the message from looking at the picture.

Figure 11.3 used a strip to show the diarrhoeal link. Few villagers realised that the pictures were related, and fewer than half looked at the left-hand picture first.

Figure 11. 2

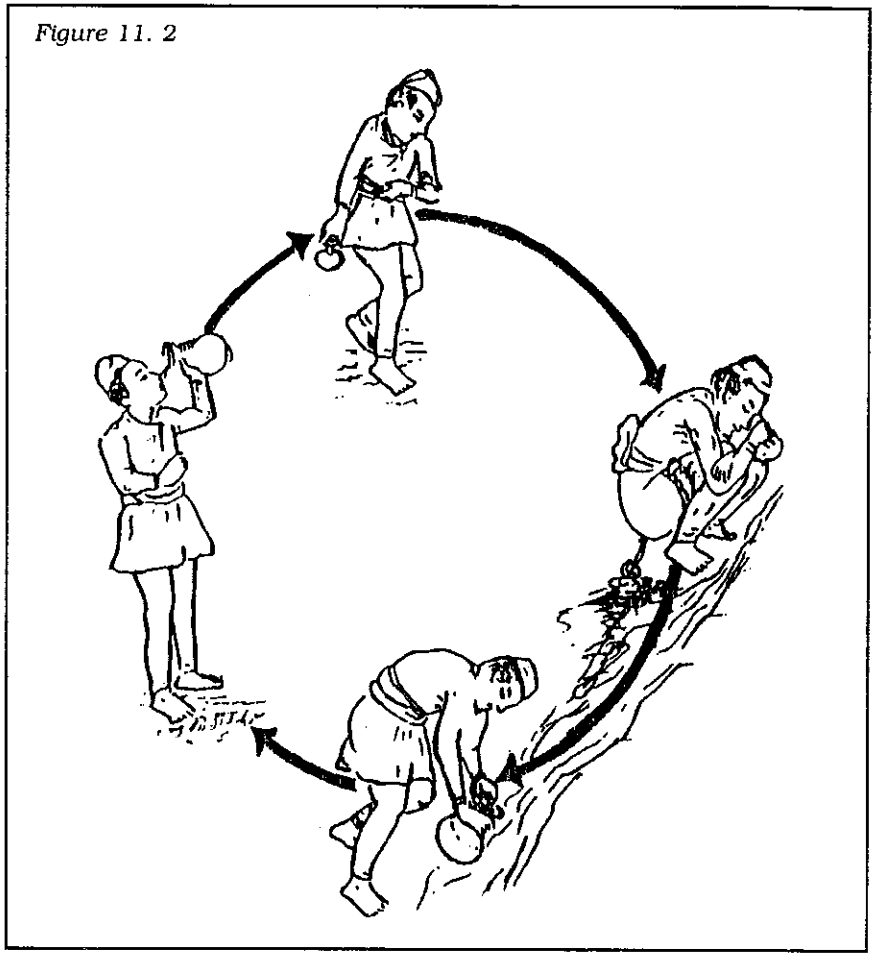
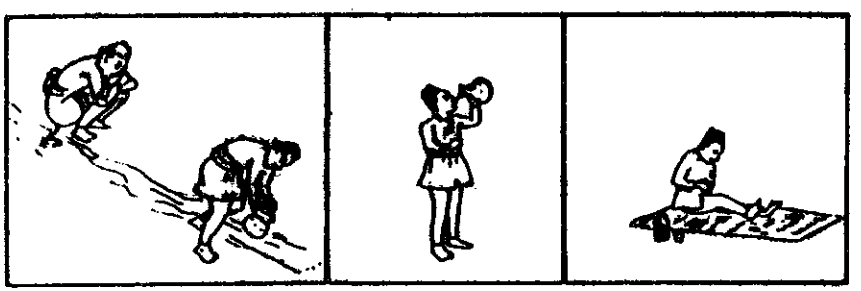
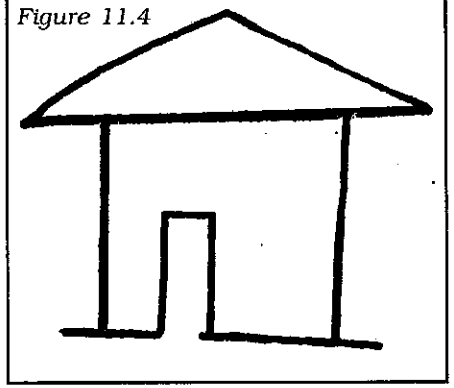


Figure 11. 3



The Nepal research also showed that people with no schooling had little idea that an arrow indicated direction or that ticks and crosses represented right and wrong. However, in a larger follow-up study conducted by the Nepal Centre for Development Communications in 1988, it was found that when pictures were explained people understood similar illustrations better in the future. Moreover, visual images could be learned more quickly if they were explained as part of a two-way communication process with the community, rather than being expected to carry the message alone.

Figure 11.4



In the first Nepal study, stick people were recognized by two thirds of villagers, while three quarters recognized a simply drawn water pot. Familiar objects were recognized more easily than unfamiliar objects. Where houses had sloping roofs, 85% of villagers recognized Figure 11.4. Where flat roofs were common, only a quarter recognized it as a building.

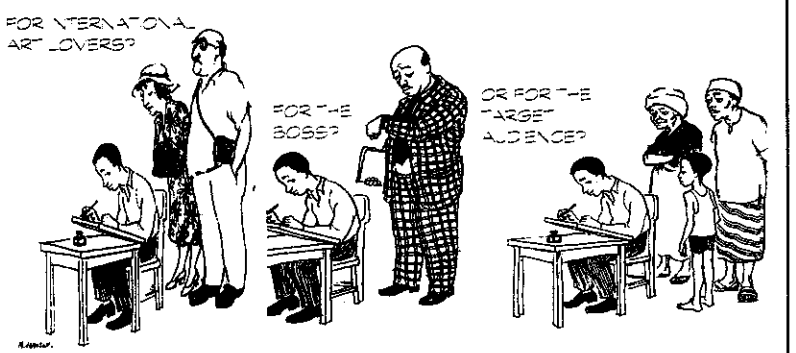
Illustrations for Development[3] noted that objects drawn at an unusual size confuse people and that conventions taken for granted in some societies are not understood in others. Lines behind a figure are only understood to represent movement if an audience is already familiar with the convention. Artists need to know or test which conventions the audience understands.

Even innovative work can only succeed if it achieves the same quality of artwork and story-telling as commercial comics and cartoons. The 1988 Nepal research suggested that testing visual literacy with poor-quality drawings was "like testing literacy with bad handwriting ... and then blaming villagers for not understanding the message".

It showed that people's understanding of visual conventions increased with exposure to the material. It also suggested that making illustrations 'understandable' may not be sufficient to challenge entrenched behaviour patterns.

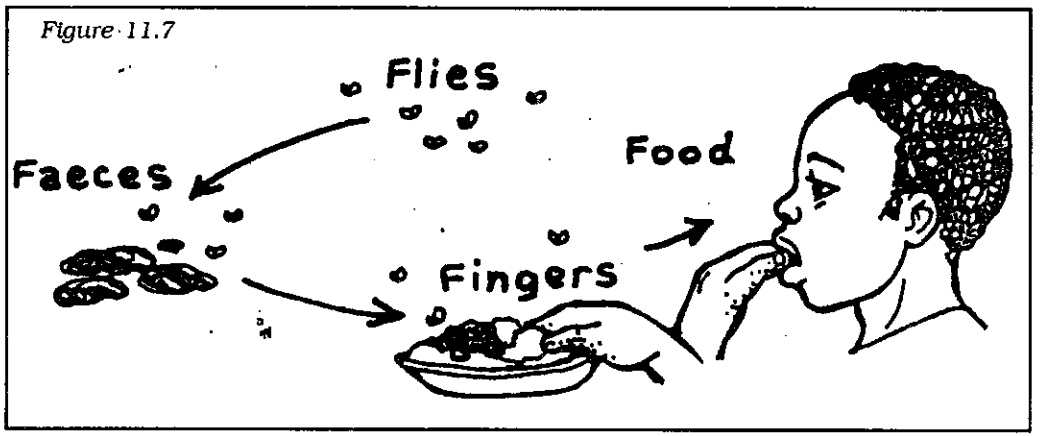
George McBean, who produces his own comic strip in the Caribbean, says: *"It is important to establish characters before plunging in with health messages. So often artists are just used to illustrate the ideas of the bureaucrat. Teenagers spot propaganda a mile away. They will often read it, but they are not hooked on it."*

Figure 11.5
A pertinent question from Illustrations for Development. *Who are you drawing for, international art lovers, the boss or your target audience?*



George McBean devised a Caribbean cartoon strip satirizing sex education for young people, and failure to communicate. Trish asks Sam: "Did your parents ever talk to you about sex?" "No," says Sam. "Their parents never talked to them ... nor their parents to them. I guess that's why birth is such a miracle."

Figure 11.7



Villagers found this picture very confusing. What did the arrows mean? What were those funny blobs? They had never seen flies that looked like that. Why did the man have one hand in his food and the other hand in his mouth?

Figure 11.8

The second drawing, in colour, still had a number of puzzling features. Flies were still not recognized. The chicken would not be allowed to eat out of a food plate. The little boy on the left would not have been allowed to defecate and eat at the same time. Villagers would not take advice from this family — their hut did not even have a roof!

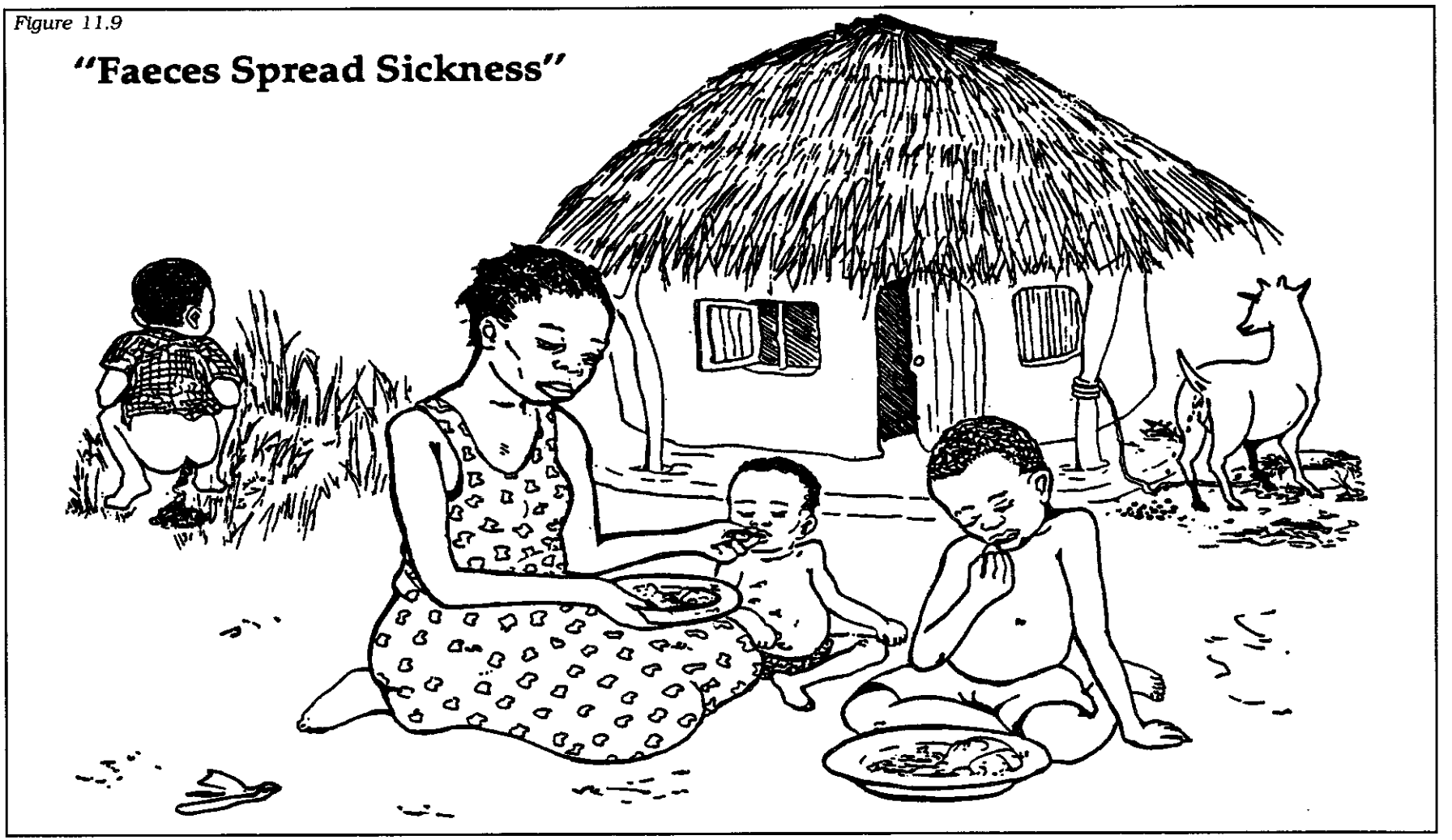
Pretesting visual material

If people in the Caribbean and in some areas of the Philippines are overloaded with imagery, people in rural Uganda see little television and few newspapers and comics. Great care had to be taken to ensure that materials were appropriate for rural audiences. It took UNICEF and the School Health Education Project (SHEP) two years to prepare the first 'Basic Science and Health Education' book.

During the preparation and production of posters for community health workers on *Facts for Life* issues, Douglas Lubowa, in charge of producing materials for UNICEF Kampala, spent 10 days visiting villages to learn the reaction of families. Draft posters were accepted by committees, but on testing, were criticized by village people. One picture, showing a child sideways-on, was interpreted as showing a child with only one leg. Another poster showed a woman taking her baby for immunization. To illustrate three separate visits the poster showed her wearing different clothes. People objected; they thought that this must be three different women, because local women would always wear the same special clothes to take their babies for immunization. Douglas said afterwards that although he had had to swallow some artisitic pride, the revised version was much more effective. "People like the pictures very much because they see a bit of their own environment," he said.

In Uganda, artists and writers came to planning meetings, and workshops were held to develop materials. These were often produced at regional or district level to encourage potential users to become involved in designing materials. Local production also improved the use, storage and distribution of materials.

Figure 11.9



In the final poster, the child has been moved to a discreet position, and the goat defecates where he is tethered. The house has a floor and a roof, and the mother is wearing a dress acceptable in most parts of Uganda. The flies that baffled villagers were omitted from the final version, and are woven into the story by the health worker. (Trouble with flies is part of the folk culture of artists.) There is no text on the front of the poster. Villagers look at the picture and describe what is happening, and health messages are introduced during the discussion. Key messages are on the back, and community health workers ask their audience: What do we see?, What are the reasons?, Does it happen here?, What should be done?

Philippines: Artists learn to draw for rural mothers

Figure 11.10
A UNICEF-sponsored comic from the Philippines

The Philippines is a country where rural and urban areas have very different cultures, but where most people are familiar with visual imagery. Midwives, nurses and a nutritionist in Ifugao worked with artists from Manila to produce messages for semi-literate mothers.

Bituin Gonzalez, UNICEF Programme Officer, said that artists went for five days to the villages. "They watched exactly how the midwives conducted health teaching. They followed the midwives on home visits, they sat through classes for mothers. Then they started doing sketches of how some of these messages could be put onto one storyboard, one set of flip charts or one poster.

"The initial sketches were very urban orientated because the artists and the cartoonists all came from the city. Many of the mothers thought that the pictures were too foreign. The hairdos were different, the women were too skinny, and their eyes were too big. The community, not just the mothers, but the mayors, the councillors, the village heads, even the fathers, pretested the materials. Then the artists went back to the drawing board, and redesigned it."

Artist Ely Santiago said: "I have to put myself in the shoes of a third-grader, and a third-grader who lives in the rural areas. If I don't get it right, instead of curing diarrhoea through my illustrations, I might worsen it.

"I have to contend with the existing beliefs, especially of the older people. So I have to be very diplomatic in the way I put the text. I suggest rather than impose. The health worker is somebody who looks like my mother. Some Filipino illustrators have a penchant for idealizing their characters, so they model them on movie stars.

"I use typical rural mothers. Even in the way they wear their hair they are not sophisticated. These are not beauty parlour types. Some of them look haggard. Even the young woman I portray is not the typical city teenager.

"In the comics that I am illustrating the central characters are two young people in love with each other, planning to have a family. Filipinos are very romantic. They won't follow a story that does not have any element of romance and love in it."

Pretesting was also invaluable in Egypt, where a colour booklet for literacy classes was prepared from the Hygiene chapter of *Facts for Life*. UNICEF Information Officer Nagwa Farag and Assistant Communication Officer (and artist) Nagui Kodsy took a draft of the booklet and accompanying flip chart to test on 95 people at literacy classes. Many pictures were changed as a result, and the logo, a picture of a pair of hands under running water, was redrawn to make it clearer. As in Uganda, some compromises had to be made because the same booklet is used across the whole country. Separate publications for rural and urban areas would have been prohibitively expensive.

Figures: 11.11 (above) and 11.12 (below). Two illustrations from literacy material produced in Egypt from Facts for Life.

Promoting sanitation in India

Indi Rana was appointed as communications consultant to the Orissa Drinking Water project in India by the Danish International Development Agency (DANIDA) in 1987. Despite objections about time and money, he insisted on pretesting drawings with the local community. The results humbled him. He found that his drawings, based on an understanding of perspective, confused rural people. They themselves drew pictures that had multiple perspectives (i.e. more than one viewpoint) and that contained a story within a single frame. Every ancient culture develops its art in this manner. Egyptian hieroglyphics portray stories within one picture as does the Bayeux tapestry. The modern Western eye has to be retrained to understand these pictures.

Indi Rani found that a poster showing a woman going to the field to defecate while a man used a latrine would not be effective, because the woman (in the foreground) was bigger than the man, and must therefore be behaving more correctly. A picture of a mother feeding her small child with a spoon was understood as a woman feeding her husband. Here the size of the figures had been disregarded.

Rani's conclusion was that visual material should imitate the art of the villagers and that village women could themselves help to illustrate the messages. An artist prepared different styles of pictures, which in Rani's view proved his point. In his account of this work[4] Rani said: *"The results made it clear that illustrations for rural people must be done in flat colours, in multiple perspective, in the broadest aspect on objects but not necessarily on people. Time within the same frame was comprehended, abstract imagery made little sense, realism was demanded in feelings, and where the artist had gone wrong on community details the objections were loud and clear."*

☞ *Incidentally, Rani's report sat in a drawer until shown to a visiting academic and then to UNICEF, which helped to preserve the drawings by the rural women. They were exhibited at the UNDP Global Safe Water Conference in New Delhi in 1990, and are now on display in DANIDA headquarters in Copenhagen.*

Above and bottom right, just two of the drawings from the UNICEF CD-ROM package being circulated to country offices.

Wall comics in Myanmar

An evaluation of Facts for Life *in Myanmar showed a tendency to use it as a reference work, rather than as a vehicle for communicating messages. A decision was taken to make the messages more accessible. One move was to persuade 10 of the country's best-known cartoonists to help, which they did by producing five wall comics.*

UNICEF produces a CD-ROM clip-art package

Artists the world over tackle the same problems and try to achieve good results, often without much opportunity to discuss with one another what has been found to work and what fails. Often communication officers and artists have to discover all over again what can go wrong with visual material, and how to put it right.

There is now at least one ally that every UNICEF artist and communication officer can use, following the publication of a CD ROM containing thousands of drawings that can be used, copied or adapted. The drawings have been provided by more than 70 artists so that they could be pulled together into an art library and offered copyright free to UNICEF offices worldwide. The drawings were collected by George McBean and assembled into the CD ROM package by Nick Narishkin at UNICEF headquarters in New York.

The drawings are mostly line-art, covering as wide a variety of development topics as possible, and can be found either by leafing through a catalogue or by searching the disk using key words to identify the pictures. The finished product was being sent out to field offices as this book went to press in late 1995. An example of the artwork is used on this page as well as at the top of the staircase on page 11.

Target posters at the audience — don't use them for decoration

After all the effort that goes into the production of visuals, they are sometimes wasted. Posters have to be placed where they will be seen by their target audience. Too often, they are used simply as decoration for waiting-rooms. For example, posters supporting immunization are placed in health centres, where they will be seen by mothers who have already brought their children for immunization. Not only should posters be placed where they will be seen, but help should be at hand to explain and expand on the messages. It is as important to train health workers and others in using materials as to produce quality work in the first place.

Story books in Egypt: Bringing artists and writers together

One of the most remarkable transformations of Facts for Life has been the production in Egypt of illustrated story-books for children in rural areas. At a three-day workshop jointly organized by UNICEF and the National Centre for Children's Culture (NCCC), 40 writers, teachers and television programmers were presented with Facts for Life and asked to make the messages interesting to children in rural areas. As a result, 27 stories were sketched out and taken to a second workshop. There, writers paired up with illustrators and completed 10 illustrated stories. Most of the stories concentrated on pollution and the risk of bilharzia or other infections. Production of the books was overseen by UNICEF, and 25,000 copies of each of the 10 books were printed. The standard of production is very high and all the books are in full colour, but they cost only 80 cents each to produce after the artists and authors donated their work free "for the children of Egypt".

In The Puzzled Raindrop (pictured right), a drop of water lands on a leaf and wants to join the river so it can be of use to people and to plants. Then it sees a dead animal in the water and a child urinating, and begs the sun to take it back away from the pollution. Author Fatma Taha said: "The ideas in Facts for Life are somewhat difficult, especially when one tries to simplify it to get to the children's level, but thankfully we were able, with encouragement from UNICEF personnel, to achieve what we started." Illustrator Nabil said: "This is the first opportunity for illustrators and writers to interact at the personal and artistic level. We now have a sort of brotherhood of artists and writers for children." The aim of initiatives like these is to try to make Facts for Life more accessible. The Black Chick (left), one of this series of books, won the 1995 First Lady Award for the best story in Egypt for children under the age of five.

Dr. Alaa Hamroush, head of NCCC, said the active involvement of UNICEF communication staff had been vital (Assistant Communication Officer Nagui Kodsy oversaw the production). "Their technical expertise was very important for us and for the writers going to the two workshops. They made us more aware of what is going on in the community and directed our thoughts to areas we knew little about. We consider this the most important work that we have done during the year, not only because it has to do with Facts for Life but because of the process that took place over two years to reach this point. This was the first artistic workshop held for artists and writers to come up with ideas and to develop them." As soon as the books were printed, a set was presented to Dr. Hussein Kamel Baha'a El Din, Minister of Education. He immediately ordered three or four copies of each book to be placed in every school library in every Egyptian village.

Transforming Facts for Life through drama

Traditional culture offers a route to poor communities with little access to television or radio. It also offers an avenue for health communicators who seek face-to-face communication with communities. Traditional entertainment including song, drama and poetry, is well accepted by communities and can be adapted to reach new audiences. Drama can move people's hearts and excite and entertain as well as enlighten.

Lynn Geldof, who studied the process of social mobilization in Nigeria for UNICEF,[5] wrote: *"The potential of (drama) to communicate, inform and educate is far greater than any other because it is at once intimate, immediate, accessible and full of cultural resonances in which the seeds of new knowledge can take deep root .... The 'Third Channel' also has more participatory potential than the mass media."*

The Third Channel is generally understood as the world around us — everyday life. So we learn how to speak our own language from the Third Channel and we learn about our own customs and beliefs. It is popular education that goes on every day without being planned or organized. In this way, traditional songs and theatre, which can be seen simply as entertainment, carry with them messages about how we see our society.

In Uttar Pradesh, India, *Facts for Life* messages were incorporated into thousands of performances by 400 song and drama troupes. As a result, 700 village action groups have been formed to help implement the messages.

The Philippine Information Agency (PIA), a major partner in *Facts for Life*, helped to transform it in a number of ways, including a dramatized film, a series of slide shows and puppet street theatre. The then UNICEF Representative in the Philippines, Dr. Pratima Kale, said: *"We have learned that in the Philippines you have to relate global and national events to their own world and when that happens it really works. So the translations into their own language, the adaptations of the messages to their own culture, the local songs, and the local dance and folk songs and the local artists and their interpretation in their local language; that I think appeals to people."*

In Quezon City, UNICEF and PIA organised a puppet theatre workshop to support urban basic services. Drama group organizer, Bing has little doubt that this method of communication is effective. *"We always feel, give us those who are on the bottom line, without access to water and let us see what we can do. The response is not limited to clapping after the show, but we see it in their homes, when they start cleaning their hands before eating, or after going to the toilet. When a parent says 'my son or my daughter is doing this', that is beautiful."*

The Philippine *Facts for Life* film, *Kung Bilid Mo Lang*, made in 1991, has been shown in 40 cinemas in Metro Manila and 250 in rural areas, taken around by the rural health unit. The film covers all 11 basic subjects in the Philippine version of *Facts for Life* by telling a simple story. This means that the film runs for more than 30 minutes, requiring a substantial commitment on the part of the audience. PIA staff feel that the length has not been a problem, although there has been no formal evaluation. People recognize and laugh at the human situations they see.

Drama in Nigeria: Reaching the most remote areas

Nigeria, with 80 million people, is the most populous country in Africa, and millions of its people have little access to mass media. A strategy has been devised to bring Facts for Life messages to remote areas through local drama groups, supported by service delivery teams providing, for example, immunization. Using local groups gives UNICEF some prospect of covering the country in a way not possible by a few centrally trained theatre groups.

The idea was born when Roger Tangara, former Programme Communication Officer for UNICEF asked actor and performer Jimi Solanke if he would be interested in transforming Facts for Life messages. The first play, The Postman Calls, was about immunization. Its first public performance in the village of Yoruba was such a success that people lined up for immunization — and there was none available. Now, whenever a drama advocating a service is shown in a village, a service delivery team is on hand to meet demand.

Community theatre workshops to train local drama groups run side by side with participatory development workshops for local government officials. Local government is taking over some of the cost of the drama, and this allows each to understand more fully what the other is doing. The training is designed to encourage actors to initiate discussions with the audience after a performance. After one performance by the Ede Theatre Group about the threat of guinea worm disease, a village elder stood up and declared the play to be absolutely true from his experience, authenticating the message for the whole audience.

Even a successful initiative like this has set-backs. In one Islamic Fulani village, the actors found they were performing a play about immunization to a men-only audience. The village head was sympathetic, but concluded that women could only watch if the cast was also all female. However, other Islamic villages allowed mixed audiences to watch the performances.

Dr. Ziky O Kofoworola, Senior Research Fellow at the Department of Nigerian Cultural Studies, believes that drama has a long-term effect if the audience is encouraged to participate and to create songs or stories from the play. "The theatre does not end with that single performance. It is stored in the memory and recalled by extracting some element of it, like the songs or the new dance that has been created."

Once training and funding were sorted out, community theatre developed rapidly in Nigeria. The Network of Educational Theatre in Nigeria now covers four health zones. More than 20 drama groups have been trained, using 14 scripts based on Facts for Life material.

Facts for Life was also used as course content for scriptwriting at a regional training course supported by Radio Netherlands and involving scriptwriters from Ghana , Nigeria and Sierra Leone. The outcome of the course was a radio series that was broadcast throughout the region and has been repeated several times by popular demand. It is a drama series about AIDS, entitled Ojuju Kalakuta: Strange Stories from a Wise Old Man.

The Sudan: Theatre for Life

In Kordofan, the Sudan, most people do not have access to mass media, and literacy levels are low. Theatre is used to bridge the gap between UNICEF material and villagers.

Theatre for Life was tried first in 1990 and then in 1992. For various reasons, these attempts had limited success. This was partly because young urban actors created more curiosity in rural areas than the content of the plays.

In 1994, the project was changed so that each village taking part in the Child Friendly Village programme would develop its own theatre group of young actors who would develop plays from Facts for Life materials.

Theatre for Life groups grew from 20 in 1993 to 41 in 1994 and to 60 by the end of the first quarter of 1995. Since the beginning of 1994, 219 shows have been put on in 40 villages, with total audiences of more than 166,000 people.

Bangladesh: Theatre that talks back

In Bangladesh, Gram (village) Theatre combines drama and discussion. The theatre group arrives carrying banners and posters that advertise the messages and the performance. They tour the village, stopping to give basic information about sanitation and why it is needed. In the evening, they perform a 25-minute play on sanitation, followed by a discussion with the audience.

Mozambique: Short health plays

In Mozambique, UNICEF and the Ministry of Health produced a book, Teatre para a Saude (Theatre for Health), which includes 22 short plays on seven health-related subjects — maternal and child health, nutrition, AIDS, hygiene, diarrhoeal diseases, malaria and tuberculosis.

Folk poets in Bangladesh

In the early 1990s, UNICEF Bangladesh, began to work with 'traditional roving poets' recognizing that the poets were reaching families that UNICEF was failing to reach in remote rural areas. The poets represented an existing and effective communication channel. Poets write stories and copy them. Hawkers take them to cities and towns on market day and read them aloud where rural people gather, for example, at the railway station. Some 150 people may listen to each reading, and out of those perhaps 20 or 30 buy a copy of the poem to take home. That night after dinner, a homestead of 50 to 100 people listen to the poem being read aloud. The best-known formal poet in Bangladesh has sold perhaps 50,000 copies of his work, while each roving poet has a minimum 100,000 print run, which may possibly reach a million people over two to three months.

The poems are designed to entertain, not to instruct. Stories are taken from newspaper reports of murder or intrigue and are usually about love gone wrong. One is about a rickshaw driver who falls in love with someone above his station. Another is about three sisters who commit suicide because their father will never be able to afford the dowry to marry them off.

This was not at first sight promising material for Facts for Life hygiene messages. The poets were persuaded to attend a workshop, where they were asked whether they would add a four-to-eight line message at the end of each poem.

The poems succeeded in reaching large numbers of people because of their long tradition, because they were entertaining and because they were inexpensive. The poets said that if their poems were printed on better paper people would think it was difficult to read!

During the life of the project, Facts for Life reached a new audience of tens of thousands of people while the circulation of the poems and the prestige of the poets increased.

Caravan for Life: Ecuador

MARUSKA BONILLA

In Ecuador, community theatre people worked with staff in the UNICEF office in Quito to devise a show containing health messages for people in the poorest areas of the country. A sort of travelling circus without a tent was put together to move through the poorer areas of several provinces bringing entertainment and education under the slogan 'artists working for life'. The artists included singers, actors, mimes, clowns, sculptors, puppeteers, magicians and jugglers. They became known as the caravan of joy, caravan of hope or caravan of health. The major themes were vaccination, acute respiratory infection, diarrhoeal diseases, education, breastfeeding and children's rights. Special shows on cholera, sanitation and other issues were also prepared.

In all, approximately 2,000 shows, seen by a million people, have been presented over the past five years. At present there are six caravans funded by local artists in five provinces of the country. The simple language used by entertainers has paid off. There was a significant increase in knowledge about immunization and about oral rehydration therapy for children with diarrhoea.

Evaluating the effectiveness of drama

Drama is rarely evaluated in terms of the extent to which it brings about change. Drama is, like every form of communication, a force for good or for evil. The question is when to use it and how? It has to be recognized that there is bad drama as well as good drama; boring theatre as well as moving theatre. Traditional entertainment can be used to distort messages or to reinforce social patterns that oppress women. If questions of quality and appropriateness are not addressed, then using drama can be seen as self-indulgence; even patronizing. Shankar Singh, a folk artist who has tackled social issues through his puppet drama group in Rajasthan, India, has thought deeply about the link with social change. He wrote:[6]

"Several questions began to bother me. How many of the audience actually internalize the issues? How many actually changed because of a good play? What was our relationship with the audience? We showed a play on funeral expenses that pushes a poor family into bondage and further poverty. After 300 performances, we still hadn't heard of a single case where there was a resistance to the practice. So what was I doing for social change?

"Slowly I realized the limitations of theatre, however effective. We could only create energy for a short while. We were unable to create the confidence required for making a leap forward, a confidence which can only come from sustained work and commitment to face the reactions together. Even in motivational efforts that don't involve conflict, a performance by itself only creates temporary energy.

"It has become 'in' to have songs and plays and street theatre. It has become the standard formula to have 'jathas' and 'padyatras' [forms of drama] of various sorts, through districts, states and across states. But what have they achieved? The team that is involved has fun, learns some lessons and feels a glow of achievement. But what of the people for whom the plays are evolved? Change cannot happen without the participation of the people for whom it is important and relevant. It cannot come by just watching performances of passing plays."

He concludes that change needs sustained work and "the participation of the people for whom it is important and relevant".

This is a useful warning, but we must conclude that the experience of using drama is productive, when coupled with other efforts, particularly those that involve some degree of interpersonal communication, such as group discussions or question-and-answer sessions. Drama can break down barriers and open up topics for discussion. Drama can help people recognize themselves and their situations. Drama reaches the heart and catches the attention.

UNICEF: Rivadi

Puppets in Indonesia introduce a health message on the benefits of oral rehydration.

(For a description of the use of drama in schools in Uganda, see Chapter 12 - Sexual Health and Cultural Sensitivity.)

Animation, multimedia and 'enter-educate' — new art forms come of age

The power of storytelling and drama is today being harnessed to the most up-to-date technologies and art forms. Computer animation is becoming more widely available as skills are shared and computers help to reduce the time and people needed to produce even a few seconds of lifelike film. In addition there is increasing use of mixed media and multimedia to bring subjects to life. Today, there is an enter-educate movement that seeks to use a wide range of art forms, including pop music.

Animation

Use of animation has become more widespread as skills in this field grow and people see how much can be achieved. Animation is a natural medium for blending fact and fantasy, and for embedding health or social messages into a story in such a way that the entertainment and storytelling come first. It does, however, require a high level of technical competence, time and money to prepare the material and be sure that the finished product will strike a chord with the audience.

In Mexico, UNICEF worked with the producers of *Plaza Sésamo* (the Latin American version of *Sesame Street*) to incorporate animated segments on the physical, social and emotional development of three- to six-year-olds. *Plaza Sésamo* has been broadcast for 25 years in Spanish. New material prepared for the current (fourth) series includes 130 half-hour programmes that blend animation and real life film.

The series follows Abelardo, Lola, Pancho and the Plaza children as they travel on an old bus through Latin America looking for Plaza Sésamo. The animation has been prepared by the Baer Animation Company in California, a company that specializes in 3-D animation where animated character interact with live characters.

Many familiar themes are present. Young viewers learn the alphabet and basic arithmetic. However, for the first time, messages promoted in *Facts for Life* have been incorporated into the scripts. The series promotes simple hygiene, nutrition and breastfeeding as well as safety. A small eagle who is always looking out for children's well-being is featured in the each of the health segments.

In Ecuador, Máximo, an animated character developed by Disney/UNICEF has so far covered the topics of immunization and iodine deficiency.

Although these projects do not carry the *Facts for Life* stamp, they cover issues

Bolivian film

In Bolivia, film rather than animation was chosen for three films based on Para la Vida (Facts for Life), *'The Family', 'The Child' and 'The Mother'.*

found in *Facts for Life* and they have come out of UNICEF's exploration of more creative way of publicizing health.

Teenagers at risk in the Caribbean

In the Caribbean, animation has been used for several years. The latest production from Animation for Development, *The Teen Years*, shows young people in a variety of situations coping with the consequences of their decisions. Key messages from the script are: *Your best protection is the right decision* and *You can't re-play your life like a video.*

The Teen Years is part of a broad-ranging life skills initiative by UNICEF in the English-speaking Caribbean, aimed at improving the decision-making skills of young people, reducing the number of unwanted pregnancies to teenage mothers, and improving parenting skills. In a policy paper, UNICEF says: *"The greatest social challenge in the English-speaking Caribbean area lies in meeting the needs of young people through educational programmes which are both flexible and relevant, by raising their awareness of the health and social consequences of their behaviour, and by helping them to master life skills."*

The overall objective is a comprehensive and integrated preventive and developmental programme for the promotion of healthy lifestyles and to establish the initiative within the mainstream education system. Activities in every aspect of school life will be far broader than animation alone, but this form of entertaining education sets the tone for tackling far-reaching social issues. Use of animation in the Caribbean is not new. Some material is designed specifically for parents-to-be. Other films are for teenage girls and are aimed at helping them to resist peer pressure. One film about a young girl who becomes pregnant includes a dream sequence about getting married — a dream because 60% of the young mothers watching the cartoon will be unmarried. Each of these films is designed to capture the attention of a young woman by describing a situation and story-line she can relate to.

Meena in South Asia

In South Asia, Meena, her brother Raju and their parrot Mithu have become forms of mass entertainment — with comics and animated films based on health or social messages. So far, 13 episodes have been or are being produced, and their popularity is such that probably more are to come.

Meena was conceived in Bangladesh but is also being used to promote the Decade of the Girl Child in Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. Images were first produced in each country and then worked up into a cast of characters by Ram Mohan, the leading animator in Bombay.

Storyboard drawings from Teen Years.

Illustration from Meena Saving a Life *(above) and the pet parrot Mithu (below).*

The films are produced by Hanna-Barbera Productions, creators of *Tom and Jerry* and *The Flintstones*, and are being produced in their Fil-Cartoons studios in the Philippines, where artists from Bangladesh, India, Nepal and Pakistan were trained in animation techniques.

The pilot episode showed Meena sending her pet parrot to school to learn for her, and ends with her parents agreeing to send her to school. The next two films developed the theme of the competent resourceful girl who could hold her own against bullies and moneylenders. Later films have health themes, so far covering sanitation, hygiene and diarrhoea, and all using *Facts for Life* as source material.

The films are brilliantly made and full of humour, mainly at the expense of an unfavourite aunt who descends on the family and criticizes every attempt to introduce change.

The films have been produced in English, Bangla, Hindi, Nepali and Urdu. The first episode has also been dubbed into 13 South Asian languages, 8 European languages and Arabic. UNICEF Myanmar and China are also planning to dub the series.

The films are backed up by comic books, posters and training material. The success of the characters is shown by the growth of commercial products in Bangladesh based on Meena and Mithu. From now until 1998, the plan is to focus on mass dissemination of the Meena concept through South Asia. Puppet shows and songs are also being developed.

An evaluation of the pilot film concluded: *"It appears that Meena's potential is unlimited and should be exploited."* It recommended that family planning, health and hygiene and *Facts for Life* topics be woven into future stories.

Multimedia in South Africa

In South Africa, a multimedia project was launched in 1994 to teach rural and urban black families. Six months of television, radio and newspaper spots reached almost half the black population with material containing one or more of the eight priority maternal and child health topics.

Soul City One received funding from UNICEF and other agencies but more than half the funding came from the commercial sector, and the idea was sold to television and radio channels as a basis for increasing their audiences, rather than as a way of doing socially useful programming.

The main event was a 13-part prime time drama series, *Soul City*, which had been carefully scripted and tested through 35 focus groups. This alone reached more than 4.3 million people. A radio serial, *Healing Hearts*, reached over

3 million people while newspaper inserts reached 2.4 million and booklets 3.4 million. *Soul City* was five times more popular than other health-related television programmes: the combination of drama and health was a winner.

The packages were developed at the Institute for Urban Primary Health Care in South Africa, but success came from the human story-lines. As one of those interviewed afterwards said: "Soul City *has greater impact. You feel it and it sort of shakes you inside.*" Almost 90% of the audience felt they had learned something from the programmes (although only one in five had actually changed behaviour as a result). *Soul City* is scheduled to be shown in Kenya, Namibia and Zambia, while a new series is planned in South Africa for 1996.

The 1996 Africa Cup soccer tournament was broadcast to mass audiences throughout the continent. Regular advertisements at half-time included a series of mini-stories of African families where the brightest and most aware family member carried condoms and was prepared to talk to other family members about the issue. Each little story was told with humour, and packed the power of a soap story into the concentrated time-capsule of an advertisement. These ads, made with financial support from the European Union, carried a powerful punch and were certainly talked about.

The enthusiasm for this form of programming is growing, and it will undoubtedly become more popular and more professional. Every major soap opera is now bombarded with requests to insert health or social messages, and most agree to do so, sometimes very effectively. In the UK, one of the main characters in the most popular evening soap, *EastEnders*, has lived with HIV infection for several years without acute illness. *The Mark and Gill Story*, an edited tape from the programme, was specifically designed to be used by health educators.

However, even these high-profile, professional and immensely valuable products cannot become a short cut to behaviour change. The mass media, as we saw in Chapter 4, are excellent for highlighting issues and raising awareness, but are relatively ineffective alone in changing behaviour. Professor Everett M Rogers, of the Annenberg School for Communication, University of Southern California, told a conference on Entertainment for Social Change in 1989[7] about an evaluation of the television soap opera *Hum Log* in India: *"We found that 90 or 95% of those who had TV sets had been exposed to* Hum Log. *A very large percentage of these people —70 or 80% — knew what the message was about. They were informed. Some of them were persuaded and 1 or 2% actually changed their behaviour. These findings are typical of most mass communication interventions."*

It should be noted that this very successful soap opera, *Hum Log*, started by giving family planning messages, but only became truly popular when it stopped preaching to its audience and buried its messages in the drama.

Enter-educate and popular culture

In the Philippines, Lea Salonga, one of the most popular singers, supported the Music for Young People Project developed by the Population Centre Foundation and Johns Hopkins University. Her songs reached number one in the Philippine hit parade and carried social messages. She said:[8] *"Music draws people in. It is a powerful way to send messages. We toured schools where I sang and we held competitions asking specific questions about the songs, and the meaning of certain lines. The students understood the messages fully."*

There was evidence of some behaviour change, particularly an increase in the number of young people who sought information about contraception. It is not clear, however, how songs which call on young people to postpone sexual experience, affect behaviour. There may be a tendency to reinforce existing beliefs in people who are already sympathetic to the message.

New opportunities to combine entertainment with education are opening up. CTW has set up a unit with the specific purpose of working with partners in the developing world to expand the national capacity for health promotion through entertainment. There are initiatives under way for a radio drama series on AIDS in Africa, and CTW has developed a five-day training course for national broadcasters and social development agencies to help them develop national strategies. Such developments should be welcomed and encouraged. Songs and drama make the ground more fertile for health education and may transform the way in which messages are put across. However, they cannot do more than raise the questions and initiate debate. There still has to be human contact and discussion — the interpersonal support — if people are to transform some new piece of knowledge into action.

1. *Report of UNICEF Facts for Life/All for Health Meeting*, Amman, Jordan, June 1992.
2. *Can Mass Communication Change Anything?* by Ashoke Chatterjee, in People's Action (CAPART) November 1989.
3. *Illustrations for Development* edited by George McBean, Norbert Kaggwa and John Bugembe and published by Afrolit Society, Kenya, 1980.
4. *Culture, Communication and Change*, report of symposium on affecting social change through communication.
5. *Social Mobilization in Nigeria*, Lynn Geldof, 1994.
6. *Language of Change*, Shankar Singh, in Culture, Communication and Change, August 1993.
7. The Enter-Educate Conference, California, March 1989. Proceedings jointly published by Johns Hopkins University, University of Southern California and the Center for Population Options.
8. *Promoting Sexual Responsibility in the Philippines through Music: An Enter Educate Approach*, published by Johns Hopkins School of Public Health, 1994.

12. Sexual Health and Cultural Sensitivity

ACTION POINTS

- **Issues of sexual health and sexual behaviour are the most difficult to address openly in many societies.**
- **Birth spacing, contraception, HIV/AIDS and other aspects of sexual health are part of the core knowledge that needs to be communicated, especially to young people who are becoming sexually active.**
- **Some countries found it was impossible to publish information on AIDS in the first national editions of *Facts for Life* because of society's taboos.**
- ***Facts for Life* rests on its ability to provide accurate timely and factual information.**
- **Where this information may offend some systems of belief, careful patient work is needed to win alliances to bring these issues into the open.**
- **Sensitivity to people's cultural wishes is essential for successful work with *Facts for Life*. Ultimately, however, ways must be found to raise issues of birth spacing and sexual health, or *Facts for Life* will fail to deliver on its promise of providing the essential health messages that communities need to know.**

Introduction

The selling-point of *Facts for Life* is that it tells the truth. The book contains the most important information that families and communities need to act on to stay healthy. It was put together bearing in mind that some things are true for humanity everywhere, irrespective of systems of belief or values. *Facts for Life* tries to keep to essentials, but it does not omit facts because they are inconvenient, or because some might wish they were not true. There has been debate about the technical content of chapters, the emphasis (for example, on breastfeeding) and the wisdom or otherwise of adding extra chapters. Topics have not, however, been omitted because they might offend. The first international version of *Facts for Life* contained chapters on birth spacing and AIDS.

Against this desire to 'tell it like it is' we also acknowledge the need to enable communities to set their own agendas and to concentrate on issues that cause them most concern.

These two principles may come into conflict when discussing intimate practices and people's deepest-held beliefs. This conflict may arise over gender roles or hygiene customs, but it finds its sharpest expression when family planning or sexual health is addressed. We may claim that 'facts' are neutral, but the presentation of facts can still cause deep offence. If people are being invited to use information as a guide to action, then their beliefs and values become a crucial part of the equation. The initial tendency is usually to deny something that offends our beliefs or customs. The second reaction may be to condemn it. If the conflict is not resolved, it may become impossible to discuss the matter at all without taking sides 'for' or 'against' the facts themselves.

Immunization is culturally unacceptable to some people, and because it offends their beliefs, the very 'fact' that immunization can protect children is seen as a hostile fact. It causes internal conflict, not because they do not love their children — but because they do. If they did not care about the fate of their children they could ignore the advice. Because they do care they feel they must attack this so-called fact.

Age-old sanitation practices of some communities are no longer safe, given the pressure on water and land and the increase in population. Persuading people that poor sanitation is the cause of some ill health in their communities is difficult, because it suggests a change in deep-rooted human behaviour — where and how people defecate — that demands an understanding of the transmission of disease, and carries a high financial cost.

These are just two subjects that must be treated with cultural sensitivity.

The unmet need for family planning

About a quarter of all women want to stop having children or to postpone the next pregnancy for at least two years, but are not using contraceptives.

Such women are defined by DHS [Demographic and Health Surveys] as having 'an unmet need' for family planning.

Unmet need does not necessarily mean that family planning services are not available. It may also mean that women lack information, or that the quality of the services on offer does not inspire the necessary confidence, or that women themselves have little say in the matter.

The Progress of Nations, published by UNICEF, 1995

Nobody, however, suggests that they should not be addressed. The same is not always true of sexual matters. Several messages — about birth spacing, about avoiding pregnancy below the age of 16, and about the risk of the spread of HIV disease and AIDS — affect the most sensitive of all human activities. Raising these issues is to some people an insult against deeply held beliefs. Many countries, including those in the vanguard of working with *Facts for Life*, found it impossible to include the international chapter on AIDS, while some softened the message about avoiding pregnancy below the age of 16. Even now, several years on, these issues cannot be raised in every arena.

In Bangladesh, the AIDS chapter was not included in the first national version because there were not then many cases, and because of the conservative nature of society. A second revised edition in 1995 included a chapter on AIDS, showing how quickly public opinion had shifted. In Egypt, the chapter on AIDS was left out of the first edition. Communication Officer Nagwa Farag said: *"The media would have ignored the whole package and only talked about AIDS. It is difficult in Egypt to associate the issues of AIDS with children."* Four years later, UNICEF Egypt has a national strategy on AIDS and is tackling the problem head-on.

The question of when and how issues can and should be raised, and how far they should be pushed is one that has to be taken in the field in the light of local circumstances and conditions. It is important to remember, however, that opposition to information on sexual matters does not usually come from those who need the information. In some countries, political or spiritual leaders decide what it is appropriate for young people to know and hear, while young people pay with their lives for lack of knowledge or skills. Some people claim that this is a private matter that should be handled within communities and families. Yet there are few cultures where sexual matters are openly discussed between parents and children. A survey of families in some poor South African towns and rural areas found that very little sex education was given in the homes and that 90% of parents had not talked to their children about AIDS. This is a common pattern. Women in a community may discuss family planning among themselves, but find it difficult to discuss it with those outside their own community. Where UNICEF cannot address these topics directly, it may be able to work with an NGO which already has the respect of the community. In Egypt, an NGO added material on female circumcision to their edition of *Facts for Life*, and although there is resistance, they try to raise it in both urban and rural communities. UNICEF is not involved in this activity but provides training in communication skills, through workshops on the UNICEF *Facts for Life* topics. In this way support is provided without jeopardizing other work.

Minimizing opposition to sexual health education

Here are a few practical tips to increase support for sexual health education and to minimize opposition:

- *Anticipate opposition and from where it will come.*
- *Become familiar with the opposing arguments and be prepared with clear counter-arguments and explanations.*
- *Identify supportive leaders of opinion and organize them to advocate your programme. Once support is strong, invite opposing leaders to discuss the issue with their peers.*
- *Invite those who are opposed to visit programmes they criticize, giving clear explanations of the activities and why they have been introduced. This can sometimes swing opponents to support a programme.*
- *Encourage those who have been reached by a programme to provide testimonies. This can legitimize activities with the public.*

UNFPA, Internal document, 1995.

Bushra Jabre from the Johns Hopkins Center for Communication in Baltimore, USA, says the most difficult step is often to open a subject for discussion. *"Three quarters of couples in the Middle East do not talk about family planning. The first step was to get people talking about it by using songs, plays and TV dramas. Training in interpersonal relationships and counselling is important, but not enough. It is also important to promote the image of the local health care provider. For example, in Turkey the midwife is the main health care provider in villages, but she is usually young, so people don't look up to her."*

It is often the male partner who creates obstacles for child spacing and timing of births. Family planning programmes cannot therefore assume that the woman always makes these decisions, but must also direct messages and services to men, especially in cultures in which the male controls sexual events, inside or outside marriage. The relative powerlessness of women can extend not just to fertility, but also to the control of infectious diseases.

Males, therefore, need education about their role in family responsibilities, including family planning and child-rearing. Men should also be the primary audience for education about HIV and AIDS. Above all, programmes should encourage and facilitate communication between partners.

Boys should be given special attention when attitudes are being formed, if they are to learn to respect girls and women, and to take responsibility for their actions. Programmes should reach boys early enough to affect sexual behaviour. They are more open to information and education at puberty then in their later teens.

Most of the rest of this chapter is devoted to a detailed look at how the issue of AIDS is being tackled in Uganda. The issues and lessons have general application. Uganda is a poor country, with a predominantly rural population. It is a Catholic country where strongly held religious convictions provide a kind of moral code. It is a country where the issues of AIDS forced itself onto the agenda, because of the very high incidence of HIV infection and AIDS. It is a country where there has been a high level of innovation and a wide range of approaches to tackling the issues. Uganda lived at rapid pace through many of the problems found wherever this issue is on the agenda. It is a country where the difficulty of raising sexual issues was so profound that there were no polite words in local languages, only 'hard words'. Yet it is also the country where the national edition of *Facts for Life* includes a series of very frank questions and answers at the back of the chapter on AIDS to answer doubts and questions on the topic.

Because AIDS posed such a threat to Uganda, the need for action was essential for the future survival of the economy, and for the nation. UNFPA has pointed

Introducing population education into schools

Being resolute about subjects of cultural sensitivity does not mean being clumsy. If population education and sex education are being introduced into a school curriculum, important steps should be taken to maximize community support and minimize opposition.

1. *Strengthen community support by helping parents to understand the problems young people face — e.g. risks of unwanted sexual advances and pregnancy.*
2. *Relate the material being introduced to important community issues, such as adolescent pregnancy, so that the education meets specific relevant needs. Consult parents during curriculum development.*
3. *Use appropriate language and cultural references. Avoid controversial labels and slogans.*
4. *Set priorities for the content of these lessons, so that if some material has to be omitted from the curriculum it is not the most important.*
5. *Incorporate the content and teaching methods into teacher training colleges.*

Suggested by UNFPA, 1995.

out that family planning and AIDS prevention programmes mobilize broader support when they address a wide range of concerns. Policies and programmes that set objectives including health, economic, social, family and personal interests attract more political and popular support than those that focus exclusively on health. Although AIDS is foremost a medical and health promotion problem, its effects on the labour force, on technological advances, on the ability to sustain social services and many other concerns of national importance should also be highlighted.

In the same way, the issue of teenage pregnancies can best be tackled as part of a broad movement for adolescent health, recognizing that adolescent child-bearing is not an isolated phenomenon but is directly related to education, employment, culture, recreation and physical and mental well-being.

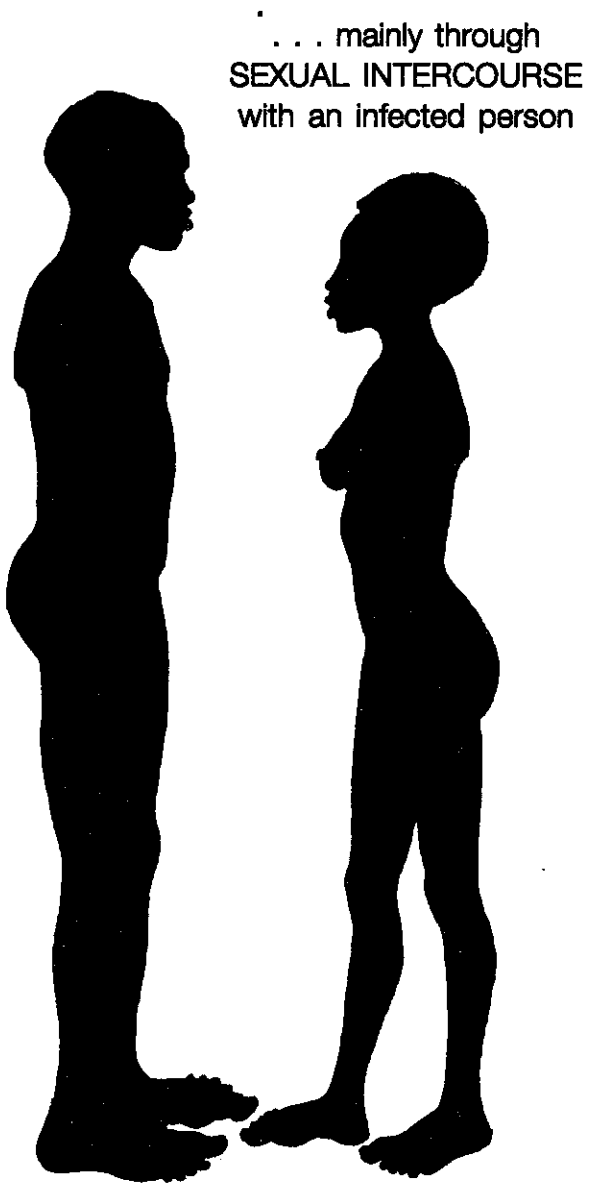
Addressing AIDS in Uganda

AIDS became known in Uganda in the early 1980s at a time when the country had been ravaged by war and economic retreat. The orphans created by AIDS were added to those who had lost parents in civil war. The challenge of the HIV invasion came at a time when the country was seeking to recover social cohesion and economic growth. By 1990, one in five of the population under the age of 19 had lost one or both parents. War, malnutrition or psychological distress had left more than 800,000 children with mental, physical or sensory disability.[1]

By late 1990, Uganda had reported more AIDS cases than any other African country. In June 1992, the Uganda AIDS Control Programme estimated that 1.5 million people out of the total population of 17 million were infected, and 33,971 cases of AIDS had been reported. AIDS is now the leading cause of death among Ugandan adults, and most cases affect people aged 20 to 40. Younger people are also affected. Between the ages of 15 and 20, six times as many girls as boys are affected.[2]

AIDS is most common in urban areas and imposes an economic as well as a human cost. Government departments and businesses lose key staff as they fall ill. Up to 50 students a term withdraw from Makerere University because they develop AIDS symptoms. By the year 2010, the population of Uganda is expected to be 20 million, instead of a predicted 37 million if the country had remained AIDS free. Many of those who die are the wage-earners and main supporters of families.

The Ugandan Government was one of the first in Africa to address AIDS openly. It adopted a multisectoral approach, emphasizing the responsibilities of all



The compromise picture adopted in Uganda, after health professionals debated the degree of frankness that the public would accept.

sectors of society. The Uganda AIDS Commission was created in 1991 to coordinate government and community efforts and, working with donors, to ensure that AIDS was not simply a health sector issue. The Commission is now based in the office of the Prime Minister. UNICEF increased its contribution to these efforts and in September 1991 launched the Safeguard Youth from AIDS (SYA) movement, concentrating on young people aged from 5 to 19. The movement was designed to strengthen the School Health Education Project (SHEP), the health education network of the Ministry of Health and the People with AIDS project, each of which plays a role in alerting people to risks.

Dealing with sensitive issues in posters

Among the materials jointly produced by UNICEF and SHEP for schools was a pack on AIDS. This was a sensitive issue in a society where sexual matters are not traditionally addressed except in private. There were arguments within committees responsible for approving material. One of the first posters showed a man and a woman in bed together, illustrating that HIV could be transmitted through sexual intercourse. Mary Owor, Coordinator of SHEP, said: *"The doctors said it was fantastic. The Ministry of Health said it was very good. The Ministry of Education said: 'Are you mad? Why must you advertise sex? You will teach the children how to do it'.*

"We called a workshop composed of doctors, teachers and parents. At the end of the first day, we asked them to let their children took at the pictures and give us their point of view. The next day, they said "How could you do such a thing? I could not show that picture to my children." Now we have a blacked-out silhouette of a couple facing each other. That was how we compromised."

Using drama to alert people to AIDS

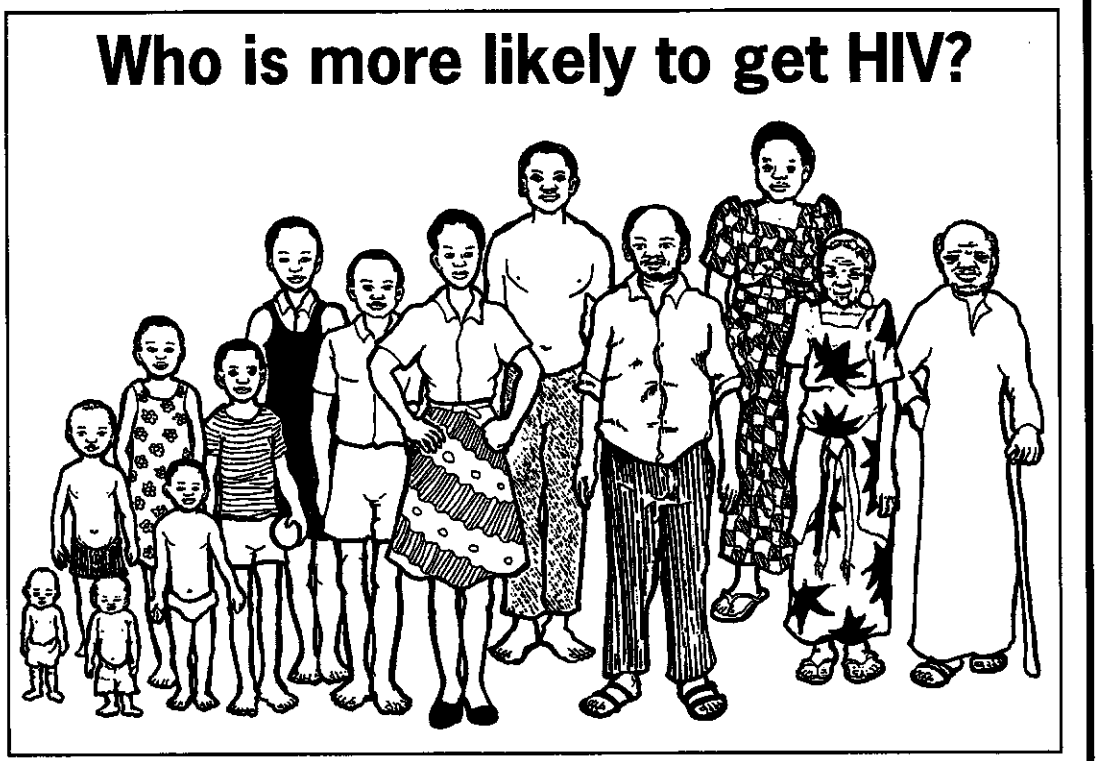
In 1991, primary schools throughout Uganda were asked to stage a play about AIDS, called *The Riddle*. This was the first truly mass education project about the disease carried out by the children themselves. In all, 6,000 out of the 9,000 primary schools took part, and they staged the play for their parents and communities. Following this success, it was decided to commission a more sophisticated play for secondary schools. *The Hydra* was the result, a play that has been the subject of a countrywide competition and translated into 12 local languages. *The Hydra* tells the story of Mirembe, who leaves her home to stay with her aunt so that she can attend a good school. There she has to fight off the sexual attentions of the very teacher who instructs the children about AIDS. Meanwhile, her cousins Flora and Joy find boyfriends, and tell her to do the same. The play ends with the teacher discovering that he is HIV positive and committing suicide. *(continued on page 130)*

Tackling AIDS in schools

SHOMINI PRIMARY SCHOOL, KAMPALA — FEB. 94

Teacher Joseph Kigosi is at the blackboard in front of 40-50 children aged 10 to 12. He asks them about the threats in their lives. They shout out "Lack of food" ... "lack of water" ... "mistreatment". He asks about diseases. "Tsetse fly?" suggests a girl. "AIDS." says a boy.

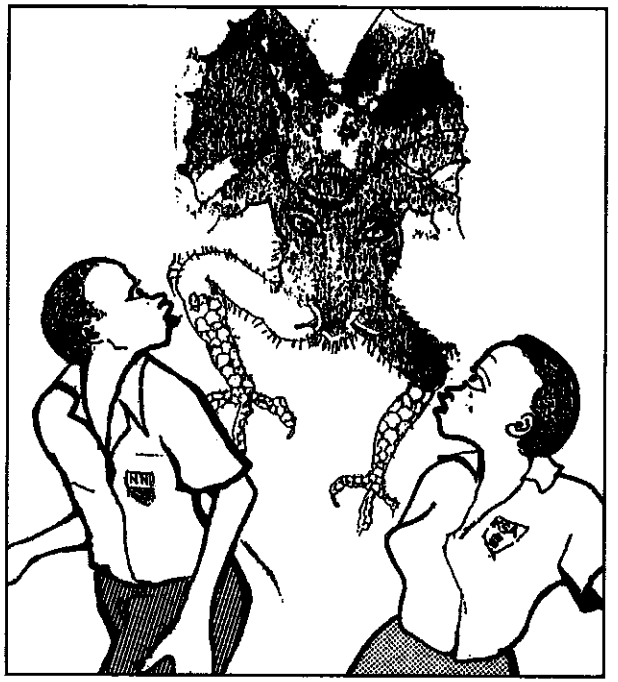
The teacher pounces. Why has the boy picked AIDS? "It has no cure," someone says uncertainly. "It has no cure", he agrees emphatically. "If you get gonorrhoea, syphilis, or typhoid, you can go to the hospital and be given some medicine, but for AIDS there is no cure."



This is a lesson in life and death, but a lesson all the same. The teacher pins the words Acquired Immune Deficiency Syndrome on the board, and discusses the words one by one. HIV is a term rarely used in Uganda, but Joseph explains that the virus can stay in the body for a long time without causing symptoms, and that the most common causes are infected blood and sex. UNICEF posters go up on the board. Which person has AIDS? The children shout out answers. Some pick the soldier, because it is well known that soldiers spread AIDS as they return to their communities. Others pick the smallest and skinniest. This gives Joseph a chance to explain about blood tests being the only way to tell. "Are you infected? Am I infected? No? Are you sure? We don't know. You remember that boy in P5 who died? He was given the wrong blood."

A child asks if the virus can be spread by mosquitoes. Joseph knows the text book answer (no), but he also knows that AIDS has been a story with many twists. "Mosquitoes? Yeah. How far are you sure the man is wrong? Tomorrow they may say bedbugs. We don't know everything. Every day something new comes out, and you have to be prepared. Unless you all fight it, and we all take responsibility for it will never stop." The lesson strongly emphasizes individual responsibilities, but the children are also told that they should look after relatives who have AIDS and that they cannot acquire the disease through doing so.

The head teacher, Lwanga-Kizza Eria, says the UNICEF material made it possible to put the issue on the agenda. "UNICEF has produced good materials for our pupils. Every child going to school has no excuse today of saying I didn't know. They all know."



The cover illustration for The Hydra, a play written for children to perform in secondary schools.

(continued from page 128) Joy waits for the outcome of an AIDS test while her shocked parents weep. Meanwhile, Mirembe launches a behaviour change club to tackle health issues in the school.

Peter Lwanga, one of the authors of *The Riddle* and *The Hydra*, says that drama was the natural route to a mass campaign. *"The teachers and the doctors were talking about AIDS but everybody was lending a deaf ear to what they were saying. They had all come to a dead end. We thought that the way of bringing the message home was to use theatre. The person watching it sees his way of life is reflected. The theatre acts like a message and something connects. Although they enjoy what is going on in the story they begin to think. They think deeply about what they have seen. It could be their own story and it changes a person. Here, many people cannot read and most people cannot write. You can't use TV. Radios are few and those who have radios don't have batteries. Theatre is second only to soccer in popularity. Our way of doing things in the villages is theatrical. We enjoy that way of doing things without making it very formal."*

UNICEF ran workshops for artists as early as 1989, originally to devise short plays about immunization. Writer Kiyuba Musisi attended the workshops and later became involved in forming the Association of Artists and Intellectuals for Child Survival and Development. *"We said, why don't we try it in schools? The schools have got the biggest population of the youth, and these youth are at a very dangerous age so far as sex is concerned."*

A national AIDS Drama Committee was established, and the authors worked first on *The Riddle*, for young children who were not yet sexually active. *The Hydra* was more ambitious, aimed at older children, many of whom are sexually active, and because they were older needed a stronger story. Kiyuba Musisi believes that the play has to grip the audience before it can give an effective message. *"We want something hidden so that by the end of the play we are getting someone to wear a coat without them knowing."*

One or other of these plays has probably been performed or seen by most children in Uganda and their parents. The scripts turned out to be highly adaptable across regions.

How AIDS was tackled in Ugandan Facts for Life

Nobody can doubt the commitment and scale of the effort in Uganda to alert the population, and young people in particular, to the dangers of AIDS. The efforts have full government backing and have shown that Ugandan people have a flair for creativity and innovation. Much has also been done in trying to create a climate of compassion, where the fear is taken out of AIDS. People

(continued on page 132)

People with AIDS

There are areas of western Uganda where AIDS is so common that funerals have to be staggered. In other areas, people do not connect AIDS with their lives. One way of spreading awareness in remote rural areas is through village meetings.

In Ssango village primary school, the children are outside looking in through the window while their parents line the school benches. The head teacher, Matia Tula-Biddaawo, talks about Slim (AIDS). The discussion is vague and academic, and a number of theories are aired.

Then, without preamble, the first of four young people visiting from the People With AIDS organization begins to speak.

Lubkiama Mayanja, now 25, left school in his teens and joined the army. "After battle we used to go after women and girls. After the war, I went back to school but continued my previous ways with girls. My mother persuaded me to go for a blood test because we wanted to get a passport so we could travel and trade in fish. I was taken to a little room, and the lady told me that my blood test showed I had the virus. I was so shocked I didn't see any value in life any more. She discussed how to keep myself healthy, and to stop drinking and stop smoking. She told me not to have sex except with my wife and then to use a condom. I now teach other people. I will continue to work. I am still young. I love to live. Go and tell your children." The atmosphere in the classroom changes. The academic discussion is over. Every adult sits forward, straining to hear.

Seventeen-year-old Nalumansi Sarh had almost completed her schooling when her parents sent her to look for a job. She wanted to be a nurse, but her sister told her she could earn more if she took up with a sugar-daddy. "If you eat rich man's food you must pay for it. When I was having sex with him I found his body was full of rashes. When the family found I was infected they took me to Kampala and deserted me."

PETER McINTYRE

The People With AIDS group at Ssango village school, Uganda.

Florence Naga, 26, joined the army and married a soldier. She left the army after having a baby, but her baby was sick. She discovered her husband had another wife who had AIDS. Her husband said the rashes were mosquito bites and drove Florence out of their home, accusing her of witchcraft. Although HIV+ for five years, Florence looks well. She says: "Some of us with AIDS look just like me. I could come here and look for a husband. Don't trust anybody except yourself."

These young people now tour communities telling them about AIDS. Many village women in the meeting are crying. Florence tells them: "Most of us, we are dying of ignorance. We can stop this thing but not if we keep on believing it is witchcraft."

Extracts from Ugandan Facts for Life
Questions about AIDS, HIV and sex

Q: Is it true that to get AIDS one must be involved with many sexual partners?

No, a single sexual encounter can be enough to pass HIV to an uninfected person. The risk of getting HIV through unprotected sexual intercourse increases:

- *The more partners a person has sex with.*
- *With the presence of blood during sexual intercourse, (due to sores, menstruation or abrasive sex).*
- *With the presence of other sexually transmitted diseases in either partner.*

Q: Is it possible to tell who has HIV or AIDS by their hairstyle or their clothes?

No, many people have HIV in Uganda, and they wear different types of clothing. Anybody, irrespective of what they wear or how they look, can have HIV. One infected partner is enough to transmit HIV.

Q: How safe are condoms?

Today's modern condoms are as reliable as any man-made product when they leave the factory. But if they are not correctly stored or correctly used, they may not protect a person completely from AIDS, other sexually transmitted diseases or unwanted pregnancy. Correct use of condoms includes:

- *Always checking the date of manufacture. (If it is less than five years since manufacture, the condom should be okay.)*
- *Keeping a good number of condoms at hand.*
- *Keeping condoms out of direct sunlight and in a cool place.*
- *Using the condom for only one sexual act.*

(continued from page 130) are strongly encouraged to care for relatives who are infected and are assured that they are not at risk from doing so. The public campaign tells young people that they can only be safe from AIDS if they have one sexual partner for life and that both partners to a marriage have an AIDS test beforehand. However, this approach will not provide a solution for all young people. The average age of first sexual experience in Ugandan society has been as low as 14, although one of the aims of the programme is to raise this to 17 or 18, and effort is going into campaigns to protect children from exploitative adults.

The range of risks varies in Uganda as it does elsewhere, depending on the number of sexual partners, sexual practices, and whether couples always use a condom. There is a need to help everybody to learn not only the dangers, but also how they can reduce their risks of infection and how to talk to each other and negotiate emotional and physical relationships.

The Hydra has been seen by hundreds of thousands of people in Uganda, since almost every secondary school entered a competition and performed the play for parents. However, all the sexual relationships in the play are exploitative — young women or men being sexually attacked and harassed by older people. The play does not address sexual relationships between young people who are boyfriend and girlfriend. The challenge for health education efforts in Uganda is how to put up a second line of defence against AIDS, by promoting risk reduction, in order to protect the majority of people, those who have more than one sexual partner in their lifetime.

It is now possible in Uganda to advocate the use of condoms and to distribute them. In November 1990, President Yoweri Museveni signalled an important change in approach. He advocated monogamy within marriage as the most effective way of halting AIDS, but said he could no longer put the nation at risk by discouraging the use of condoms.[3] President Museveni has visited villages in highly infected areas to press people to change their lifestyles and customs. One custom is that when a man dies, his brother takes over his wife — a very efficient way of spreading HIV. The president has suggested that a man supports his brother's wife financially but does not have sexual relations with her. Condoms are available in Uganda at a price, although the number in circulation would be far too few, if they were universally used. In *The Hydra*, the condom puts in an appearance as a dangerous 'toy'. Student teachers, in a discussion after their performance, highlight negative aspects of condoms — saying that they are not 100 per cent reliable, and discarded condoms can be a risk to children.

However, the team preparing the Ugandan edition of *Facts for Life* won

agreement from all those involved, including the Ministry of Health, to address the pros and cons of condoms openly. Stress is placed on storing and using condoms properly, and their role is promoted in marriages where one partner is infected. The Ugandan version contains 16 pages of information about AIDS, with a variety of messages. Launched in 1993, this chapter is commendably open and a valuable source of information. This approach might not have been possible if the edition had been published two years earlier. However, UNICEF Uganda has shown that it is possible, with care, planning and cooperation, to publish a frank and useful chapter on AIDS without putting alliances at risk.

Monitoring and evaluation

Monitoring and evaluating the quality of work on sexual matters will involve many of the same steps as any other topic. However, it would also be helpful if those who are devising a strategy to prevent the spread of AIDS and other sexually transmitted diseases carry out an audit of the topics being covered and how they are being dealt with, in which case some of the following questions may be useful.

1. *What information is it be desirable for men, women and young people to know?*
2. *Of these topics, how many are fully dealt with in the national version?*
3. *Are there any persuasive influential figures who could become allies in pressing for more openness on these issues?*
4. *Are there any NGOs who could present issues omitted from* Facts for Life*?*
5. *Are there innovative ways of reaching target audiences, (e.g. radio programmes for young people) which may be able to address these issues more openly?*
6. *If some issues are not being raised at all, is there a plan of action for trying to change circumstances so that they can be raised?*
7. *Are accurate figures being kept of the cost in human lives of AIDS and other sexually transmitted diseases?*
8. *Are the broad social costs being collected and talked about (the economic costs etc.) so that a broad alliance can be created who want to tackle the issue?*
9. *Are people who want condoms able to get them at an affordable price?*

1. *Support to Basic Education in Uganda through Families-Orientated, Community Action Link Project.*
2. UNICEF *Annual Report* on Uganda, 1992.
3. *The New Vision*, 15 November 1990.

13. Evaluation — Can We Do It Better?

A survey[1] carried out for the Development Communication Round Table on the attitude of decision makers on communication for development found, among other things, that:

- Decision makers were unanimous in regarding communication as essential for successful development programmes. However, communication is given relatively little importance when resources are allocated.
- Most development agencies have policies to promote participatory communication but there is a perception that they are not succeeding to the extent they would like.
- Lack of evidence of the impact and cost-effectiveness of communication is considered a major weakness. Decision makers want impact evaluation.

The survey found that most decision makers regard communication as vague and ill defined, and that many middle-level and technical staff dispense with it when resources are short. It suggested that the only way to convince decision makers to devote additional resources to communication was to provide evidence of impact and cost-effectiveness, through short descriptive case-studies and innovative evaluation methods.

It is clear from the results of this survey, and the lack of immediate evidence of effectiveness, that almost everybody is in the same boat. Everyone wants to evaluate their efforts, and show the benefits of effective communication, but they do not know how. It follows that efforts by those working with *Facts for Life* to assess success and failure is of great value not just to UNICEF but to everyone who has a commitment to participatory development.

We have tried in this survey of issues raised by *Facts for Life* to suggest ways in which work can be monitored and evaluated. Most chapters contain a section on evaluation, because it is important that this be planned alongside the initial work, rather than tacked on afterwards.

Evaluating communication is a complex issue. On the one hand, we say that effective communication is often the missing link that leads to programme

initiatives breaking down. On the other hand, we are never sure what it is fair to measure. Do we judge the success of *Facts for Life* by a decline in the infant mortality rate, by an increase in parental knowledge, or by a change in the way that outside agencies approach communities? We are often only able to say that effective communication has succeeded in raising awareness, and increasing levels of knowledge, and this is not enough if we are thinking of communication that leads to behaviour change. Our challenge is to document the incremental changes that enable us to say that we know that if communication is effective then there will be measurable real life improvements in the conditions of women and children.

When this review of *Facts for Life* was being planned in Amman in 1992, Ed Lannert, then UNICEF Middle East Regional Director, talked of his concern about whether there was enough reflection before action. *"In some places we have rushed to prepare messages and we have not given sufficient time to the survey work that is necessary for testing messages, for finding out more about audiences and for setting objectives that can be measured later in the programme. There has been a lot of motion, but if you ask what have we learned out of this, you come up with big question marks. We have to ask what have we learned about communicating to people to change their attitudes/processes, and how can we strengthen the monitoring and evaluation component."*[2]

On the part of communication officers there has been frustration because evaluation too often becomes a question of how many leaflets and books have been printed, how many workshops have been held and how many column inches of publicity have been gained. Nurper Ulkuer, Education Officer in Turkey, said she would like to see outcome targets at the start of every programme. *"We talk about how many versions and how many copies we have produced, but we need to be able to measure the impact. Unless there are clearly stated objectives and monitoring indicators for assessment, it is not easy to assess what we have achieved and how well we have achieved it. We disseminate knowledge, yet are not always sure we are on the right lines when it comes to changing attitudes and practices. We are assessing learning achievements and attitude changes but UNICEF objectives just refer to the number of copies printed. It says 10,000 should be printed and 22,500 have been, so I have exceeded my mission!"*[2]

We need to meet the concerns of managers and decision makers and to show that communication increases the effectiveness of programmes, without over-simplifying. The chain between effective communication and success is a complex one, and there are many other factors involved in a successful programme. We need the confidence to say that effective communication is essential, without making insupportable claims that x amount of communication = y lives saved.

Proving the value of communication

"We are being asked to provide proof of the value and impact of communication, for it is not being accepted at face value as a good thing that automatically merits the investment of resources, as is, for example, basic education. Yet education and communication are both difficult to evaluate in terms of impact and precise cost-benefit ratio. We are going to have to be far more meticulous about evaluations in the future, and develop innovative evaluation methods."

From *How Decision Makers See Communication for Development*, by Colin Fraser, 1994

Why people act

It appears that in order for a person to perform a given behaviour, one or more of the following must be true:

1. *The person has formed a strong positive intention (or made a commitment) to perform the behaviour.*
2. *There are no environmental constraints that make it impossible for the behaviour to occur.*
3. *The person has the skills necessary to perform the behaviour.*
4. *The person believes that the advantages ... outweigh the disadvantages, in other words a positive attitude towards performing the behaviour.*
5. *The person perceives more social pressure to perform the behaviour than not to ...*
6. *The person perceives that performance of the behaviour is more consistent than inconsistent with his or her self-image ...*
7. *The person's emotional reaction to performing the behaviour is more positive than negative.*
8. *The person perceives that he or she has the capabilities to perform the behaviour under a number of different circumstances ...*

The first three factors are viewed as necessary and sufficient to perform the behaviour. The remaining five influence the strength and direction of intention.

From *Developing Effective Behaviour Change Interventions: Some Lessons Learned from Behavioural Research*, in Research, monograph series of the National Institute on Drug Abuse, 1995, Martin Fishbein, University of Illinois, Champaign-Urbana, USA

What can we fairly expect from evaluation?

One of the most important questions is to decide what it is that you want to measure. Nagwa Farag, Communication Officer in Egypt said: *"Safe motherhood involves six, seven or eight messages, and the impact is too remote to measure the effect. We develop a counselling techniques package. We provide a video and booklet and we train physicians to communicate with the mothers. We observe how they are doing counselling. We may say they have improved the way they explain, and the time they give and the words they use. I don't think we can go further than that. It is not even certain that because the mother now washes her hands the child will not get diarrhoea. Where does the mother see the consequences of the new methods? What we are doing is only part of what is happening in society. The agricultural system in Egypt has been going for 8,000 years. I cannot change it with a few TV spots."*[2]

Dr El-Fathih El-Samani, Senior Health Adviser to UNICEF in the Middle East and North Africa region, said: *"Measuring impact is one of the most complex aspects of evaluation. It is difficult to measure impact on people because there are many sources that influence behaviour, and we are just putting in one factor. So we look at indirect indicators. How many people did you train? How many trainers are now in the field? These can be used as a proxy."*[2]

Dr Suomi Sakai, Health Programme Officer in China, said: *"At some point you have to take a leap of faith. Even sophisticated statistical models are said to be able to explain perhaps 20% of what is happening with health status. The other 80% is a leap of faith. You have to evaluate whether people did the training correctly. 'How' is as important as 'how many'."*[2]

Evaluations do not have to be complex in order to be meaningful. We can reasonably expect only *some* information about accomplishments and challenges and determine *some* strategies that will lead to improvement, such as training, skill-building, planning, or knowledge. The degree of certainty with which an evaluation will provide this information will depend on: the extent to which evaluation is built into a programme from the start; what questions you ask; how you answer them; and the number and characteristics of the people involved in the evaluation process. Evaluations may not always tell you what you want to hear, but even negative information is useful since it tells you what not to do the next time.

Tony Hewett, during his time as Programme Communication Chief in New York, said it had never been intended to isolate the effects of *Facts for Life* from the work of sectoral programmes. *"Our ideal would be to see* Facts for Life *disappear into all the sectoral programmes, and at the same time to see the sectoral programmes*

acknowledge that Facts for Life *and communication had played a role. We have no desire to chase after the nutrition person and say 'How much of this change did FFL create?' The idea was to be helpful, to improve the effectiveness of programmes, not to impose demands."*[2]

From this discussion, it seems we should be careful to distinguish between the different kinds of things we may seek to evaluate. A programme based on *Facts for Life* messages can be evaluated at several different levels. The first level, commonly referred to as process evaluation, focuses on assessing the programme itself.

- We can measure activity: so many column inches, so much air time, so many leaflets printed. These things are a kind of guide to how energetic we have been, and they may show that we were successful in persuading journalists to write about child issues or about UNICEF. They do not show the quality or effectiveness of this energy.
- We may also measure internally how well and to what extent *Facts for Life* has been integrated into the work of a UNICEF office. Here we are interested in discerning where implementation may differ from initial plans and the amount of adaptation that may have taken place.

At a second level, one can assess the effectiveness of a programme along three dimensions, each interrelated to the other.

- We can measure changes in knowledge and understanding linked to communication activities (although we cannot isolate *Facts for Life* messages, per se, from other factors).
- We can measure changes in health-related practice and may be able to attribute some of this to effective communication. Again, it is the comprehensive communication programme strategy in which *Facts for Life* is a component that must be evaluated, not *Facts for Life* in isolation.
- We can also measure changes in health outcome; although attributing such change to a particular intervention strategy, such as communication, is often very difficult. It is more common that different evaluation approaches enable us to document the contributory role that communication has made in the measured changes.

Attempting to attribute changes in a population to *Facts for Life*-based communication requires evidence; but this does not mean that programme work should cease until the evaluation has been completed. On the contrary, we are interested in obtaining proof in a feasible manner that does not presuppose unrealistic levels of financial and human resources. For example, evaluation can be successfully undertaken during a face-to-face communication

Feedback in Myanmar

Facts For Life questions are included in the nationwide Buddhist theological examination, the Mingala Sutta in Myanmar. An evaluation revealed:

- *the need to strengthen the training of those who teach theological students, with classes that focus on this material for those taking the exams;*
- *the need to reach other target groups, including other religious groups and mothers;*
- *the need for separate exams for younger students, to give them a chance to shine and to win prizes.*

A review of national adaptations and their usage recommended: regional adaptations including extra topics such as the environment, women's and adolescent health, food for the family, hygiene in food preparation and consumption, girls' education and health messages for young people, including a FFL flip chart, videos and a pamphlet with the 10 key messages.

Myanmar attempted to obtain some direct feedback on Facts for Life by including a reply coupon in every copy, asking: 'What is your opinion of this book? How would you effectively disseminate the information in this book to your field of work?'

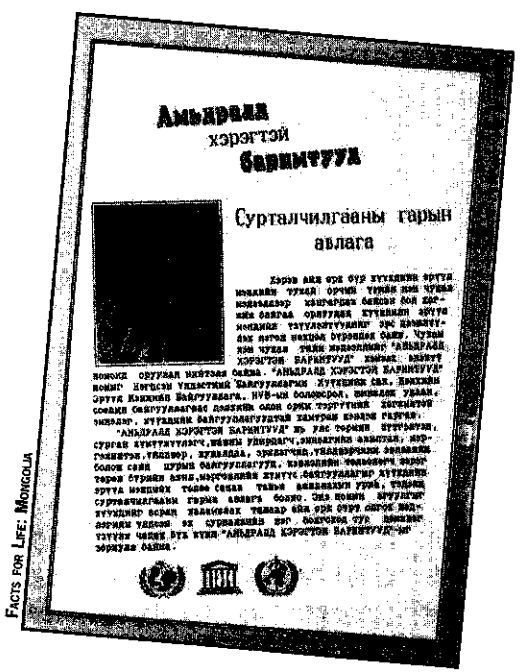
A small prize was offered for the best 10 replies. Over 8,500 coupons were returned.

Planning monitoring and evaluation

UNDP guidelines for communication support identify the need to formulate the following questions:

- *What should be achieved? (success)*
- *What will be accepted as evidence of success? (indicators)*
- *What information is needed to produce this evidence? (data)*
- *What sources of information are to be used?*
- *How is data to be collected?*
- *What tools and instruments will be used?*
- *Who will carry out these activities?*
- *Who will use the information obtained?*

Guidelines for Planning Communication Support for Rural Development Campaigns, UNDP 1984



activity by asking some specific questions such as:

- Is the information valuable to you?
- Does the information make any difference to your life?
- Do you find the information helpful or useful?
- What will you do differently?
- What will you do the same?

These questions can be followed up at a later stage by asking:

- How have you used the information you were given?
- What are you doing differently now in your life?
- How have you passed this information on to other people?

Building evaluation into programmes

Programme planning will benefit from the following central questions of evaluation: (1) what are the essential purposes, goals and objectives of the programme? and (2) what measurable change(s) will tell you whether you have achieved your goals and objectives?

The concept and planning of a programme will often suggest how evaluation can be used to verify the assumptions on which the programme is based, to check for expected outcomes, or to explain programme successes and failures.[3]

For example, you may find that health workers request training in how to communicate information on birth spacing. Before developing a programme, you can gather baseline data to assess the nature of information among health workers, and the nature of their communication skills. You might ask how the beneficiaries feel about health workers' communication. You could decide with the heath workers which skills would benefit from training. If objectives and goals are not being met, evaluation can help determine what changes need to be made, or whether goals and objectives need amending. Before starting an evaluation it is useful to:

- identify who has a stake in project outcomes ('stakeholders'), why they want an evaluation, and how they will use the information gathered;
- clarify long- and short-term objectives of the programme;
- make sure they are measurable (i.e. define goals and objectives);
- gather baseline data to clarify the context and situation before a programme in order to assess if there is a change afterwards.

All parties who have a stake in the project, including beneficiaries and participants, should be involved in planning the evaluation. Ideally, questions

should be based on what will be useful for them. Since stakeholders are likely to have different concerns, it is important that there be agreement about what to measure, when and how often to measure, and what the criteria for change will be. Setting short- and long-term objectives will help determine time-frames for evaluation and monitoring.

Planning evaluations for programmes already in progress

Evaluations that are planned midway through a programme must retroactively answer some of the questions above. What did you assume were the needs, and what difference did you think each step of the programme would make to meet these needs? If you plan an evaluation after you have introduced FFL, you will not have the baseline information to determine whether knowledge actually increased. A solution might be to compare the level of knowledge in a similar community that has not been exposed to FFL messages.

What kinds of questions should be asked?

Evaluation should only collect information related to important programme objectives, since resources are often limited. You need to know what you will do with the information you get. Evaluation should contain the questions that will and can be used by stakeholders to shape and sustain programmes, or influence policy. If information will not result in action to support and improve programmes, there is little reason for collecting it.

Quantitative approaches are better at clarifying exactly what happened, while qualitative methods can help understand why they happened. If you want to generalize from your evaluation, you need to make sure that the group you are studying is representative of the larger population.

Who should be involved in evaluating?

Effective evaluation needs the participation of those involved in the programme, including staff and beneficiaries. The ideal is to encourage all stakeholders to reflect critically about and respond to their own roles in the programme process. This participatory style of evaluation improves communication between people, promotes commitment to goals and fosters a sense of collective responsibility. It is easier to incorporate findings into programme strategies if all those who have a stake are involved in planning, implementing and interpreting the evaluation. They will become more motivated to create change when they become involved in identifying their problems, developing strategies to solve them, and assessing whether their approaches are working. (If an external evaluator is involved, this person should act as a facilitator and should not dominate the process.) In any event, findings should be reported back to stakeholders, who will be able to suggest how new information can improve

China: Raising the levels of skills

China's characteristics are its size, diversity, isolation in recent history, autonomy of subnational administrative units, and vertical sectors. There are 1.1 billion people with 24 million newborns every year, 55 minority ethnic groups, most with their own language and many with distinct dialects.

There are 30 provinces, with 3,000 counties; 60,000 townships and 750,000 administrative villages. There are 4m village doctors and health workers, and 88% of villages have some sort of health worker.

UNICEF has concentrated on poor remote rural areas. The average infant mortality rate is about 40-50/1,000 but there are regions where it reaches 100.

Figures from 300 less developed counties show that 81% of infant deaths occur at home or on the way to a health facility, and half the children received no treatment in the 24 hours leading up to death.

The technical branch of the All-China Women's Federation studied the impact of FFL on parents' knowledge in two rural and one urban area. All the studies showed a marked improvement in knowledge and behaviour.

What outcomes should be evaluated?

Dr. Suomi Sakai, Programme Officer for Health, said: "Our counterparts have been eager to go all the way to measuring mortality statistics in one or two years. We think we should concentrate on knowledge, attitude and practice, to set more realistic and appropriate objectives for evaluation."

How should the process be evaluated?

Dr. Sakai: "There is a tendency to measure how many people have been trained and how much material has been produced. We need to stress the importance of measuring how much people understand and remember the quality, not just the quantity.

What methods should be used?

Dr. Sakai: "We want to use a mix of quantitative, semi-quantitative and qualitative methods. We are trying to build the capacity of the counties to do this kind of study."

Evaluating awareness in the Philippines

The Department of Health conducted a survey of health reference works used by staff at health centres. Facts for Life was in the top three most commonly used reference works. The others were a family health guide and a household consumer manual.

The Philippine Information Agency (PIA) carried out an evaluation of Facts for Life, based on the knowledge, attitude and practice (KAP) of mothers of children aged 0-6, in the area-based child survival and development programme. The knowledge ratings were in general quite high: 70% of mothers knew they should attend antenatal clinics, up to 80% knew they should be immunized against tetanus. 96% of those who had attended would continue to attend check-ups. Only 35% would give oral rehydration if their child had diarrhoea, but 55% were aware of the causes of pneumonia and coughs and colds.

The survey showed that as many as 11% of mothers were aware of Facts for Life as a book or campaign or a series of messages.

This was felt by some of the PIA team to be a disappointing result, but the visibility of Facts for Life as an identifiable package is not the important issue for mothers. Their knowledge of the causes of childhood disease and their ability to take steps to avoid it are the critical factors.

Setting targets in Turkey

The Turkish Government and UNICEF set goals for 1991-95, against which programmes will be evaluated:

- *to reduce infant mortality by a third (by 2000);*
- *to reduce maternal mortality by a half;*
- *to reduce severe and moderate malnutrition;*
- *to ensure universal access to safe drinking water and adequate sanitation;*
- *to ensure universal access to basic education and completion of primary education by 80%;*
- *to reduce adult illiteracy;*
- *to provide improved protection for children in difficult circumstances.*

the programme, and help mobilize their communities to create the change needed.

Precise questions in evaluating Facts for Life

Before planning your evaluation, you should answer as many of the following questions as possible:

- What problems of the community is your programme meant to alleviate? Who defined the problem?
- Is the objective to enhance services, increase knowledge, enhance skills, change behaviour? Who is the audience?
- What are the stated or unstated assumptions of the programme?
- Where are you now in your programming phase? Where will you focus your evaluation?
- Who has a stake in the evaluation? Who will use its results? What difference will it make?
- Is the evaluation to be of process or outcomes?
- What is the purpose or objective of your evaluation? What information is needed?
- What will be the scope of the evaluation?
- What resources/skills are available to help you evaluate?

Once you identify who will use and help the evaluation, you can bring together a group to identify indicators that reflect underlying concerns and that will measure programme progress. However, you must be able to compare findings to some pre-set criteria, such as the programme objectives, baseline information, earlier achievements, other programmes, or national goals and objectives.

Evaluating the use of Facts for Life in a country office

In 1990, following a New York meeting that examined the first year of *Facts for Life*, the late UNICEF Executive Director, James P. Grant, sent out a challenge to country offices *"to review what has been done — or what may need to be done, to make the best use of this initiative within your country programme of cooperation and as part of your annual workplan."*[4] In an accompanying report,[5] the objectives of *Facts for Life* were outlined as:

1. To increase and maintain the involvement of allies, partners and communicators in promoting child survival and development (CSD) actions and advocacy for children, especially those from the most underserved and hard-to-reach groups.

2. To increase the knowledge and participation of communicators in CSD issues and concerns.
3. To support sectoral programmes in influencing and sustaining behaviour to achieve child survival and development goals for the 1990s.

The report gave a checklist of points, each of which ended with questions for self-monitoring. These questions are reproduced here. The earlier questions are more useful at the start of the process. Many country offices will by now be looking at the later questions, such as those under point seven, which concentrate on outcomes. However, even those who have made considerable use of *Facts for Life* can mentally review earlier questions. A more formal approach may be useful to assess the relationship between communication and programmes in a country office.

Process questions

1. Integration into country programme

a) Does FFL have clearly defined objectives and a workplan?

b) Does FFL have its own budgetary allocation?

c) Are all UNICEF staff familiar with the concepts of FFL and aware of its purpose and scope?

d) Are all UNICEF programme staff involved in some way in FFL implementation?

e) Is there a focal point within the office responsible for coordinating FFL activities?

f) Has FFL been taken account of in the Situation Analysis?

2. National ownership

a) How is FFL integrated into the policies, programmes and activities of national institutions and organizations (both governmental and non-governmental)?

b) Is FFL being implemented within an overall administrative framework (eg. a national committee or task force)?

3. Analysis, baseline research and strategy formulation

a) How has the office assessed strengths, weaknesses and potential roles of partners in the implementation of FFL?

b) How have the information and communication networks within the country been documented and analysed?

c) What are the KAP findings on FFL messages of health service providers, non-health communicators, mass media professionals and the target audience?

d) Does it address the important needs of a community?

e) What is the overall strategy for implementing FFL, including identifying partners, selecting communication channels, time-frame, scale, and linkages with training and service delivery?

Ghana: Who are the communicators?

Even before Facts for Life *was published, communication staff in UNICEF Ghana were grappling with communication issues. Arthur Tweneboa-Kodua, Programme Communication Officer, describes the process. "In 1987 social mobilization activities in Ghana were fragmented and we were not getting the impact we wanted. We planned a study with the guiding principles: keep it simple, do it fast, make it relevant and keep costs down."*

The three objectives were:

1. *Identify individuals, institutions and organizations in rural and urban areas with greatest potential as health communicators.*
2. *Assess the support they needed, to maximize their potential as health communicators.*
3. *Identify strategies to involve them in promoting maternal and child health.*

- *Every programme officer interviewed potential allies, including government ministries, youth and women's movements, religious groups, the commercial sector and prominent individuals.*
- *A communication researcher analysed the radio, TV and the press, set up focus groups and carried out interviews with 130 media professionals.*
- *An anthropologist surveyed 480 mothers and 240 fathers with children under the age of five and interviewed people with potential to be health communicators: teachers, religious leaders, women's leaders, agricultural officers, herbalists.*
- *The UNICEF programme officer and a communication researcher interviewed 370 mothers about immunization.*

The conclusion was that there was an enormous untapped communication capacity in Ghana, and a need for information and training.

Facts for Life was introduced at this point. The Government and NGOs decided that the Ministry of Social Mobilization rather than the Ministry of Health would take the lead.

Baseline study in South Africa

In 1992, a baseline study in Natal, South Africa, showed the scars of racial funding for health, education and welfare, in a system where the Government kept records of deaths of animals, but not of deaths of black children.

Baseline research for Facts for Life was carried out by the Centre for Social and Development Studies at Natal University. Researchers looked at a rural village without electricity or water; a squatter camp with a rudimentary infrastructure and an urban township. Among the findings were the following:

- Facts about safe motherhood were known by a majority of women, but not implemented because of lack of finance, and lack of support;
- Mothers knew that 'breast was best' but did not know why. Half the sample breastfed for less than 10 months, and half would stop if they had the money for bottles and powder;
- 40% of households in the peri-urban area had a child ill with diarrhoea in the preceding month. Most believed that food and liquid intake should be reduced when a child had diarrhoea;
- People were aware of the need for hygiene, but few had an opportunity to practise what they knew. In rural areas, 92% used the river as their main water supply.

Suggestions for building on this research included:

- Gathering statistics on why children are dying, and presenting these back to the community, so that people feel that their problems are being approached;
- Isolating those moments when people are most receptive to information on nutrition or safe motherhood (e.g. women when they are pregnant);
- Using rapid assessment to look at the credibility of different types of communicators;
- Capacity-building among NGOs;
- Monitoring changes in beliefs and knowledge.

4. Preparation of materials

a) How has a national consensus of the contents of FFL been achieved?

b) In what ways have local partners, as well as health and communication experts, been involved in adapting FFL for local communities?

c) How are local communication agents and the mass media involved in 'transforming' FFL messages for particular target groups.

5. Implementation of FFL Communication Strategy

a) What materials have been produced, in what quantities, and for which audiences?

b) To whom have these materials been distributed, and in what quantities?

c) To what extent, and how, is the target audience exposed to FFL messages?

d) What is the frequency, volume and timing of radio and TV broadcasts incorporating FFL messages?

e) What special events promoting FFL have been organized, by whom, and who have they reached?

f) How many meetings have been held, and with whom, in planning and managing the implementation of FFL?

g) How many FFL orientation and training meetings or workshops have been held, for whom, and what topics have they covered?

h) How many meetings etc have been targeted on beneficiaries?

i) What kind of face-to-face communication efforts have incorporated FFL?

6. Monitoring system

a) Is there a monitoring and evaluation component in the FFL workplan?

b) How frequently are meetings held to monitor the process of implementing FFL?

c) How is the feedback on the implementation of FFL obtained from partners, communication channels and the main target audience?

d) What use is made of the results of monitoring and evaluation?

Justification (ie. outcome + impact + cost-effectiveness)

7. Outcome analysis

a) What increase (or decrease) has occurred in the number and range of allies, partners and communicators involved in promoting CSD actions and advocacy for children?

b) What changes have occurred in the knowledge and participation of communicators in CSD issues and concerns?

c) What arrangements have been made to evaluate the impact of FFL messages on the KAP of the target audience (parents and other child caregivers)?

d) How do the participants feel about the programme/its services?

e) Has the programme met its objectives?

To these original sets of questions we might add:

8. To determine the impact on behaviour

a) How does the progress of programme participants compare to their pre-programme knowledge/behaviour? Is there a difference or change?

b) How is the programme area or its participants faring in comparison to either a non-programme area or non-participants?

c) What is the impact of the programme on the lives of participants?

d) What are the unintended effects of the programme?

e) What are the consequences for communities and institutions?

f) How many people benefited?

g) What contribution did the programme make?

9. To determine programme sustainability

a) Is the programme compatible with national development goals and objectives?

b) Is there policy support for it?

c) Are its objectives socially acceptable?

d) Are there sufficient funds for the programme to continue once the current donor terminates grants?

e) What are the incentives for staff to continue working?

f) What are the long-term and short-term benefits for participants?

g) Will results remain over time, and can they be multiplied?

h) Who is not being reached? How can programmes be extended?

j) What strategies work, and can they be replicated?

k) Is the programme flexible and adaptable to different contexts?

10. To determine cost-efficiency

a) What is the financial cost of the programme, including inputs from international donors, national and local governments, and NGOs?

b) What are the inputs from the community, such as labour, technical know-how and materials?

c) Do beneficiaries contribute payment for services?

d) Are the stated objectives of the programme being met in a timely manner with the human and financial resources at hand? (This is a measure of cost-effectiveness: whether you are meeting your goals with available resources.)

Egypt: Testing the communicators

A baseline study on communicators was carried out in Egypt "to find where various groups placed children on their agenda, how much they knew, what knowledge they wanted, and what they knew about women's issues and UNICEF."

One thousand individuals — health educators, mass media professionals, public figures, religious leaders and NGO representatives — answered a questionnaire about their major concerns, child-related issues and UNICEF. Each group put the economic situation and the population explosion at the top of its list. Mother and child care was hardly mentioned unprompted.

When prompted, mother and child care was placed sixth in order of importance behind inflation, population growth, debt, health and pollution, but ahead of illiteracy, the status of women and fundamentalism. Overall, 57% said they thought that child care was a very important problem in Egypt, and 65% said they were involved in communication related to child care.

Lack of information, lack of funding and illiteracy were named as the most common obstacles preventing more effective communication.

The survey asked these educated respondents whether they knew what UNICEF stood for. Forty-eight per cent knew it was the UN children's organization, while another 10% connected it with the UN or with children. There was a small but significant confusion with UNESCO, while 22% of respondents did not know. Among wild answers were 'medications', 'antibiotics' and 'a magazine'. Few respondents could name any of UNICEF's activities in Egypt.

Following this survey, intensive efforts have been made to target the media with information about women and children and the work of UNICEF (including Facts for Life) and, as the media chapter shows, there has been a significant increase in media coverage.

Rapid assessment procedures

Rapid assessment procedures (RAP) began in the 1980s and are now well used and well documented. RAP came out of a frustration with long-term academic studies used in traditional research that reported long after people had put plans into effect. There was a dichotomy between the work of academics, who were studying what people did and why they did it, and the work of programme people, who were trying to make an impact on these things.

RAP is an attempt to strike a balance between speed and comprehensiveness so that programmes can be implemented on something more than the basis of hunch, prejudice or anecdote. It is a qualitative assessment aimed at improving the planning and evaluation of health-related interventions, recognizing that community participation in programme planning needed new tools.

Michael Cernea, Senior Adviser on social policy at the World Bank, illustrates the creative way in which research can be conducted, by citing his favourite question: "When a family's hut and crops happen to catch fire and burn down, how does the village help out that family?"[5] Through this question he learns about traditional obligations, social structures and networks.

Bjorn Ljungqvist, Senior Programme Officer at UNICEF Kampala and previously Programme Officer in Tanzania, uses similar questions. In a paper,[6] he says: "For example, looking at the mother and the child in Rukungiri. How does she manage to meet the basic food, care and health needs of herself and the child?

"What happens during times of stress? What is the role of the neighbours and the relatives? What are their sources of information, their understanding of the problem, their resources and their social obligations? "

(continued on page 145)

e) *Are there programme areas that were inadequately allocated or over-allocated with funds?*

f) *Are there ways to reduce costs, while still achieving the same objectives?*

Some tools and methods to answer evaluation questions

To gather information from participants, you can use the following strategies:

a) *Interviews are useful especially with people who are not literate. These can be with individuals or with focus groups, community meetings or small group meetings. Group settings with open-ended questions are useful to promote dialogue and generate solutions.*

b) *Written questionnaires, filled out by participants can test skills, awareness, beliefs. One advantage is that people can fill them out at their own pace, in their own time. A disadvantage is that written questionnaires do not allow people to clarify questions, and cannot be used where literacy is low. Questions should be devised with the help of beneficiaries and/or partners.*

c) *Observation of practices and relationships. Observers must understand what they are looking for, and have the consent of those observed. The major disadvantage is that when people are observed their behaviour changes. If you have an opportunity to observe through repeated visits, take it.*

d) *Analyse health or medical records to monitor change without relying on self-reports. Keep in mind e.g. the identity of the person who made the recordings, and why they may have identified what they recorded. Height/weight measurements are useful in monitoring nutrition status.*

e) *Informal questioning of participants, gathering information during informal conversations, or visits.*

f) *Creative expression, such as drama, songs, or dance to bring out experiences in ways which might not otherwise be revealed.*

g) *Mapping. Participants can map social organization, availability of services, a community's physical layout, or resources. Maps differ depending on who makes up the group.*

To gather information about how the programme is working, you can use other techniques in addition to those above.

a) *Analyse programme records, financial reports, plans, minutes of meetings. These tell you what actually happened in a program, as opposed to perceptions of what happened. Keep in mind who recorded it and for what purpose.*

b) Case studies that detail events or programmes and provide information about what worked or did not work in a particular context.

c) Rapid assessment techniques, which combine qualitative and quantitative approaches to gather relevant information in a short time span. You can combine any of the above strategies.

Rapid assessment procedures

(continued from page 144)

Roger Pearson, Senior Evaluation Officer at UNICEF, and Susi Kessler, former Senior Adviser to the Central and Eastern European Unit of UNICEF,[6] suggest 10 hallmarks for effective use of RAP.

1. *RAP is action oriented, geared to programme improvement and decision making.*
2. *RAP is investigative, trying to find out what is happening, and why.*
3. *RAP is process oriented, analysing not only end results but the process of getting there.*
4. *RAP is holistic, looking at situations from many perspectives, and placing problems in context.*
5. *RAP derives confidence from using a broad range of informants, policy makers, managers, service providers and beneficiaries.*
6. *RAP emphasizes 'informed judgement', by observing, describing, listening and arriving at collective judgements.*
7. *RAP is efficient, using existing data and collecting and analysing available information.*
8. *RAP uses multiple skills, bringing together experienced people from different backgrounds into a well-led team.*
9. *RAP teams include insiders and outsiders, those familiar with the project and those who can bring a fresh perspective.*
10. *RAP facilitates community involvement, through open-ended interviews, listening and learning and promoting dialogue.*

They conclude: "Resources are slim, the days are long, and issues being tackled are usually broad; mistakes are made, but usually, on balance, lessons are learned and ways are found to better the way resources are being used to benefit the well-being of children."

1. *How Decision Makers See 'Communication for Development'*, carried out in 1994 by UNICEF consultant, Colin Fraser; UNICEF document 1994.
2. *Report of Facts for Life/All for Health Meeting*, Amman, Jordan, UNICEF, 1992.
3. *An Approach to Evaluation for Breastfeeding Campaigns*, Working Paper No 123. Robert Hornik. Annenberg School for Communication, 1986.
4. Letter from James Grant to Country Offices. August 1990.
5. *Report of New York Evaluation Meeting* by Glen Williams, 1990.
6. *Rapid Assessment procedures. Qualitative Methodologies for Planning and Evaluation of Health-related Programmes*, edited by Nevin Scrimshaw and Gary Gleason. International Nutrition Foundation for Developing Countries, 1992.

Appendix 1: National Versions and Translations of Facts for Life

Country	Languages	Extra features	Comments	Address
Afghanistan	Dari Pashto		Revised edition produced in collaboration with Ministry of Public Health. FFL incorporated into EduKit Project. FFL used in story-books and educational radio drama.	UNICEF Kabul c/o UNICEF Peshawar P.O. Box 1078 Peshawar, Pakistan
Algieria	Arabic		FFL adapted for Women's Literacy classes.	UNICEF Boîte postale No. 660 Alger-Gare, Algeria
Angola	Kimbundo Umbundu Kikongo		Produced in collaboration with AGIP, Italian Oil Company. FFL used in community training sessions and community theatre.	UNICEF Caixa Postal 2707 Luanda, Angola
Armenia	Armenian			UNICEF Hotel Hrazdan, 2nd Fl. Pionerskaya st.2 Yerevan, Armenia
Bangladesh	Bangla	IDD AIDS	Second edition issued 1995. Workshops for radio and television producers held in 1995.	UNICEF P.O. Box 58 Dhaka, Bangladesh
Benin	Waama, Baatonu, Yoruba, Aja, Gun, Fon, Yom			UNICEF BP 2289 Cotonou, Benin
Bhutan	Dzonghka	Leprosy, TB Child Development	National edition includes Foreword by the King	UNICEF P.O. 239 Thimphu, Bhutan
Bolivia	Spanish, Aymara, Quechua, Guarani	Paternity Sexual Diseases IDD	Armed forces adaptation integrated into military instruction programme. FFL Radio programmes and video series extensively broadcast.	UNICEF No. 10728 La Paz, Bolivia
Brazil	Portuguese		National Adaptation CFH. Training programme for radio broadcasters on FFL topics.	UNICEF Caixa Postal 08584 Brasilia, DF Brazil

Country	Languages	Extra features	Comments	Address
Burkina Faso	Moore Jula Fulfulde Gulmacema		FFL being integrated into school curricula.	UNICEF BP 3420 Ouagadougou 01 Burkina Faso
Burundi	Kirundi		National FFL and individual booklets on immunization, AIDS, diarrhoea.	UNICEF BP 1650 Bujumbura, Burundi
Cambodia	Khmer		Endorsement by Ministry of Health. FFL Calendar.	UNICEF No. 11, 75th Street Srachark Quartier Phnom Penh, Cambodia
Caribbean	English	Adolescent Life Skills	FFL messages available in comic strips/magazines/ animated videos *Safe Motherhood, The Teen Years.*	UNICEF P.O. Box 1232 Bridgetown, Barbados
Cameroon	French		FFL being integrated into school curricula. Several religious NGOs piloting FFL training for teachers and students.	UNICEF c/o UNDP P.O. Box 836 Yaounde, Cameroon
Central African Republic	French		National adaptation being developed.	UNICEF Boîte postale 907 Bangui, Central African Rep.
Chad	Arabic		Simplified version with essential messages.	UNICEF, BP 1146 N'djamena, Chad
China	Chinese, Han, Yi, Uygur, Kazak, Wa Bai, Mongolian, Dai, Jingpo, Naxi, Hani, Lisu, Miao, Korean, Tibetan, Dedai, Lagu, Xibo, Herks		Language adaptations produced by Child Development Centre. Audio versions available in Miao, Tujia, Han, Buyi and Dong. A Chinese version of *All for Health* is also available.	UNICEF 12 Sanlitun Lu Beijing 100600 China
Côte d'Ivoire	Arabic		Koranic School version	UNICEF, Boîte postale 443 Abidjan 04, Côte d'Ivoire
Croatia	Serbian, Albanian, Macedonian, Bosnian			UNICEF CSO, Savska 41/XVI 41,000 Zagreb, Croatia

Country	Languages	Extra features	Comments	Address
Cuba	Spanish	Adult, Adolescent and Family Health, Accidents	FFL television spots.	UNICEF Calle 1ra B. No 15201 esq a 152, Reparto Nautico Habana, Cuba
Djibouti	French			UNICEF PO Box 583 Djibouti, Djibouti
Dominican Republic	Spanish		Literacy materials based on FFL. FFL being integrated into primary school curricula and teacher training.	UNICEF Apartado Postal 1649 Santo Domingo Dominican Republic
Egypt	Arabic English	Bilharzia Accidents Girls' Education	FFL being integrated into school curricula and literacy training. Series of 10 children's storybooks based on FFL topics distributed to schools.	UNICEF 8 Adnan Omar Sidky Street, Dokki, Cairo, Egypt
Equatorial Guinea	Spanish		Used in community literacy activities.	UNICEF PO Box 490 Malabo, Equatorial Guinea
Eritrea	Tigrigna			UNICEF, PO Box 2004, Asmara, Eritrea
Ethiopia	Amharic Oromigna	Peace Education	Amharic edition *Children for Health* under production. Peace Education aspect developed for primary school radio education.	UNICEF PO Box 1169, Africa Hall, Addis Ababa, Ethiopia
Fiji	Fijiian Fiji-Hindi Kiribati		FFL Integrated into nurses' training courses.	UNICEF, c/o UNDP Private Mail Bag Suva, Fiji
Gambia	English		Training modules for community, government, NGOs.	UNICEF Private Mail Bag 85, Banjul, The Gambia
Ghana	English, Ga, Ewe, Fantsi, Akwapim Twi, Dagbani, Kassem		*Children for Health* being used with primary school teachers.	UNICEF PO Box 5051, Accra North, Ghana

Country	Languages	Extra features	Comments	Address
Guatemala	Spanish Huehuetenago Quiche Indigenous Languages	Cholera Adolescent Health Women's Health Home Accidents Disabled Children Environment	*Family Facts for Life* Encyclopedia is an integrated package of printed and audio materials.	UNICEF Apt. Postal 525 Guatemala City Guatemala
Guinea	Susu, Pular, Manika, NKO Alphabet for Mandinka, Harmonized Arabic Alphabet		Harmonized Arabic used as literacy tool in Koranic Schools.	UNICEF PO Box 222 Conakry, Guinea
Guinea-Bissau	Creolo			UNICEF Apartado 464 1034 Bissau Codex Bissau, Guinea-Bissau
Haiti	Creole			UNICEF P.O. Box 1363 Port-au-Prince, Haiti
Honduras	Spanish		National newspaper *La Prensa* distributed a million FFL inserts. Training for radio broadcasters. Religious organizations trained in FFL.	UNICEF Apartado Postal 2850 Tegucigalpa MDC, Honduras
India	English, Hindi, Bengali, Kannada, Malayalam, Oriya, Tamil, Talegu	Leprosy TB		UNICEF 73 Lodi Estate New Delhi 110 003, India
Indonesia	Indonesian			UNICEF P.O. Box 1202 Jakarta, 10012, Indonesia
Iran	Farsi	Farsi CFH	FFL used in literacy classes to share health information and promote gender equality. *Education for Life* project focuses on FFL knowledge, life skills and education of girls. FFL public service announcements and posters widely disseminated.	UNICEF P.O. Box 15875-4557 Tehran, Iran
Iraq	Iraqi Arabic Kurdish English	Child Labour Street Children Accidents	National edition produced with support of Ministry of Health, Education, Culture and Information, and the National Childhood Welfare Council.	UNICEF, P.O. Box 10036 Karradah, Baghdad, Iraq

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Japan	Japanese			Japan Committee for UNICEF UNICEF House 31-10 Daikyo-cho, Shinjuku-ku Tokyo 160, Japan
Kenya	Kiswahili Dholou Luhya		Facts for Life topics featured in children's magazine, *Pied Crow.*	UNICEF PO Box 44145 Nairobi, Kenya
Korea, Dem People's Republic	Korean		Emphasis on breastfeeding.	UNICEF, c/o UNDP P.O. Box 27 Pyongyang, DPR Korea
Lao PDR	Lao	Goitre	FFL activities integrated into all related programmes, particularly women's non-formal education and teacher training.	UNICEF PO Box 1080 Vientiane, Lao PDR
Liberia	English	Tuberculosis	Annual FFL Festival. Adapted version with cartoons. FFL bumper stickers popular in 'Talking Taxis' campaign.	UNICEF P.O. Box 10-0460 1000 Monrovia 10, Liberia
Macedonia	Macedonian	TB	Planning to produce a local version of *Children for Health.*	UNICEF P.O. Box 491, 91000 Skopje TFYR Macedonia
Madagascar	Malagasy	IDD	*Facts for Life* used in literacy training and as teachers' guidebook.	UNICEF P.O. Box 732 Antananarivo, Madagascar
Malawi	Chichewa		Produced as both book and individual topic booklets.	UNICEF, PO Box 30375 Lilongwe 3, Malawi
Malaysia	English Bahasa Malay	Dengue Accidents	FFL launched by wife of Prime Minister, June 1994.	UNICEF PO Box 12544 50782 Kuala Lumpur, Malaysia
Maldives	Dhivehi		Produced as booklet and individual topic leaflets.	UNICEF Maaveyodhoshuge Maaveyo Magu Male, Maldives

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Mali	Bambara, Peulh, Songhoi, Kassonke		Produced in collaboration with the National Centre for Information, Education and Communication for Health.	UNICEF BP 96 Bamako, Mali
Mauritania	Hassanya Arabic, Pular, Soninke, Wolof		FFL audio cassettes with popular music. Mauritanian adaptation of *Children for Health* under production.	UNICEF P.O. Box 620 Nouakchott, Mauritania
Mauritius	French	Alcoholism	Adaptation developed for Year of Family activities. Simplified version for out of school youth and semi-literate women.	UNICEF 4th Floor, Ken Lee Bldg. 20 Edith Cavell St. Port Louis, Mauritius
Mexico	Spanish Mixteco Zapoteco	Accidents Adult Health Working Women Summary AFH	Issued by Ministry of Health.	UNICEF Apartado Postal 10-1022 Mexico City, Mexico
Mongolia	Mongolian		Produced with the Ministry of Health as part of Family Education Package. FFL messages extensively broadcast on Mongol Radio after training and orientation.	UNICEF, c/o UNDP, 7 Eldev-Ochir St, Sukhebaatar Region, Ulaan Baatar, Mongolia
Morocco	French Arabic	Tuberculosis Sexual Diseases Nicotine Addiction Oral Hygiene	Individual booklets and audio cassettes.	UNICEF 28, Rue Oum Rabia Agdal, Rabat, Morocco
Mozambique	Portuguese, Xitswa Emakhuwa, Shimakonde	Peace Education Child Rights	Daily Radio Mzambique programme on FFL, child rights, peace education. Three children's books in Portuguese and Ciutewe widely distributed through MoH/MoE.	UNICEF Caixa Postal 4713 Maputo, Mozambique
Myanmar	Burmese, Chin, Kachin, S'Gaw, Kayin, Shan, Mon, Po	IDD	Primary school health education kit. Evaluation of FFL revealed need for training, training materials and development of additional topics.	UNICEF P.O. Box 1435 Yangon, Myanmar
Namibia	Nama-Damara, Oshiherro Oshidonga, Kwanyama, Afrikaans			UNICEF P.O. Box 1706 Windhoek, Namibia

Country	Languages	Extra features	Comments	Address
Nepal	Nepali Maithili Bhojpuri Newari	Environment Accidents Leprosy TB	Standard and school editions of FFL.	UNICEF UN Building, Pulchowk Kathmandu, Nepal
Niger	French			UNICEF, B.P. 12.481 Niamey, Niger
Nigeria	Hausa Yoruba Igbo Pidgin English, Tiv	Guinea Worm	FFL extensively incorporated into radio, television dramas and soap operas, newspapers, comic strips, theatre groups, poetry, songs. Pictorial version also developed.	UNICEF P.O. Box 1282 Lagos, Nigeria
Oman	Arabic English	Disabilities, Family Safety, Inherited Diseases, Life Styles, Environment	Resource booklets, slide sets and flip charts produced for training on FFL topics.	UNICEF, P.O. Box 6787, Ruwi, Muscat, Oman
Pakistan	Urdu, Sindhi Dari, Pashto			UNICEF P.O. Box 1063 Islamabad, Pakistan
Papua New Guinea	English Pidgin English	TB	Teachers' guide and literacy materials developed. Daily radio quiz programme.	UNICEF, P.O. Box 472, Musgrave Street, Port Moresby, Papua New Guinea
Peru	Spanish		FFL provides central themes for a national literacy project disseminated through literacy groups, community centres and BBC radio in Andean region.	UNICEF P.O. Box 18-0573 Lima, Peru
Philippines	English, Ilocano, Pilipino, Tausug, Cebuano, Yakan, Maranao, Hiligaynon	TB Iodine Deficiency	Adaptation developed for Muslim religious leaders.	UNICEF, P.O. Box 7429 Airmail Distribution Centre, NAIA, 300 Pasay City, Philippines
Rwanda	Kinyarwanda	Trauma	Revised edition issued 1995.	UNICEF, BP 381 Kigali, Rwanda
Saudi Arabia	Arabic		FFL colouring books distributed through waiting-rooms at health centres.	UNICEF P.O. Box 18009 Riyadh 11415, Saudi Arabia

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Sierra Leone	Krio, Limba, Temne, Mende, English		FFL training for health workers, religious leaders, TBAs, community volunteers, teachers and social workers. Special adaptation for illiterates.	UNICEF, c/o UNDP, P.O. Box 1011, Freetown, Sierra Leone
South Africa	Zulu, Xhosa, Afrikaans Setswana, Sotho, Sipedi, Sindebele, Siswati Tsonga, Shagaan	Bilharzia Accident Prevention	Launched 1994 by National Children's Rights Committee and Centre for Health and Social Studies. *Soul City* multimedia communication project draws on FFL topics.	UNICEF, P.O. Box 4884 Pretoria, 0001, South Africa
Sri Lanka	Sinhala Tamil	Japanese Encephalitis Dengue Haemorrhagic Fever Filariasis, Accidents	Adapting *Children for Health* into local languages. *Child Care in Buddhism* booklet also produced.	UNICEF P.O. Box 143 Colombo, Sri Lanka
Sudan	Arabic		Third edition FFL. FFL Artist Manual. FFL Integrated into Water Manual and School Package. 'Theatre for Life' plays with FFL themes. Post Literacy Booklets on FFL topics.	UNICEF P.O. Box 1358 Khartoum, Sudan
Swaziland	Siswati	Bilharzia Mental Disability Oral Hygiene Tuberculosis		UNICEF P.O. Box 1859 Mbabane, Swaziland
Syria	Arabic English	Accidents Girl Child	Children's version. Working women's adaptation. FFL used in literacy activities.	UNICEF P.O. Box 9413 Damascus, Syria
Tanzania	Swahili	Micronutrients	Launched by President in 1991. Weekly radio programme on air since 1994. Documentary video. Village Health Workers Communication Kit developed to provoke discussion of local problems and solutions.	UNICEF P.O. Box 4976 Dar es Salaam, Tanzania
Thailand	English Yawi	Mosquito-borne diseases, Child Mental Health		UNICEF P.O. Box 2-154 Bangkok 10200, Thailand
Togo	French, Ewe Kabye, Tem Ben	Guinea Worm, Handpump Maintenance		UNICEF P.O. Box 80927 Lome, Togo

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Tunisia	Tunisian			UNICEF, BP 008, El Manar III Tunis 2092, Tunisie
Turkey	Turkish	Accidents TB	FFL being utilized in school curricula through collaboration of Ministries of Health and Education.	UNICEF PKC 17 Cankaya Ankara, Turkey
Uganda	English, Luganda Runyankole, Rukiga	Expanded AIDS chapter. Q&A on each topic	FFL being used as starting-point for integrated communication strategy to facilitate behaviour change.	UNICEF, P.O. Box 7047 Kampala, Uganda
Vanuatu	Bislama		Produced by Save the Children/Ministry of Health. Training workshops with emphasis on participation for health workers and NGOs. Messages reinforced through discussion and role-play as community does not have a reading tradition.	Save the Children Australia Vanuatu Field Office, P.O. Box 283, Port Vila, Vanuatu
Viet Nam	Vietnamese, Tay-Nung, Thai, H'Mong, Bana Giarai		Women's credit programme combined with training on FFL to enhance benefits.	UNICEF Hanoi, c/o UNICEF Bangkok, P.O. Box 2-154, Bangkok, Thailand
Yemen	Yemeni		*Musid and Musida* radio programmes incorporate FFL messages. FFL being incorporated into education curricula.	UNICEF, P.O. Box 725 Sana'a, Yemen
Federal Republic of Yugoslavia	Serbian (Cyrilic Alphabet) Albanian			UNICEF Svetozara Markovica 58 11000 Belgrade, Yugoslavia
Zaire	Lingala, Kiswahili, Chiluba, Kokongo, Mashi	Iodine Deficiency Onchoceriasis Trypanosomaise		UNICEF, BP 7248 Kinshasa, Zaire
Zambia	English, Nyanja Bemba, Tonga, Lozi, Kaonde, Luvale, Lunda	Cholera	*Children for Health* being used with primary school teachers. Local versions to be developed.	UNICEF P.O. Box 33610 Lusaka, Zambia
Zimbabwe	Shona Ndebele			UNICEF PO Box 1250 Harare, Zimbabwe

Appendix 2: Facts for Life chapters and the top ten messages

There are 11 Chapters in *Facts for Life*, namely: *Timing Births, Safe Motherhood, Breastfeeding, Child Growth, Immunization, Diarrhoea, Coughs and Colds, Hygiene, Malaria, AIDS, and Child Development.*

The top ten messages distilled from Facts for Life

1 *The health of both women and children can be significantly improved by spacing births at least two years apart, by avoiding pregnancies before the age of 18, and by limiting the total number of pregnancies to four.*

2 *To reduce the dangers of child-bearing, all pregnant women should go to a health worker for prenatal care, and all births should be assisted by a trained person.*

3 *For the first few months of a baby's life, breastmilk alone is the best possible food and drink. Infants need other foods, in addition to breastmilk, when they are about six months old.*

4 *Children under three have special feeding needs. They need to eat five or six times a day and their food should be specially enriched by adding mashed vegetables and small amounts of fats and oils.*

5 *Diarrhoea can kill by draining too much liquid from a child's body. So the liquid lost each time the child passes a watery stool must be replaced by giving the child plenty of the right liquids to drink — breastmilk, diluted gruel, soup, or a special drink called ORS. If the illness is more serious than usual, the child needs help from a health worker — and the special ORS drink. A child with diarrhoea also needs food to make a good recovery.*

6 *Immunization protects against several diseases that can cause poor growth, disability and death. All immunizations should be completed in the first year of a child's life. Every woman of child-bearing age should be immunized against tetanus.*

7 *Most coughs and colds will get better on their own. But if a child with a cough is breathing much more rapidly than is normal, then the child is seriously ill, and it is essential to go to a health centre quickly. A child with a cough or cold should be helped to eat and to drink plenty of liquids.*

8 *Many illnesses are caused because germs enter the mouth. This can be prevented by using latrines; by washing hands with soap and water after using the latrine and before handling food; by keeping food and water clean; and by boiling drinking water if it is not from a safe piped-water supply.*

9 *Illnesses hold back a child's growth. After an illness, a child needs an extra meal every day for a week to make up the growth lost. Children from birth to the age of three years should be weighed every month. If there is no gain in weight for two months, something is wrong.*

10 *AIDS is a fatal and incurable disease that is passed on mainly by sexual intercourse. Intercourse is safe if both partners are free of infection and if they only have sex with each other. If in doubt, sexual intercourse can be made safer by using a condom.*

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Children for Health

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